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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.

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