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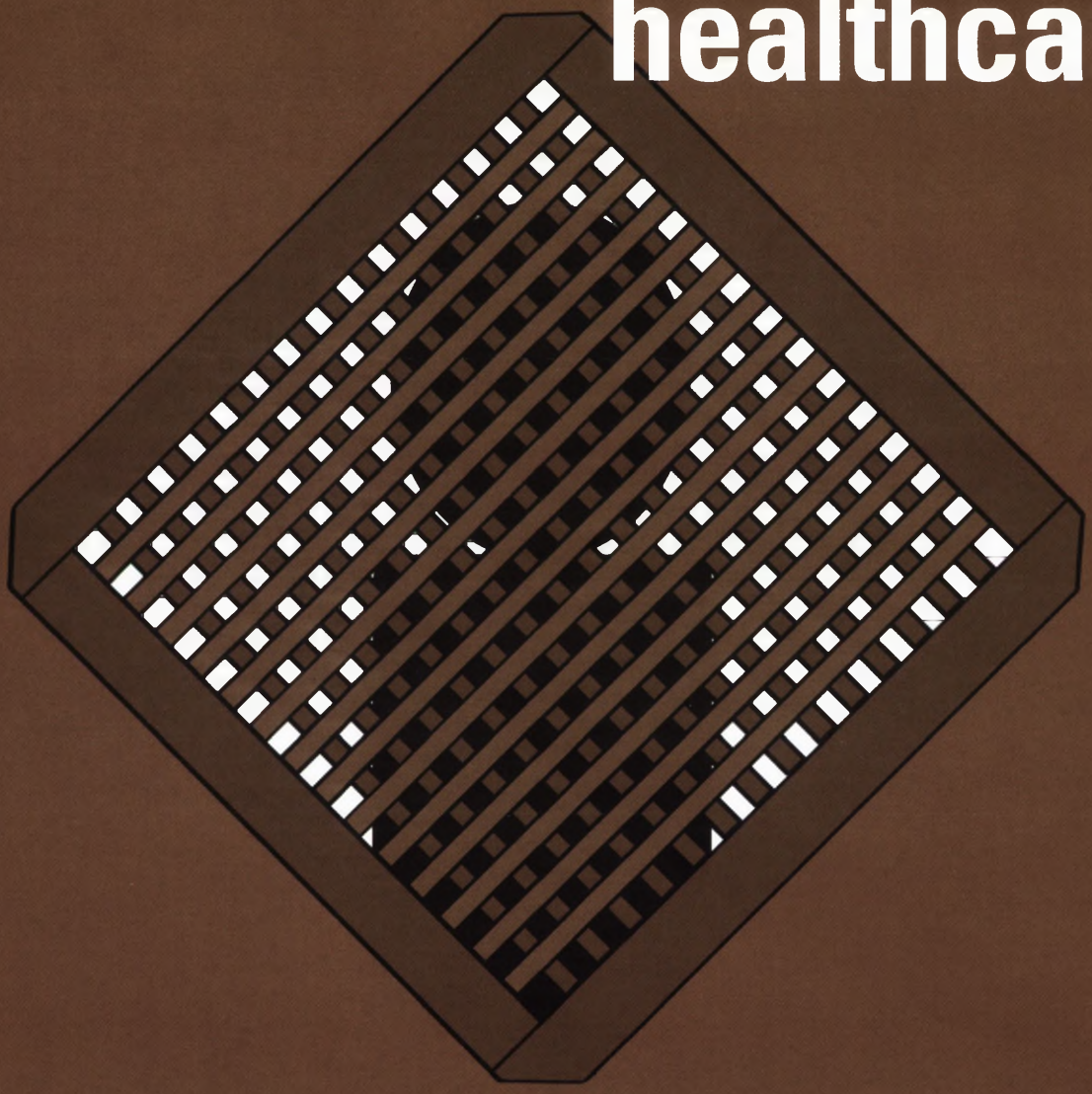
# The insurance implications of open disclosure in healthcare



Open disclosure is the '...open discussion of incidents that result in harm to a patient while receiving health care'.[1]



In contrast to as little as a decade ago, open disclosure is now regularly the subject of government policies, professional conferences and academic publications.[2] Open disclosure has been advocated since the late 1980s for a variety of reasons, including organisational and legal risk management considerations and, more recently, the need to show respect for the feelings and dignity of victims of adverse events.[3] This article examines the insurance and other legal implications of open disclosure in Australia.

## A BRIEF HISTORY OF OPEN DISCLOSURE IN AUSTRALIA

Open disclosure entered the national policy agenda as one dimension of improved clinical incident management, in a climate of new awareness of the frequency of adverse events >>

and a national litigation crisis.[4] The Australian Open Disclosure Standard (the Standard) was published in 2003,[5] following endorsement by the Australian Health Ministers' Conference. The intention of the Standard is to facilitate more consistent and effective communication after adverse events. It describes the elements of open disclosure as: an expression of regret, a factual explanation of what happened, consequences of the event, and the steps being taken to manage the event and prevent recurrence.[6] Since publication of the Standard, states have begun to create supportive policy.[7]

In addition to the inconsistency and uncertainty of the protections of the apology laws, qualified privilege laws may affect open disclosure processes.

## A SUMMARY OF THE MAIN LEGAL IMPLICATIONS OF OPEN DISCLOSURE

According to the Medical Indemnity Industry Association of Australia (MIIAA),[8] where an obvious mistake has been made, members might expect the following advice from their medical defence organisation (MDO):

- engage with the patient in discussing the adverse event in a timely manner;
- provide the patient with the known facts on how the incident occurred and what the consequences are for the patient – do not speculate; particularly on causation;
- apologise for what has occurred;
- investigate the incident thoroughly;
- reassure the patient that appropriate steps are being taken to ensure that the error doesn't happen again;
- feed back findings to the patient; and
- document the process.

Although in line with the Standard,[9] implementing such advice is more complex than it first appears, because several legal issues impact upon open disclosure. In the context of insurance, the main legal issue is the potential for open disclosure to trigger an admission clause in the insurance contract. This possibility arises for three main reasons. First, state and territory apology laws provide inconsistent protections to expressions of regret and admission of responsibility. Secondly, despite apology laws existing in all states and territories, there is a lack of awareness among clinicians about their existence. Thirdly, clinicians feel unprotected because qualified privilege laws do not apply to information conveyed in the open disclosure process.

As many of the legal issues relating to open disclosure have not been tested by the courts, there is little guidance for health service-providers and professionals through the legal complexities of conducting open disclosure. As a result, in a fault-based legal system, healthcare organisations and clinical staff find themselves in a challenging situation, having to discuss adverse events with victims and offer apologies. In essence, open disclosure confronts healthcare staff with tensions between openness about what went wrong and vulnerability to legal action by victims and/or their families. Some of the main legal issues impacting upon open disclosure are discussed below.

### Admission clauses

Many insurance contracts contain a clause that prevents the insured from making an admission, or an admission of liability, or from compromising a claim without the consent of the insurer. Such a clause is known as an 'admissions and compromises' clause. In many cases, an insurance contract will provide that the insurer may refuse to pay the claim in respect of certain acts (including, for example, breach of an admissions and compromises clause). An apology admitting fault made in the course of an open disclosure process may therefore be perceived as triggering the admissions clause and result in the insurer refusing to indemnify and/or provide legal representation or assistance in relation to any court or other proceedings arising from the incident.

The problem with admissions clauses arguably stems from the degree of ambiguity and inconsistency in the application of apology laws to open disclosure.

### Apology laws

The Standard mandates that an 'expression of regret' – defined as 'an expression of sorrow for the harm experienced by the patient' – be given to the victim of the adverse event.[10] All Australian states and territories have apology legislation in place to protect statements of apology or regret made after 'incidents' from subsequent use in various legal contexts.[11]

However, the scope of protection provided in the legislation in each jurisdiction varies. A basic 'I am sorry' will be protected in most circumstances in all jurisdictions. However, an apology including admission of responsibility is protected only in the ACT and NSW.[12] Also, the legislation varies in relation to the protection given to whether the apology is relevant to any determination of fault and liability and whether it is admissible as such.[13] This is similar to the position in America, where most US states with apology legislation protect only the expression of regret. This has led Gallagher and colleagues[14] to speculate that apology legislation is a useful policy endorsement of open disclosure, but will have little influence on promoting open disclosure communication. Similarly, Studdert and Richardson[15] state that, as a shield, Australian apology laws are neither large nor thick. Their variability (across jurisdictions) and inherently selective nature (in addressing only one element of open disclosure – the expression of regret) limit their reach.

Despite the limited scope of protection, the literature on apology[16] makes the point that the legal concerns about an apology constituting an admission of liability may be overstated. Even if an apology constituted an admission at the time it was given, legally that admission is not

conclusive.[17] The apology is one piece of evidence that has to be weighed up with all the other evidence in the case. It is for the courts to find whether, on all the evidence in the case, there is or is not legal liability.[18] According to Vines,[19] the courts, even outside of legislative protections, have been loath to find an apology accepting responsibility as evidence of fault in the absence of other evidence.

In addition to the inconsistency and lack of certainty as to the protections afforded by the apology laws, qualified privilege laws may impact upon open disclosure processes.

## Qualified privilege laws

The Commonwealth and all the states and territories have enacted legislation that protects from disclosure to third parties certain information generated by particular 'quality assurance activities' and 'quality assurance committees'.[20] The quality assurance committee, or its equivalent, is defined as a body engaged in quality assurance work and is formally declared by the relevant minister as enjoying qualified privilege.[21]

While the qualified privilege legislation is not uniform in each jurisdiction, all qualified privilege legislation is based on the premise that it is in the public interest that staff cannot be forced to divulge information about adverse events gathered in the course of these activities. This is to help clinicians and the health system to learn from mistakes and to ensure that mistakes do not occur again, without the fear of legal liability.[22]

Open disclosure processes are not quality assurance committees nor declared quality assurance activities. Therefore, the connection between state qualified privilege laws and the open disclosure process is relatively weak.[23] A weakness that, according to Studdert and Richardson,[24] cuts in two directions: On the one hand, it means that qualified privilege laws do not pose major barriers for standard open disclosure practice. Indeed, in most jurisdictions, provided appropriate pathways for releasing information are followed, qualified privilege should not even bar feeding into the open disclosure process information that comes out of quality assurance and root cause analysis activities.[25] On the other hand, the corollary of this weak connection is that existing qualified privilege laws do not provide robust protections over the content of open disclosure conversations.[26]

## Clinicians' and managers' perceptions of apology and privilege laws

Given the current status of apology laws and qualified privilege laws, it is not surprising that the evaluation of the Standard's implementation in 21 pilot sites demonstrated that while supporting open disclosure, clinicians also expressed general concern about the uncertainty of legal implications of open disclosure.[27] Similarly, in a recent survey of 51 health professionals at the forefront of open disclosure practice in Australia, designed to gauge clinicians' views on the medico-legal implications of open disclosure, Studdert, Piper and Iedema detected considerable apprehension about the liability implications of engaging in open disclosure.[28] Fear of medico-legal consequences was perceived to be the leading barrier to open disclosure. More than two-thirds of participants rejected, or only tepidly supported, the proposition that the willingness of health professionals to conduct open disclosure is enhanced by existing laws that protect the information from use in legal proceedings.[29] This is despite the fact that there is, as yet, a lack of empirical evidence in relation to whether or not open disclosure has any impact on litigation for medical negligence.[30]

More specifically, participants were roughly equally divided as to whether apology laws made participants much more or more willing to conduct open disclosure (19/51); somewhat more willing (14/51); or not more willing (18/51).[31] Among those in the third group, a majority (14/18) indicated that lack of awareness of apology laws was a key inhibiting factor. In four states and territories (Western Australia, South Australia, Tasmania and the Northern Territory), a majority of participants was unaware that their own jurisdiction had apology laws that applied to open disclosure.[32] In relation to privilege laws, 30/50 participants correctly viewed them as having limited or no effect on open disclosure.[33]

All but four participants in the Studdert et al study[34] recommended law reforms. The most frequent recommendations were the need to bolster existing protections by strengthening or clarifying them (23/47), particularly qualified privilege laws. The other leading recommendation was to improve education and awareness of existing laws (11/47).[35] >>

## THE NEED FOR REFORM

According to Studdert and Richardson,[36] there is a strong case for law reform. Ideally, those reforms would provide strong, clear and reliable protections against use of the contents of open disclosure conversations in subsequent legal proceedings; clarify that qualified privilege law does not obstruct health professionals' ability to conduct open disclosure; be broadly consistent across jurisdictions, and be accompanied by an effective outreach effort that educates health professionals about what the new laws do.[37]

## CONCLUSION

Open disclosure operates in a legal environment that is perceived to be unsupportive by clinicians and managers. Generally, clinicians' and managers' concerns spring from the potential liability affecting medical practitioners and health service-providers in the Australian fault-based legal system. These concerns are motivated by the uncertain status of the apology, the relationship between other investigative processes attracting qualified privilege to the disclosure process, and the over-arching fault-based philosophy underpinning legal thinking in Australia with regard to adverse events. If open disclosure is to be successfully implemented, it is vital that its legal context supports both the victims of adverse events and the healthcare professionals involved in such events. ■

**Notes:** **1** Australian Council for Safety and Quality in Health Care, *Open Disclosure Standard: A National Standard for Open Communication in Public and Private Hospitals, Following an Adverse Event in Health Care.* Commonwealth of Australia, Canberra, 2003. http://www.safetyandquality.org/internet/safety/publishing.nsf/Content/3D5F114646CEF93DCA2571D5000BFEB7/$File/OpenDisclosure_web.pdf (accessed March 2011). **2** J Conway, 'The Contributions of Patient Advocacy in Patient Safety', in *Patient Advocacy for Health Care Quality: Strategies for Achieving Patient-centred Care*, JAL Earp, EA French, and MB Gilkey (eds), Jones and Bartlett Publishers, Boston, 2008, pp263-88. **3** SS Kraman and G Hamm, 'Risk management: Extreme honesty may be the best policy', *Annals of Internal Medicine*, 131(12), 1999, pp963-7; R Lamb, 'Open disclosure: The only approach to medical error', *Quality and Safety in Health Care*, 13, 2004, pp3-5; A Peterkin, 'Guidelines covering disclosure of errors now in place at Montreal hospital', *Canadian Medical Association Journal*, 142, 1990, pp984-5. **4** R Iedema, N Mallock, R Sorensen, E Manias, A Tuckett, A Williams, B Perrot, S Brownhill, D Piper, S Hor, D Hegney, H Scheeres, C Jorm, 'The national open disclosure pilot: Evaluation of a policy implementation initiative', *Medical Journal of Australia,* 188, 2008, pp397-400. **5** Australian Council for Safety and Quality in Health Care, see note 1 above. **6** *Ibid.* **7** NSW Health, *Policy Directive: Open Disclosure,* NSW Health, Sydney, 2007. http://www.health. nsw.gov.au/policies/pd/2007/pdf/PD2007_040.pdf (accessed March 2011); NSW Health, *Open Disclosure Guidelines*, NSW Health, Sydney, 2007. http://mhcs.health.nsw.gov.au/policies/gl/2007/pdf/GL2007_007.pdf (accessed March 2010); Queensland Health, *Queensland Health Incident Management Implementation Policy,* Queensland Health, Brisbane, 2008. http://www.health.qld.gov.au/qhpolicy/docs/pol/qh-pol-012.pdf (accessed March 2010); Queensland Health, *Clinical Incident Management Implementation Standard,* Queensland Health, Brisbane, 2006. http://www.health.qld.gov.au/patientsafety/documents/cimist.pdf (accessed March 2010); WA Health, *Open Disclosure Policy: Communication and Disclosure Requirements for Health Professionals Working in Western Australia,* WA Health, Perth, 2009. http://www.health.wa.gov.au/circularsnew/attachments/395.pdf (accessed March 2010). **8** C Edwards-Smith, *Open Disclosure: An opportunity missed? (The MDO's perspective)* http://www.miiaa.com.au/__files/f/1190/Chad%20Edwards-Smith%20PowerPoint.pdf (accessed March 2011). **9** Australian Council for Safety and Quality in Health Care, see note 1 above. **10** *Ibid.* **11** *Civil Liability Act* 2002 (WA) ss5AF, 5AH(1)(a), 5AH(1)(b), 5AH(2); *Civil Liability Act* 1936 (SA) s75; *Civil Liability Act* 2002 (Tas) ss7(1)(a), 7(1)(b),7(2), 7(3); *Personal Injuries (Liabilities and Damages) Act* 2003 (NT) ss12(b), 13; *Civil Law (Wrongs) Act* 2002 (ACT) ss14(1)(a), 14(1)(b), 14(2); *Civil Liability Act* 2002 (NSW) ss69(1)(a), 69(1)(b), 69(2); *Wrongs Act* 1958 (Vic) ss14I, 14J(1)(a), 14J(1)(b), 14J(3); *Civil Liability Act* 2003 (Qld) ss71, 72; D Studdert and M Richardson, 'Legal aspects of open disclosure: A review of Australian law', *Medical Journal of Australia* 193 (5), 2010, pp273-6; P Vines, 'Apologising to avoid liability: Cynical civility or practical morality?' *Sydney Law Review*, 27(3), 2005, pp483-505. **12** *Ibid.* **13** *Civil Liability Act* 2002 (WA) ss5AF, 5AH(1)(a), 5AH(1)(b), 5AH(2); *Civil Liability Act* 1936 (SA) s75; *Civil Liability Act* 2002 (Tas) ss7(1)(a), 7(1)(b),7(2), 7(3); *Personal Injuries (Liabilities and Damages) Act* 2003 (NT) ss12(b), 13; *Civil Law (Wrongs) Act* 2002 (ACT) ss14(1)(a), 14(1)(b), 14(2); *Civil Liability Act* 2002 (NSW) ss69(1)(a), 69(1)(b), 69(2); *Wrongs Act* 1958 (Vic) ss14I, 14J(1)(a), 14J(1)(b), 14J(3); *Civil Liability Act* 2003 (Qld) ss71, 72. **14** TH Gallagher, D Studdert and W Levinson, 'Disclosing Harmful Medical Errors to Patients', *The New England Journal of Medicine*, 356, 2007, pp2713-9. **15** D Studdert and M Richardson, 'Legal aspects of open disclosure: A review of Australian law', *Medical Journal of Australia* 193 (5), 2010, pp273-6. **16** . 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D Studdert and M Richardson, see note 15 above; *Health Services Act* 1988 (Vic) ss139(4), 139(5); *Health Administration Act* 1982 (NSW) ss20H(1)(a), 20H(1)(b), 20I; *Health Services (Quality Improvement) Act* 1994 (WA) s10; *Health Act* 1997 (Tas) ss4(4), 4(6); *Mental Health and Related Services Act* 1998 (NT) ss148, 149; *Health Act* 1993 (ACT) s47; *Health Services Act* 1991 (Qld) ss34, 35; *Health Care Act* 2008 (SA) s66(3); *Health Insurance Act* 1973 (Cth) ss124Y(1), 124Y(2); R Cavell, 'The legal risks of quality assurance in Australian public hospitals', *Journal of Law & Medicine*, 15, 2007 pp219-41. **21** D Studdert and M Richardson, see note 15 above. **22** *Ibid.* **23** *Ibid.* **24** *Ibid.* **25** *Ibid.* **26** *Ibid.* **27** R Iedema, N Mallock, R Sorensen, E Manias, A Tuckett, A Williams, B Perrot, S Brownhill, D Piper, S Hor, D Hegney, H Scheeres, C Jorm, 'The national open disclosure pilot: Evaluation of a policy implementation initiative', *Medical Journal of Australia,* 188, 2008, pp397-400. **28** D Studdert, D Piper and R Iedema, 'Legal aspects of open disclosure II: attitudes of health professionals – findings from a national survey', *Medical Journal of Australia,*193(6), 2010, pp351-5. **29** *Ibid.* **30** D Studdert, M Mello, A Gawnde, T Brennan, and C Wang, 'Disclosure of medical injury to patients: an improbable risk management strategy', *Health Affairs*, 26(1): 2007, pp215-26; S Kraman and G Hamm, 'Bad modelling?', *Health Affairs*, 26(3), 2007, p903; J Wakefield, C Jorm and C Ryan, 'Open disclosure: details matter – A response to Studdert et al 2007', *Health Affairs*, 26(3), 2007, pp903-4; CB Liebman and CS. Hyman, 'A mediation skills model to manage disclosure of errors and adverse events to patients', *Health Affairs*, 23(4), 2004, pp22-32. **31** D Studdert, D Piper and R Iedema, see note 28 above. **32** *Ibid.* **33** *Ibid.* **34** *Ibid.* **35** *Ibid.* **36** D Studdert and M Richardson, see note 15 above. **37** *Ibid.*

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