

## **Open Disclosure: An Opportunity Missed? (The MDO's Perspective)**

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# Outline

- MDO's role
- The Disclosure Options
- Personal Barriers
- Systemic Barriers



# MDOs Role

- More than just an insurance company = Dr owned organisation.
  - Core Business: Protection of our Members' interests when faced with medico-legal issues.
    - Claims
      - Negligence = Duty, Breach, Damage & Causation
    - Complaints & Investigations
      - Medical Board
      - Coronial Inquests
      - Health Complaints Bodies
  - More than just insurance.
    - Advice
    - Support
    - Promote
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# The Disclosure Options



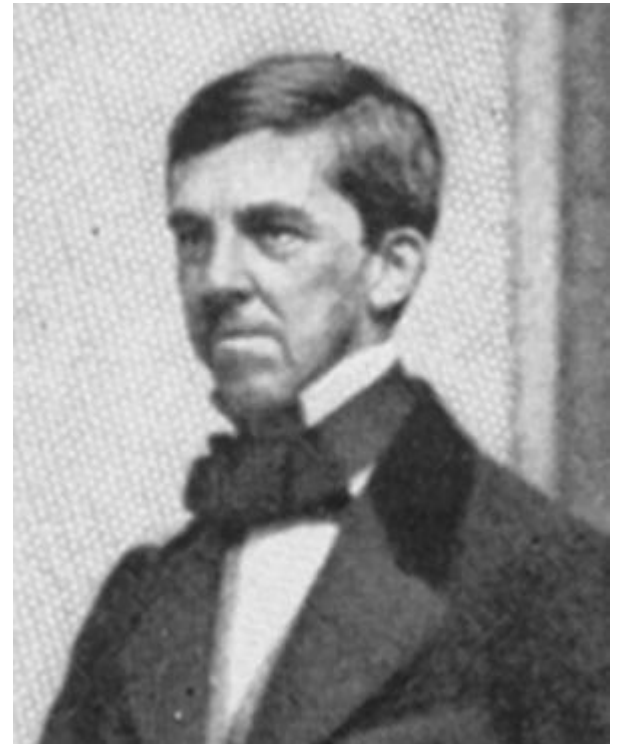
# The Disclosure Options

- Options following an adverse event:
  - No Disclosure
  - Incomplete Disclosure
  - Open Disclosure



## Oliver Wendell Holmes, Sr

*“ Your patient has no more right to all the truth you know about him than he has to all the medicine in your saddlebag. He should only get as much as is good for him”.*  
(1893)



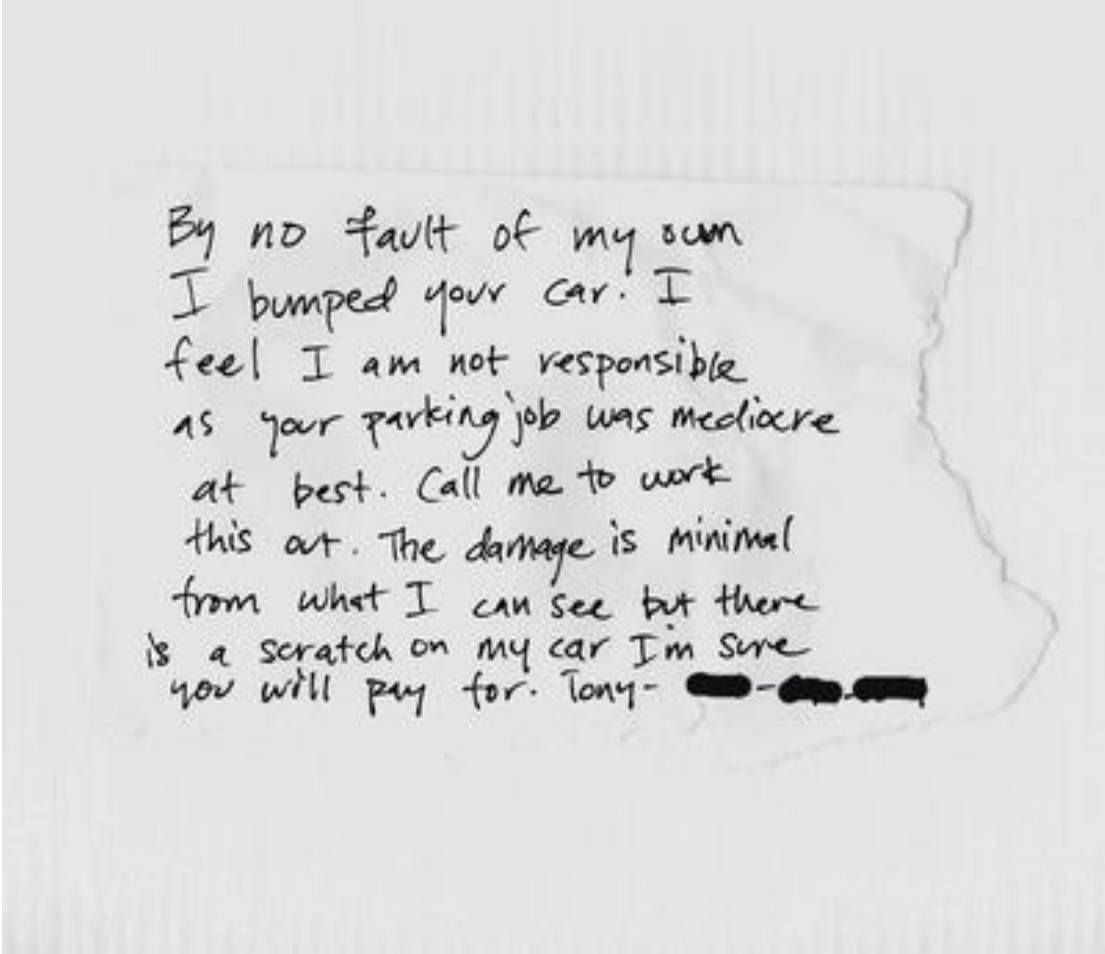
## **“that horrible feeling”**

*“Virtually every doctor knows the sickening feeling of making a bad mistake. You feel singled out and exposed – seized by the instinct to see if anyone has noticed. You agonise about what to do, whether to tell anyone, what to say. Later the event replays itself in your mind. You question your competence, but fear being discovered. You know you should confess, but dread the prospect of potential punishment and of the patient’s anger”*

Wu AW “Medical error: The Second Victim” BMJ 2000,320:726-7

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# Incomplete Disclosure



By no fault of my own  
I bumped your car. I  
feel I am not responsible  
as your parking job was mediocre  
at best. Call me to work  
this out. The damage is minimal  
from what I can see but there  
is a scratch on my car I'm sure  
you will pay for. Tony- [REDACTED]

## Open Disclosure

*“When adverse events occur, you have a responsibility to be open and honest in your communication with your patient, ....[e]xplaining to the patient as promptly and fully as possible what has happened and the anticipated short-term and long-term consequences.”*

Good Medical Practice: A Code of Conduct for Doctors in Australia.

*“For health care professionals, there is an ethical responsibility to maintain honest communication with patients and their support person, even when things go wrong. By ensuring that there is good communication when an adverse event occurs, we can begin to look at ways to prevent them from recurring.”*

The National Open Disclosure Standard (2003)

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# Systemic Barriers

## Perceived “legal implications”

- Exposes medico-legally.
  - Presumes open disclosure → \$\$\$
  - “may constitute an admission” – complexity, inconsistency and ambiguity of protective legislation.
  - Conflicts with MDOs’ “do not admit” clause.
  - Prejudices MDO’s ability to defend.
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## Personal Barriers

- Reputational damage
    - Criticism of colleagues , loss of face, perception of infallibility.
  - Individual consequences
    - Disciplinary, loss privileges, training consequences.
  - Difficulty of breaking bad news
  - Feeling a lack of support / exposure
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## **Drivers of MDOs' approach to Open Disclosure**

- Member's best interest
  - Members' (the Profession's) desired approach
  - Community expectation
  - Global trend towards accountability and OD
  - Standards/Regulators pressing for greater transparency
  - Impact on the organisation
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## Weighing the Options – Open Disclosure

- May help to preserve the Dr:Pt relationship
  - Possible benefit in avoiding litigation or complaint
  - Ultimately OD is the right thing to do – Members / Patients / Society
  - Importantly, OD is not about negligence or blame. The standard itself states:
    - *“Health care professionals need to be aware of the risk of making an admission of liability during the open disclosure process”* (p11)
    - *“...it is important that those involved in the adverse event are fully aware of their own responsibilities in regard to their relevant insurance policies”* (p15)
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# Typical Advice dealing with Open Disclosure

- Where an obvious mistake has been made, Members might expect the following advice:
    - Engage with the patient in discussing the adverse event in a timely manner.
    - Provide the patient with the known facts – do not speculate; particularly on causation.
      - How the incident occurred.
      - What are the consequences for the patient.
    - Apologise for what has occurred.
    - Investigate the incident thoroughly.
    - Reassure the patient that appropriate steps are being taken to ensure the error doesn't happen again.
    - Feedback findings to the patient.
    - Document the process.
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## In Summary

- MDOs are supportive of the open disclosure process.
  - MDOs have a lot to offer their members when an adverse incident occurs, and they should be contacted promptly.
  - The perceived ‘systemic barriers’ to open disclosure are misconceived, and it is likely that the personal barriers are, in fact, the more significant factors.
  - If you damage a car in the car park, and you plan to take the ‘no disclosure’ option, **MAKE SURE IT WASN’T CAPTURED ON FILM!**
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