The law as a barrier to error disclosure: A misguided focus?

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ABSTRACT

At the core of the patient safety movement is the open communication about medical errors. It is seen as important that errors are reported so that opportunities for system improvements can be identified and addressed, and disclosing errors to harmed patients is now seen as an ethical, professional and legal duty. There remains, however, a large 'gap' between expected communication practice and what is actually being done. Legal fears are consistently identified as one of the most important barriers to error communication. Efforts to improve medical error communication are ongoing and there is a need to reflect on where the focus of these efforts should be moving forward. It is argued that the focus on the law as a barrier to medical error communication is misguided and efforts should instead be focused on addressing issues around the culture of individual hospitals and departments, and the training and support of clinicians.

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1. Introduction

The issue of medical errors has been a central concern to health systems since international research was published highlighting the significant harm medical errors cause to thousands of patients each year [1,2]. Anaesthesiology has been one of the leading medical specialties in the patient safety movement that has subsequently emerged, and the related shift towards transparency and open communication about medical errors [3]. With a new "systems" concept of error causation emerging which holds that most errors have their roots in wider organisational factors [4], it is seen as important to foster an environment where people feel supported and are encouraged to identify and report errors so that opportunities for systems improvements can be identified and addressed [5]. A new ethic of transparency has also been advocated in relation to the communication of medical errors to harmed patients. Clinicians are now widely considered to have an ethical, professional and legal obligation to disclose medical errors to patients [5–9]. Disclosure is thought to potentially have a number of positive benefits, including assisting the recovery of harmed patients, promoting forgiveness and the early resolution of disputes, and reducing litigation and legal costs [10,11].

There remains, however, a large 'gap' between expected communication practice and what is actually being done [12], with research indicating that errors are often not reported within hospitals or disclosed to patients [13,14]. Indeed, medical error communication provides some unique challenges to medical specialties such as anaesthesiology given the limited contact with the patient, the absence of an ongoing professional relationship, and the complex teams in which anaesthesiologists typically work [15,16]. A number of barriers to open and honest communication about medical errors have been identified, however, legal fears have consistently been identified as a primary barrier; including the fear that such communication may lead to a complaint or lawsuit, that an apology will be seen as an admission of fault or liability or will void liability insurance coverage [17,18].

Efforts to close the current 'gap' between expected communication practice and what is actually being done are ongoing. There is a need to reflect on where the focus of these efforts should be moving forward. While legal fears are undoubtedly *a factor* in some organisations' and clinicians' reluctance to communicate medical errors, it is this author's view that there has been at times too much focus on the law as a barrier to medical error communication, and that addressing issues around the culture of individual hospitals and departments, and the training and support of clinicians, will more likely lead to improvements in medical error communication practices.

2. The law as a barrier to medical communication: a misguided focus

International research and experience indicates that the focus on the law in relation to medical error communication is misguided

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for two reasons: 1) the legal environment appears to have a more limited impact on clinicians' medical error communication attitudes and practices than is often believed, and 2) that changes in the law are neither sufficient nor necessary to improve medical errors communication.

2.1. The law's limited impact on medical error communication attitudes and practices

In 2006, Thomas Gallagher and colleagues surveyed 2637 physicians in the United States and Canada from various specialties, partly with the aim of examining the malpractice environment's actual effect on physicians' medical error communication attitudes and experiences [19]. The study found that United States and Canadian physicians' attitudes and experiences were similar despite very different malpractice environments. Physicians' estimates of the probability of being sued in the next year were not found to affect their beliefs about error communication, indeed, the study reported that 66% of respondents agreed that communication serious errors made lawsuits *less* likely [19].

The risk of malpractice complaints is an issue that is particularly well known among anesthesiologists [20]. However, there has been limited research on anesthesiologists' attitudes and experiences regarding medical errors communication [21–25], particularly the disclosure of errors to patients, and how these might be affected by the legal environment. In 2012/2013, this author therefore conducted a modified version of Gallagher's survey in Switzerland involving anesthesiologists to characterize anesthesiologists' attitudes and experiences regarding communicating medical errors with the hospital and to patients, and to examine factors influencing their willingness to communicate errors [26]. This study found no correlation between Swiss anesthesiologists' attitudes about malpractice and willingness to communicate serious errors. Indeed, while 59% of anesthesiologists thought that it was somewhat likely or likely that they would receive a malpractice complaint within the next year, 71% of respondents thought that disclosing a serious error to a patient would make it *less* likely that a patient would complain about them [26].

The findings of these two studies strongly suggest that the legal environment may actually have a more limited impact on physicians' error communication attitudes and practices than often believed. Legal fears may not in fact be such as a significant barrier to error communication.

2.2. Law reform neither sufficient or necessary to improve medical error communication

Various international experiences also suggest that changes in the law are neither sufficient nor necessary to improve medical error communication practices.

Two international examples support the view that changing the law to remove real or perceived barriers is not sufficient to improve medical error communication practices. In 1974, New Zealand abandoned a tort-based system for compensating personal injuries in favor of a government-funded compensation system known as the Accident Compensation Corporation (ACC) [27]. The ACC legislation covers all personal injuries and effectively prevents injured or otherwise aggrieved patients from pursuing legal action in court against health providers after a medical error. As a result, injured patients seeking compensation may make a claim to ACC. Amendments in 2005 removed the need for ACC to find fault on behalf of a health professional, bringing this form of cover in line with the overall no-fault nature of the scheme [27]. However, even though New Zealand has had a no-fault system since the 1970s, and thus virtually all legal barriers have been removed, cultural barriers

to openness and honesty persist [28]. Legislation has also been widely enacted in the United States, Australia, and Canada to protect apologies from being used a proof of negligence in legal action, and in some countries preventing liability insurance being voided [29,30]. While many of these "apologies laws" cover all civil cases, they are one of the best examples of the law being used to explicitly promote medical error communication and apologies. However, while apology laws have been in place in some U.S. states since 1986 [31], there has been no evidence from any of these countries that these laws are increasing the frequency of error disclosure and apologies.

While may be argued that such law reform may not be sufficient to improve error communication practices it is a necessary condition for significant changes in practice, the evidence suggests otherwise. Some of the most successful medical error communication programs, for example the Veteran Affairs Hospital in Lexington, Kentucky, and University of Michigan, have occurred in very challenging legal environments and did not required any law reform to achieve these results [32,33].

It is this author's contention that the assumption that law reform will increase error communication falsely assumes that we are primarily dealing with a legal matter rather than one grounded in human relationships. While law reform may be desirable for other reasons, it seem unlikely that it would lead to major changes in medical error communication practice.

3. The importance of culture, training and support

Medical error disclosure is one of the most complex and difficult conversations that occur in healthcare. While legal fears are undoubtedly *a factor* in some organisations' and clinicians' reluctance to communicate medical errors, the true reasons are usually more complex, including a professional and organisational culture of secrecy and blame, clinicians lacking confidence in their communication skills, high workload, the belief that the circumstances or outcome of a particular case did not warrant communicating, and medicine's traditional focus on professional autonomy and individual accountability for patient outcomes [15,16]. Indeed, what seem to be more important determinants of error communication practice than legal issues are three main things: 1) the culture of the medical profession and health care organisations, 2) polices and training, and 3) supporting clinicians through the medical error communication process and with the emotional impact of medical errors.

3.1. Culture

As noted above, Gallagher et al. in their 2006 study found that United States and Canadian physicians' error disclosure attitudes and experiences are similar despite very different malpractice environments [19]. Gallagher et al. went on to argue that:

"The fact that US and Canadian physicians' attitudes transcend country boundaries suggests that these beliefs may relate to the norms, values, and practices that constitute the culture of medicine. The medical education system, a potent force for professional socialization, is remarkably similar in both countries. While acculturation begins in medical school, the most critical cultural norms are inculcated within specialties. The finding that physician attitudes generally varied more by specialty than by country further supports the role of medical culture in shaping these views" [19].

The results of this author's survey with Swiss anesthesiologist have also given more weight to the view that medical culture may

be the more important determinant regarding medical error communication [26]. However, these results go further in suggesting at which level these cultural norms may be being instilled. While Gallagher et al. suggested that this may occur most critically within specialties, partly due to their sampling technique, their study did not report on subgroup analysis such as department. While attempts to survey more than one specialty in Switzerland were not successful, the study was able to survey all of the university hospitals' anesthesia departments in Switzerland [26]. Significant differences in attitudes between departments regarding medical error communication were found. Given that this study only included clinically active anesthesiologists working in university hospitals, and that Switzerland is a reasonably small and dense country, these large differences are noteworthy, and indicate that the individual departments' or hospitals' culture may be the more important factor. However, further research is needed to examine whether significant differences in medical error communication attitudes between departments exist in other specialties and countries, and to understand the factors that influence local culture and thus the actions required.

3.2. Polices and training

International research has found that governmental and health organisations policies, along with the increase of specially trained staff, have been one of the driving forces behind the increased communication of errors [34]. However, in contrast to some other countries where such policies and mandatory [5—9], it appears that many hospitals in Europe currently do not have a policy concerning medical error communication, or have any plans to do so. For example, surveys in Switzerland and Germany have found that only 46% hospitals in Switzerland and 22% in Germany currently have a policy in place regarding disclosing medical errors to patients [35,36]. As the implementation of a policy may be an important indication of organisational culture concerning medical error communication, this fact is potentially very concerning. However, it is clear that policies by themselves are no magic bullet. Internationally there has been a challenge of turning policy into practice, particularly on a large scale. Wu et al. have described the experience of the United Kingdom in implementing the 2005 national policy, Being Open:

"… although the policy achieved endorsement and alignment at the highest levels of the health service, the engagement and support needed to implement Being Open were not adequately transmitted to those on the front line. Despite guidelines in place on how to create a patient safety culture, an eLearning tool, and Being Open training workshops (the most extensive of which included opportunities to practice disclosure skills with actors), uptake was slow—perhaps because insufficient numbers received the training and perhaps because of the lack of enforcement and potential sanctions for noncompliance" [28].

Indeed, the issue of education and training appears to be one of the most important steps in increasing medical error disclosure. For example, Jericho and colleagues 2010 study evaluated the effect of an educational intervention on anaesthesiology residents in Chicago and found that following the education intervention that error reported increased by 30% [37]. Unfortunately, while medical error disclosure is one of the most complex and difficult conversations that occur in healthcare, research suggests that very few clinicians receive any education or training regarding disclosure. For instance, the survey of Swiss anaesthesiologists found that only 12% of respondents had received any education or training on how to disclose errors to patients, although, 93% were interested in receiving such education or training [26].

However, it needs to be acknowledged that there are a number of challenges regarding medical error disclosure training. These are nicely described by Truog et al. talking about their experiences at the Harvard hospitals:

"Another dilemma was created by the fact that all the Harvard hospitals have hundreds, even thousands, of clinicians who at any time could become involved in a serious medical error. On the one hand, any effective educational strategy must involve a broad-based learning initiative designed to provide all these clinicians with a general understanding of the hospital's approach to disclosure, particularly in view of the fact that most of these clinicians were trained to withhold any information from patients that might convey wrongdoing or liability. On the other hand, we realized that it would be unrealistic to think that any educational program could enable this huge number of clinicians to learn and retain the knowledge needed to have these conversations well at any moment in time. Therefore we decided to endorse an approach that would assure the "just-in-time" availability of expertise and help by concentrating our educational efforts on a small number of disclosure "coaches" who would be available to all clinicians within the institution on a 24/7 basis" [38].

Indeed, it should be noted that 95% of respondents in the survey of Swiss anaesthesiologists were interested in receiving support from an expert on patient communication after a serious error [26]. While increasing general disclosure training in medical school and postgraduate training may be an important step in increasing medical error disclosure, consideration should also be given to the creation of "just-in-time" disclosure coaches.

Support

There also appears to be a link between the emotional impact of medical errors and medical error communication. Indeed, it seems that this link may go in both directions, not only will adequate support of clinicians after errors assist with medical error communication, but also that positive error communication experiences may also mitigate emotional distress associated with future errors.

Error involvement can cause significant emotional distress and intensify a clinician's already increased risk of depression, substance abuse, and suicide. Evidence suggests that individuals involved in major errors can suffer burn-out and depressive symptoms, which may in turn increase the risk for future errors and loss of empathy, if they do not receive sufficient support [39—42]. It is estimated that between 10% and 43% of clinicians are left the "second victims" after such events [43].

Both the largest study conducted internationally to date involving 3171 physicians from multiple specialties in the United States and Canada published in 2007 [44], and the study this author conducted involving Swiss anesthesiologists in 2012/2013 [45], found that distress following errors was reported by many participants: 81% in the North American study and 90% in Swiss study reported that at least one of the five work and life domains (anxiety about future errors, confidence in ability as physician, ability to sleep, job satisfaction, professional reuptation) was negatively affected following error involved [44,45]. As expected, participants in both studies were consistently more likely to be affected as error severity increased, however, the impact was still considerable even for minor errors and near misses [44,45]. It has been found that clinicians often "suffer in silence" following a medical error as they

are not offered the support that they need [46]. For example, one study found that only 10%–30% of respondents reported that various support services or interventions were actively offered to them after an incident [47]. A lack of proactive support may happen more often following minor errors and near misses because the incident is not considered serious enough to warrant support, however, it is important that health care organsiations are aware that even minor errors and near misses can have a serious effect on clinicians and that clinicians may need support after such events.

Research has also identified a number of potential predictors of increased distress following medical errors. For instance, the Swiss study found that anxiety of future errors was increased in anesthesiologists who were dissatisfied with how both their last minor and their last serious medical error disclosure went [45]. This suggests that there is a long-term importance of a "good error disclosure experience", not only for affected patients and families but also for the involved clinicians. Providing support for medical error disclosure may therefore also mitigate emotional distress associated with future errors.

Unfortunately, however, physicisn are often not adequately supported following involvment in a medical error. For example, 90% of respondents in both the North American study and the Swiss study disagreed that hospitals adequately support them in coping with the stress associated with medical errors [44,45]. However, the vast majority of respondents in both studies (82% in North American study and 92% in Swiss study) reported that they were somewhat or very interested in psychological counselling after a serious error. However, respondents in both studies identified a number of barriers to seeking psychological counselling. Support systems will also need to barriers in relation to seeking support. For example, a third of respondents of both studies felt that they did not have time to take time off work to receive counselling [44,45]. This may be particualrly difficult for those clinicians working in such fields as anesthesia. Indeed, the inability to take time off work to receive support has been an issue of concern in studies examining the impact of perioperative catastrophes. For instance, a study of 251 English anaesthesiologists found that while the majority agreed that it was reasonable for medical staff not to take part in operations for 24 hours after an intraoperative death, "given the significant financial, logistical and personnel implications involved in employing secondary operating teams and cancelling elective operating lists, this notion was rejected by the majority as impractical" [48]. While the study's recommendation, that all departments should nevertheless provide for time off if the circumstances require it, may be equally applicable to cases of medical errors, such barriers to taking time off to receive support are also applicable and there is a need for organsiations, and specialities like anaestheisa, to consider how these can be best addressed given local constraints.

4. Conclusion

While legal fears have consistently been identified as a primary barrier to medical error communication, international research and experience indicates that the focus on the law in relation to medical error communication may in fact be misguided. Research has found that the legal environment has a more limited impact on physicians' error communication attitudes and practices than often believed. Examples of law reform also demonstrate that while law reform may be desirable for other reasons, it seem unlikely that it would lead to major changes in medical error communication practice. What seem to be more important determinants of medical error communication practice than legal issues are the culture of individual hospitals and departments, and the training and support of clinicians. Further research is needed to establish how to best

address these issues.

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