MEDICAL COUNCIL OF NEW ZEALAND

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# Disclosure of harm following an adverse event

*When a patient is harmed while receiving medical treatment the Medical Council of New Zealand expects that the patient's doctor will advise the patient (or the patient's family) of the facts of the harm in the interests of an open, honest and accountable professional relationship.*

## Disclosure of harm

1. When discussing 'disclosure of harm' the Council means where a patient has been harmed as a direct result of receiving medical treatment in a clinical situation. This includes a situation where the harm may be a recognised risk of the treatment[1].
2. The Council acknowledges that the very nature of medical treatment means that a patient may be inadvertently harmed during treatment.

## Introduction

3. The Council believes that open disclosure of harm will benefit the health and safety of the public and strengthen the doctor-patient relationship.
4. You should make patients aware through the consent process that all treatment carries some risks and that they may be inadvertently harmed or experience a 'near miss'.
5. Over the past decade there have been moves toward increased accountability by the medical profession, strengthening of patient rights and improved systems. Examining adverse outcomes and ensuring that the problem that led to the harm is identified and addressed is part of this trend.

## Purpose of open disclosure

6. Open disclosure of harm is not about attributing blame.
7. Open disclosure of harm:
   - contributes to a successful doctor-patient relationship by ensuring that trust between the doctor and the patient is not compromised
   - is a right of a patient under the Code of Health and Disability Services Consumers' Rights
   - is a requirement of the Health and Disability Service Standards
   - is necessary for the informed consent process, especially when the harm results in the need for further treatment or care
   - provides an environment that enables the health team to learn in an educational manner because harm can be discussed openly
   - is part of the move for increased transparency and accountability by the medical profession
   - is an aspect of open and honest professional behaviour
   - contributes to public awareness, information and education about the reality of medical treatment
   - acknowledgement of a near miss can lead to a review of processes and contribute to a safety culture
   - is a step towards ensuring patients are advised that they may be entitled to compensation through the ACC
   - is ethically and legally the right thing to do.

[1] This definition does not include situations where an incident during treatment may have caused harm, but did not because action was taken to amend the situation before the harm occurred.

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## Attributes of harm

8. Harm is often the result of a combination of factors that are attributable to more than one member in the health practitioner team, or a breakdown in the health system.
9. Research into occurrences of harm in New Zealand, Australia, Canada and the United States indicates harm occurs in approximately 3-16 percent of hospital admissions[2].
10. Harm is rarely a result of negligence or incompetence.

## Accepted risks of treatment

11. All forms of medical treatment have recognised risks – a recognised possible outcome of the treatment that is not intended but acknowledged as a risk.
12. It is important that you discuss recognised risks with the patient as part of the informed consent process prior to starting any treatment. This means identifying the risk, explaining what the possible implications are for the patient if harm results and providing the patient with information about the implications of consenting to or declining the treatment.

## Expectations of open disclosure

13. National and international research shows that patients and doctors have different concerns and expectations about open disclosure of harm[3]. This difference can often lead to a breakdown in communication and misunderstandings. It is important that you address a patient's concerns as part of an open and honest doctor-patient relationship.
14. Research indicates that when disclosure of harm is made, the patient is usually concerned about what and how the harm occurred, why it happened, and what the long-term consequences are for his or her care.
15. Patients want to be reassured that systems have been changed to minimise the chance of harm happening again to themselves or others.
16. When disclosing harm doctors are concerned that the patient should not be overwhelmed with technical details, nor should it cause distress to a patient who is already unwell.
17. Doctors and patients share a common concern about avoiding similar incidents in the future. However, these concerns are often expressed to parties outside the doctor-patient relationship. A discussion between you and the patient can contribute to the ongoing confidence the patient has in you, the medical profession, and in the health service.
18. A major contributing factor to doctors' reluctance to openly disclose harm to patients and their families is the fear of liability, damage to the doctor-patient relationship and the possibility of a complaint. Research demonstrates the opposite is true. Research in Australia and the United States indicates that a patient is more likely to complain if the doctor fails to disclose harm to the patient, or if the disclosure is not done in an open and honest manner[4].
19. It is possible to say sorry and express regret, without accepting liability and this is a common recommendation in most literature about open disclosure of harm[5].

## What should happen before disclosure of harm?

20. It is important that you make a disclosure in a timely manner. Therefore it is appropriate to make the initial disclosure as soon as practical, with a more detailed discussion with the patient to follow once the team has had an opportunity to meet and assess the circumstances that led to the patient being harmed. This will also give time for the patient to think about the situation and provide an opportunity to ask for more information.
21. If the harm occurred during a procedure undertaken in a team environment the team should meet to discuss the incident to identify:
    - what happened
    - how it happened
    - the consequences for the patient, including continuity of care
    - what will be done to avoid similar circumstances in the future
    - who should be present when the harm is disclosed to the patient.

[2] Sally Hargreaves (2003) 'Weak' safety culture behind errors, says chief medical officer – BMJ, Vol. 326
Louise Kershaw (2002) When things go wrong: An open approach to adverse events – Australian Council for Safety and Quality in Health Care; Sydney, Australia, page 5.
P C Herbert, A V Levin & G Robertson (2001) Bioethics for clinicians: Disclosure of medical error – Canadian Medical Journal; Vol. 164, No. 4.
Peter Davis (2001) Adverse Events in New Zealand Public Hospitals; Principle findings from a national survey – Ministry of Health, Wellington, page 15.

[3] T H Gallagher, A D Waterman, A C Ebers, V J Fraser & W Levinson (2003) Patients' and physicians' attitudes regarding the disclosure of medical errors – JAMA; Vol. 289, No. 8, page 1001.

[4] Louise Kershaw (2002) When things go wrong: An open approach to adverse events – Australian Council for Safety and Quality in Health Care; Sydney, Australia, page 6.

[5] Louise Kershaw (2002) When things go wrong: An open approach to adverse events – Australian Council for Safety and Quality in Health Care; Sydney, Australia, page 6.
The Health and Disability Commissioner's *Guidance on open disclosure policies* contains advice on how to apologise.

This meeting may include a representative of the management or administrative staff to assist in assessing how any harm identified is to be addressed both for the patient and in regards to any changes to the service.

22. While it may be more appropriate to disclose the harm in stages so the patient understands and processes the information without being overwhelmed, ongoing delay in giving full information is only acceptable if this is in the patient's best interests.

## Disclosing harm

23. The senior doctor responsible for the patient's care should disclose the harm to the patient. Research indicates that patients prefer to hear from the doctor with whom the patient has established a rapport or had previous contact. In the situation where this is not the senior doctor, both practitioners should be in attendance. Research has shown that disclosure by hospital administrative staff or management alone is not well received by patients.

24 When preparing to disclose harm, you must consider the patient's cultural and ethnic identity, the patient's first language and what support the patient may need. When appropriate, you must advise the patient where and from whom the patient or the patient's family can get support.

25. You should document in the patient record details about the nature of the harm, and any subsequent action, including disclosure to the patient. The Council recommends that the patient notes include who was present, what was disclosed, the patient's reaction and any issues regarding continuity of care. If the harm occurred in secondary or tertiary care you must inform the patient's general practitioner.

26. In some situations where the patient has died, has been significantly compromised, has long-term diminished competence, or is incompetent, you will need to make the disclosure to a third party.

## A doctor's duty to protect patients

27. Protect patients from the risk of harm posed by a colleague's conduct, performance or health. Patient safety comes first at all times.

28. Before taking action, do your best to find out the facts. Then, if action is necessary, you should follow your employer's procedures, tell an appropriate person or contact the Medical Council for advice[6].

## Support for doctors

29. Although harm to patients is rarely the result of negligence or incompetence, you may find the experience stressful and difficult. It is important that you, as well the patient, have access to support.

30. Doctors need the opportunity to discuss such incidents in a safe environment, and for there to be systems put in place to prevent a recurrence of the problem. The Council recommends that employers provide training, peer support and a supportive work environment.

31. There are a number of agencies that can provide you with a confidential support network. These include employee assistance programmes, doctor support agencies and medical indemnity insurers.

32. Medical indemnity insurers can provide you with advice and support on matters including law and ethics. In situations where a patient has been harmed New Zealand indemnity insurers advise you to contact them for advice on disclosure.

## Other relevant resources

- *Good medical practice*
- Council statement on *Confidentiality and public safety*
- Council statement on *Information and consent*
- Council statement on *Reporting concerns about colleagues*
- The HDC's *Guidance on open disclosure policies*
- The New Zealand Medical Association *Code of Ethics*
- The National Health Service booklet on *Being open*

***December 2010***

***This statement is scheduled for review by December 2015. Legislative changes may make this statement obsolete before this review date.***

[6] For more advice refer to paragraphs 74-78 of *Good medical practice* (Medical Council, 2008), and the Council's statement on *Reporting concerns about colleagues* (Medical Council 2010).

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