

Guidance on Open Disclosure Policies

HDC wishes to promote a clear and consistent approach by DHBs to open disclosure. It is what consumers want and are entitled to. Right 6 of the Code of Health and Disability Services Consumers' Rights gives all consumers the right to be fully informed (ie, to receive the information that a reasonable consumer in his or her situation would expect to receive). Consumers have a right to know what has happened to them.

Internationally, there is a move towards the development of national standards and hospital policies to promote open disclosure. DHBs have a legal duty to take steps to ensure that open disclosure is practised by staff and supported by management. Part of HDC's Strategic Plan 2006–2010 includes the target that all DHBs will have open disclosure policies in place by 2010.

Set out below are guiding points that DHBs should include when developing such policies:

WHAT SHOULD OPEN DISCLOSURE INCLUDE?

- A consumer should be informed about any adverse event, ie, when the consumer has suffered any unintended harm while receiving health care.¹
- An error that affected the consumer's care but does not appear to have caused harm may also need to be disclosed to the consumer. Notification of an error may be relevant to future care decisions — whether or not to go ahead with the same procedure on another occasion. The effects of an error may not be immediately apparent.
- A disclosure should include acknowledgement of the incident, an explanation of what happened, how it happened, why it happened and, where appropriate, what actions have been taken to prevent it happening again. (In some situations specific actions will need to be taken straight away, whereas in other situations where the explanation is still unfolding, the actions that need to be taken may take longer to identify.)
- A disclosure should include a sincere apology. This is the provider's opportunity to say, "We are sorry this happened to you." It is not about allocating blame for the event's occurrence, but acknowledging the seriousness of an adverse event and the distress that it causes. Apologies can bring considerable comfort to the consumer and have the potential to assist with healing and resolution.² In some situations, an apology may be critical to the consumer's decision about whether to lay a formal complaint and pursue the matter further.
- The consumer should be given contact details and information about the local health and disability consumer advocate as well as options for making a complaint.

¹ Massachusetts Coalition for the Prevention of Medical Errors *When things go wrong: responding to adverse events* (2006) 4.

² See D Frenkel and C Leibman "Words that heal" (2004) 140 *Annals of Internal Medicine* 482; J Robbenolt "Apologies and legal settlement: an empirical examination" [2003] *Michigan Law Review* 102.

WHY IS OPEN DISCLOSURE IMPORTANT?

- Because ethically and legally it is the right thing to do.³
- There are a number of rights under the Code of Health and Disability Services Consumers' Rights (the Code) that are relevant to open disclosure (see below).
- Open disclosure:
 - affirms consumers' rights;
 - fosters open and honest professional relationships; and
 - enables systems to change to improve service quality and consumer safety.
- Because the physical harm from an adverse event is often compounded by an emotional or psychological harm when consumers discover that relevant information has been withheld from them.⁴
- Consumers want to know when things go wrong and why, and DHBs have a legal duty to promote the disclosure of such information in accordance with their organisational duty of care.
- Consumers want to know what the consequences could be for them and their ongoing care. It is important to discuss how the event could change anticipated care and any effects the consumer may experience as a result.
- Consumers are also interested in any action taken as a result of the error or adverse event. Many are concerned that the same thing does not happen to anyone else, that changes are made to the healthcare system, and that staff learn from the experience.⁵
- It also helps ensure consumers are advised that they may be entitled to compensation under ACC, so appropriate forms can be completed in a timely manner.

WHO SHOULD BE INVOLVED IN THE DISCLOSURE?

- The health professional with overall responsibility for the consumer's care should usually disclose the incident.
- Research suggests that consumers prefer to hear from a practitioner whom they have already seen, and with whom they have built a rapport. Where this is not the health professional with overall responsibility, both practitioners should be in attendance.⁶
- Research suggests that disclosures by hospital administrative staff or management alone are not well received, although in some cases, particularly where significant harm has resulted, it may be appropriate for senior management to attend with clinicians.

³ See R Lamb "Open disclosure: the only approach to medical error" (2004) 14 *Quality and Safety in Health Care* 3.

⁴ See C Vincent and A Coulter "Patient safety: what about the patient?" (2002) *Quality and Safety in Healthcare* 11(1): 76–80.

⁵ M Bismark, E Dauer, R Paterson and D Studdert "Accountability sought by patients following adverse events from medical care: the New Zealand experience" (2006) 175 *CMAJ* 889; M Bismark and R Paterson "'Doing the right thing' after an adverse event" (2005) 1219 *NZMJ* 55; A Witman, D Park and S Hardin "How do patients want physicians to handle mistakes? A survey of internal medicine patients in an academic setting" (1996) 156 *Archives of Internal Medicine* 2565; M Higorai, T Wong, G Vafidis "Patients' and doctors' attitudes to amount of information given after unintended injury during treatment: cross-sectional, questionnaire survey" (1994) 318 *BMJ* 640.

⁶ *Disclosure of harm 'Good Medical Practice'*, New Zealand Medical Council, December 2004 (available at www.mcnz.org.nz).

WHEN/WHERE SHOULD THE DISCLOSURE TAKE PLACE?

- Disclosure should be made in a timely manner, usually within 24 hours of the event occurring, or of the harm or error being recognised.
- Although disclosure to the consumer concerned should not occur until he or she is medically stable enough to absorb the information and is in an appropriate setting, there is likely to be a suitable person (ie, someone who is interested in the welfare of the consumer and is available) who should be informed. This may include an enduring power of attorney or legal guardian.
- In the immediate aftermath of an adverse event, providers may be searching for answers too. In these circumstances it is appropriate to acknowledge the limits of what is known, and to make a commitment to sharing further information as it becomes available.⁷
- It is important to emphasise that open disclosure is not a single conversation, but a process of ongoing communication. Communication should continue until the consumer has all the information and support needed.
- If the incident occurred in a team environment, it may be beneficial for the team to meet prior to the disclosure taking place. The Medical Council of New Zealand's guidelines for doctors suggest that the team meet to discuss:⁸
 - what happened
 - how it happened
 - the consequences for the consumer, including continuity of care
 - what will be done to avoid similar occurrences in the future
 - who should be present when the harm is disclosed to the consumer.
- It might not be possible, however, for the team to discuss the incident and any harm before a discussion with the consumer takes place. An opportunity for the team to debrief should not unreasonably delay the consumer's (or his or her representative's) receipt of information.
- It may be appropriate for an early initial disclosure to occur, followed by a more detailed discussion with the consumer once the team has had an opportunity to meet.

HOW SHOULD OPEN DISCLOSURE TAKE PLACE?

- Disclosures should generally be made to the individual consumer and any family/whanau/key support people the consumer wishes to have present.
- In some situations where the consumer has died or been significantly compromised, disclosure will need to be made to a third party.
- In circumstances where discussion with the consumer is not possible or appropriate, his or her next of kin, designated contact person, or representative should be informed.
- Consideration must be given to the consumer's cultural and ethnic identity and first language, and the support needed.
- Details about the incident and any harm, the disclosure, and any subsequent action should be fully documented in the consumer's records.
- It is important that health professionals and other personnel involved also have access to support. Numerous studies have shown that most errors are made by

⁷ M Bismark and R Paterson "‘Doing the right thing’ after an adverse event" (2005) 1219 *NZMJ* 55.

⁸ *Disclosure of harm ‘Good Medical Practice’*, New Zealand Medical Council, December 2004 (available at www.mcnz.org.nz).

well-trained people who are trying to do their job, but are caught in a flawed system that predisposes towards mistakes being made.⁹

- DHBs need to take steps to ensure that the policy is applied in practice. Ongoing staff training on open disclosure needs to take place so that staff are able to respond promptly and confidently when things go wrong. Staff, health practitioners with independent access agreements, and relevant contractors also need to be aware of the policy, and adequately trained and supported in its implementation.
- Training in communication is especially important.¹⁰ An adverse event or incident is emotionally charged for all parties, and specific skills are required to deliver bad news in a sincere, compassionate and thoughtful way. Effective communication and empathy is pivotal to the open disclosure process.¹¹

RELEVANT RIGHTS UNDER THE CODE

- Right 1 provides that consumers have the right to be treated with respect. Respect requires a truthful and sensitive discussion about any harm or incident affecting the consumer.
- Under Right 4(1) a DHB has an obligation to provide health services with reasonable care and skill. This organisational duty of care includes the need to have a policy on open disclosure that is well understood and implemented by all personnel.
- The provision of information in a form, language, and manner that enables the consumer to understand the information provided is required by Right 5(1). Right 5(2) also applies as it requires an environment supporting open, honest and effective communication.
- Right 6(1) affirms the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive. It is seldom reasonable to withhold information about a consumer from that consumer.
- A health practitioner has a professional and ethical duty of open disclosure under Right 6(1)(e).
- Right 6(3) gives consumers the right to honest and accurate answers to questions relating to services, including information about the identity and qualifications of providers and how to obtain an opinion from another provider.
- Right 6(4) gives consumers the right to receive, on request, a written summary of information provided.
- Right 8 — the right to have a support person(s) present — is particularly relevant in distressing situations and when people receive bad news or a shock.
- Right 10 also applies as it is important for the DHB to ensure that consumers are made aware of their right to complain and provided with information about the complaint process and their options.

⁹ L Leape "Preventing Medical Accidents: Is 'systems analysis' the answer?" (2001) 27 *American Journal of Law and Medicine* 145.

¹⁰ See Massachusetts Coalition for the Prevention of Medical Errors *When things go wrong: responding to adverse events* (2006) 19.

¹¹ See Australian Council for Safety and Quality in Healthcare *Open disclosure: health care professionals handbook* (2003) 13.