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Implementing the open disclosure of adverse events in Australia through a Mediation Model

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Adverse events happen

The practice of medicine is a risky business. The 1995 Quality in Australian Health Care Study (QAHCS)[1] indicated that 16.6% of people experienced an adverse event associated with their care. In 13.7% of these cases there was permanent disability, and 4.9% resulted in death. Fifty-one percent of the adverse events reported in the QAHCS were considered preventable. Following a comparison of methods with a similar American study, the QAHCS data was subsequently re-analysed to allow for international benchmarking which indicated an Australian adverse event rate of 10.6%[2], which is comparable with findings in the United Kingdom, United States of America, New Zealand, and Denmark[3]. The First National Report on Australian Patient Safely 2001[4] noted that re - analysis of the QAHCS study found that the Australian and US studies had a virtually identical rate of serious adverse events, totalling about 2% of cases - 1.7% leading to serious disability and 0.3% to death[5].

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[1] R Wilson, W Runciman, R Gibberd, B Harrison, L Newby and J Hamilton, "The Quality in Australian Health Care Study: Iatrogenic Injuries or adverse patient events in hospitalised patients" (1995) 163 (9) *Medical Journal of Australia* 458.

[2] E Thomas, D Studdert, W Runciman, RK Webb, RM Wilson et al, "A comparison of iatrogenic injury studies in Australia and the USA", (2000) 12(5) *International. Journal of Quality in Health Care* 371-378; W Runciman, R Webb, A Helps, E Thomas, E Sexton, D Studdert, T Brennan "A comparison of iatrogenic studies in Australia and the USA II: reviewer behaviour and quality of care", (2000) 12(5) *International. Journal of Quality in Health Care* 379-388.

[3] ACSQHC; http://www.safetyandquality.org/articles/Action/advrsefact.pdf. For a helpful analysis of the incidence of adverse events in Canada, United States, United Kingdom, Australia and New Zealand, see J Gilmour, 'Patient Safety, Medical Error and Tort Law: An International Comparison', Final Report prepared for the Health Policy Research Program, Health Canada (May, 2006), http://www.yorku.ca/osgoode/faculty/documents/FinalReport_Full.pdf, 12 April 2007.

[4] http://www.safetyandquality.org/articles/Publications/firstreport.pdf

[5] For a recent international comparison see D Hindle J Braithwaite, J Travaglia, R Iedema "Patient Safety: A Comparative Analysis of Eight Inquiries in six Countries", 2006, Centre for Clinical Governance Research, Faculty of Medicine, University of NSW, Sydney

As a result of these statistics there is currently a high level of interest and activity in Australian health care around the management of adverse events. Ethical obligations, legal duties and practical guidelines have emerged requiring the open disclosure of adverse events to improve the quality of health care provision and to increase patient safety[6].

An "adverse event" has been defined as "an incident in which unintended harm resulted to a person receiving health care"[7] and open disclosure as "the open discussion of incidents that result in harm to a patient while receiving health care[8]." The primary goals of the open disclosure movement are to ensure that patients are made aware of medical errors (to enable proper treatment and compensation), to identify systemic problems and to minimise litigation.

Routine disclosure is inevitable

The elements of open disclosure are an expression of regret, a factual explanation of what happened, an explanation of the potential consequences and the steps being taken to manage the event and prevent recurrence[9].

In Australia, practical guidelines for the open disclosure of adverse events to patients have been in place for some time. In recent years State and Territory medical boards have adopted Codes of Conduct which include provisions concerning the disclosure of medical error, although the published Code of

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[6] For a discussion see B Madden and T Cockburn "Bundaberg and beyond: duty to disclose adverse events to patients" (2007) 14(4) May *Journal of Law and Medicine* 501-27

[7] Australian Council for Safety and Quality in Health Care (ACSQHC), *Open Disclosure Standard* (2003) http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/F87404B9B00D8E6CCA2571C60000F049/$File/OpenDisclosure_web.pdf, at 12 April 2007, at 3 (Key Terms) at p6. For a summary of definitions of other key terms in this field, see W Runciman, "Shared meanings: preferred terms and definitions for safety and quality concepts" (2006) 184 (10) *Medical Journal of Australia* 41, available online at http://www.mja.com.au/public/issues/184_10_150506/run11055_fm.html, 21 April 2007

[8] Australian Council for Safety and Quality in Health Care (ACSQHC), *Open Disclosure Standard* (2003) http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/F87404B9B00D8E6CCA2571C60000F049/$File/OpenDisclosure_web.pdf, 12 April, 2007, 1

[9] ACSQHC, National Open Disclosure Standard Fact Sheet, http://www.safetyandquality.org/internet/safety/publishing.nsf/Content/6A2AB719D72945A4CA2571C5001E5610/$File/opendisclfact.pdf, 12 April 2007

Ethics of the Australian Medical Association (AMA)[10] has not yet been modified to incorporate express disclosure obligations[11]. The law relating to disclosure of adverse events is not yet clear; while there have been cases in other jurisdictions in this area, there is a dearth of Australian authority. In particular, despite some statutory protection for apologies[12], there is no corresponding express statutory duty to disclose adverse events in Australia[13], as is the position in some parts of the United States[14].

Given that the Australian system of accident compensation is fault based and focuses on the individual responsibility of health care providers, as opposed to attributing responsibility to the system within which they operate[15], a significant barrier to compliance with requirements to report error and disclose harm to patients appears to be the fear of increased litigation, although there is little evidence to support this view.

"The clash between tort law and the patient safety movement undermines efforts to improve quality. Concern about exposure to malpractice litigation diminishes interest in patient safety activities. … This reluctance is manifested in several ways, but two of the most important are underreporting to adverse

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[10] AMA Code of Ethics 2004, editorially revised 2006, http://www.ama.com.au/web.nsf/doc/WEEN-6VL8CP, at 28 January 2007

[11] By contrast, the American Medical Association's published set of principles of medical ethics contain express disclosure obligations: E-8.12 Patient Information, www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/E-8.12.HTM&&s_t=&st_p=&nth=1&prev_pol=policyfiles/HnE/E-7.05.HTM&nxt_pol=policyfiles/HnE/E-8.01.HTM&, at 18 January 2007.

[12] The legislation is not uniform: see *Civil Liability Act 2003 (Qld)* ss68-72; *Civil Liability Act 2002 (WA)* ss5AF-5AH; *Civil Liability Act 2002 (Tas)* s7; *Civil Law (Wrongs Act) 2002 (ACT)* ss12-14; *Personal Injuries (Liabilities and Damages) Act 2003 (NT)* s13, ss11,12 cf *Wrongs Act 1958 (Vic)* s14I-14J (not admission but still admissible); *Civil Liability Act 1936 (SA)* s75 (not admission only). See P Vines "Apologising to avoid liability: cynical civility or practical morality?" (2005) 27 (3) *Sydney Law Review* 483

[13] Liability may arise for nondisclosure on the basis that silence may amount to a misrepresentation under the *Trade Practices Act 1974 (Cth)* or *Fair Trading Acts.*

[14] Eg *New Jersey Patient Safety Act* 26:2H-12.25(3)(d)N.J.S.A. 26:2H-12.23 et seq; *Pennsylvania Medical Care Availability and Reduction of Error (Mcare) Act (2002)* Act 13 of 2002 s308.

[15] This issue was considered by B Walker, Special Commissioner, 'Final Report of the Special Commission of Inquiry into Campbelltown and Camden Hospitals' July 30, 2004 online at HTUhttp://www.lawlink.nsw.gov.au/lawlink/Corporate/ll_corporate.nsf/pages/sci_final_reportUTH (last accessed Dec. 2004). As to the question of systemic versus individual accountability, Walker SC concluded that this was a false dichotomy –and that both forms of accountability are essential and can co-exist. This issue is discussed by J Gilmour, 'Patient Safety, Medical Error and Tort Law: An International Comparison', Final Report prepared for the Health Policy Research Program, Health Canada (May, 2006), http://www.yorku.ca/osgoode/faculty/documents/FinalReport_Full.pdf, 12 April 2007. 4, 82-183

event reporting systems and lack of communication with patients about errors[16]."

This fear persists even though many Australian jurisdictions have enacted legislation conferring some statutory protection for those who apologize or express regret to patients following an adverse event or outcome. Unfortunately the legislation is not uniform, and, except in New South Wales and the Australian Capital Territory, there is no statutory protection for apologies which include an admission of fault.

Implementing Disclosure is difficult – a mediation model may be the way forward…

The mediation model of open disclosure is a template which encourages "physicians, hospital administrators, and other health care providers to communicate more effectively with patients following an adverse event or medical error, learn from mistakes, respond to the needs and concerns of patients and families after an adverse event, and reach a fair and cost-effective resolution of valid claims[17].

Pioneered by Leibman and Hyman, this model of disclosure was introduced in a New York hospital shortly after Pennsylvania became the first state to impose a duty on hospitals to notify patients in writing of a "serious event" in 2002.

Their recommendations following the study were:

(1) that physicians and other health care professionals develop an awareness of the communication skills most likely to be useful during disclosure conversations;

(2) that hospitals develop in-house process experts available as consultants to aid in planning, conducting and debriefing disclosure conversations;

(3) that hospitals encourage physicians, patient safety officers and risk managers to spend time planning before conducting disclosure conversations;

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[16] D Studdert, M Mello and T Brennan "Medical Malpractice" (2004) 350 (3) *New England Journal of Medicine* 283 at 287

[17] C Liebman and C Hyman "A Mediation Skills Model to Manage Disclosure Of Errors and Adverse Events to Patients" *Health Affairs,* 23, no.4 (2004) 22-32.)

(4) that physicians, hospital leaders and other health care providers offer an appropriate apology after an adverse event or error;
(5) that hospitals and senior physicians provide opportunities for debriefing and support for health care professionals after an error; and
(6) that hospitals use mediation as soon as practicable after an adverse event to settle potential claims.

In addition they commented that whilst doctors have experience in delivering bad news and discussing hard choices with patients, these skills need to be supplemented with active listening and conflict resolution skills in the disclosure conversation.

In this sense the term “mediation model” means an extension of the effective communication skills typically utilised in mediation to the delivery and conduct of disclosure discussions. It does not contemplate the conduct of a structured mediation session in the course of the disclosure conversation and it is acknowledged that a full mediation process is more appropriately conducted at a later stage when the questions of liability and compensation can be properly assessed and addressed. Rather the mediation model of disclosure enables the medical practitioner to engage in open discussions and make benevolent gestures to meet the injured patient’s immediate needs without fear of being denied indemnity for any legal liability that may later be established.

Mediation theory and research suggests that the application of mediation type skills such as open questioning, empathy and active listening which reflects back and acknowledges the emotions of the speaker are likely to enhance the effectiveness of the disclosure conversation in the following ways: the promotion of interest based solutions to meet the immediate needs of the affected patient and their family;

- the sharing of information at an early stage to promote discovery of systemic problems and to prevent recurrence;

- reduced anger and punishment behaviour[18];
- reduced litigation; and
- maintenance and protection of the physician-patient relationship after an adverse event.

Whilst investigative conversations aimed at litigation are about allocating blame or liability for what has happened in the past, mediation conversations are more focused on creating solutions for the future. It is suggested that this change of paradigm introduced by mediation type skills at this early stage could change the focus of the disclosure conversation to concentrate on interests and the sharing of information rather than positions and limited disclosure for fear of litigation.

Ironically, the available research suggests that it is not the quality of medical care that leads to litigation, but factors such as:

- Families' perceptions that the physician was not completely honest;
- the inability of family members to get anyone to tell them what happened; and
- the sense among family members that the physician would not listen[19].

The suggestion that more effective management of the disclosure conversation could affect the desire to litigate it is founded in research around what motivates people in conflict and why people choose to escalate conflict to the litigation stage. This is particularly interesting in the context of medical negligence cases where plaintiffs are often hampered by both financial and information power imbalances which should be deterrents to litigating against wealthy and well informed health care providers.

Dauer, Marcus and Payne suggest that those patients who bring these types of claims are often motivated by feelings of anger and the need for rectitude[20], whilst financial concerns explain only a part of their behaviour.

Professor Frank Sloane's research also suggests that those wanting compensation are more likely to choose non-adversarial dispute resolution processes whilst those wanting retribution are more likely to choose litigation. According to Sloane, along with retribution come the desire that the error that happened this time should not occur again and "the need to find out – in the

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[18] An explanation (emphasizing that the cause of negative behaviour was external or uncontrollable) reduces anger and punishment behaviour see: RJ Bies,and DL Shapiro,"Interactional Fairness Judgments: The Influence of Causal Accounts" *Social Justice Research,* 1987*, 1,* 199218.

[19] C Liebman and C Hyman "A Mediation Skills Model to Manage Disclosure Of Errors and Adverse Events to Patients" *Health Affairs*, 23, no.4 (2004) 22-32.)

[20] Dauer EA, Marcus LJ and Payne SMC, "Prometheus and the Litigators A mediation Odyssey" 2000 *The Journal of Legal Medicine, 21; 159-186.-*

face of a recalcitrant system operating in a closed and defensive mode – exactly what it was that happened to cause the injury"[21].

This is an abridged version of a 90 minute workshop session. The full version of this paper discusses the ethical and legal foundations for disclosure of adverse events in Australia, the current status of the law governing apologies and their impact on the litigation of these cases, the potential benefits of an early intervention/mediation disclosure model and recommendations in relation to the way it should be implemented by health professionals in Australia.

[21] Frank S**loane et al The Road from Medical Injury to claims resolution: how no fault and tort differ, 60 LAW & Contemp. Probs.35(Spring 1997)**