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Complaints and Litigation against Doctors and Lawyers are on the Rise – A Look at the Reasons Why and Some Thoughts on Prevention

Presented to the Medico Legal Society NSW, 14 March 2018

Complaints and litigation are costly and stressful. They can also be damaging to practice and reputation.

In the medico setting: complaints to the Health Care Complaints Commission in NSW generally take on average 1 year or more to resolve, and longer if they result in a prosecution. In respect of litigation: it usually takes much longer than 1 year for resolution.

The take home message of my talk: Call me idealistic – but from what the statistics suggest and certainly from what I've witnessed as a plaintiff lawyer and also as a past board member of a NSW health care council and AHPRA looking at patient complaints – a very great proportion of complaints and litigation ARE AVOIDABLE.

As we will see, as many as 39% of complaints have POOR COMMUNICATION as the main driver.

Interestingly, the high percentage of complaints with poor communication at their core, applies for both professions.

Karen Stott is a lawyer with 20 years of litigation experience, and a nationally accredited mediator. She has practised in a wide range of areas, particularly health law.

Karen's experience in this area includes representation of patients as well as individual health care providers, hospitals and insurers. She has also served as a Board member on the NSW Health Practitioners Council and also on one of the inaugural AHPRA Boards from 2009. She has first hand experience "on both sides" in litigation, Coronial inquiries, the complaints process, and in dispute resolution.

Karen became a full-time Mediator in 2016.

Medically: When Things Go Wrong – the following pathways might result:

- Root Cause Analysis & Open Disclosure
- Inquiry / Inquest
- Complaint (eg HCCC NSW, AHPRA)
- Medical Board Australia & NSW Council
- Cth PSR (re Medicare)
- Litigated Claim for Compensation

Root Cause Analysis & Open Disclosure

This is compulsory in the NSW Public Hospital system – when there is a serious adverse incident there will be an RCA. The purpose is for understanding and system improvement.

Open Disclosure was introduced in 2003 with all Health Ministers in Australia endorsing the National Open Disclosure Standard, prepared by the Australian Council for Quality and Safety in Healthcare. The National Standard was revised in 2013.

OD is also widely supported by medical defence organisations and by AHPRA. For example, the Medical Board of Australia Code of Conduct refers specifically to OD (at 3.10) and all registered healthcare professions are likely to have the same provisions in their respective Codes.

Open Disclosure is part of the process in communicating with the patient what went wrong, what steps have been identified for rectification, and for acknowledging the patient's experience – for showing empathy. RCA & OD are fantastic in theory – it's the execution that can be challenging.

Inquiry

The most notable example of an Inquiry in the healthcare setting is a Coronial Inquest – the purpose of which is to determine the manner and cause of death. In relation to healthcare, Section 6 of the *Coroners Act NSW* provides that a death is reportable to the Coroner if it was not the reasonably expected outcome of a health related procedure.

Often the issue in the clinical setting will involve an analysis into whether there were systemic failures concerned. For example, the Coronial Inquest in this week's news regarding the neonatal death at the Fairfield Hospital Maternity Ward 25/11/15 when the mother gave birth without anyone in attendance, and the umbilical cord was wrapped around the baby's neck, the baby had stopped breathing, and the autopsy revealed toxic levels of pethidine. Staffing levels at the hospital are apparently in issue.

Complaint to Health Care Complaints Commission (NSW) and to NSW Medical Council (and to AHPRA – Aust Health Practitioner Regulation Agency) re other states

The focus is on low quality care, and/or patient dissatisfaction with care – and performance issues of the healthcare provider. I'll elaborate on this in a moment.

Commonwealth Professional Services Review Agency – (re Medicare billing) – *not referred to in this talk*

Legal proceedings

(mainly re negligence – that is when substandard care causes patient harm) with monetary damages being the remedy.

The first 2 (RCA & Inquiries) are INQUISITORIAL – with learning and system improvement being the purpose and goal.

The next 3 (Complaints to HCCC, AHPRA & PSR matters) are inquisitorial but which may turn adversarial (if there is a prosecution) and with potential DISCIPLINARY consequences, depending on the outcome.

The last – litigation – is ADVERSARIAL. Each party is legally represented. The plaintiff bears the onus of proving the cause of action (Negligence), to the balance of probabilities. The monetary outcome depends on who wins/loses. If successful, monetary compensation and legal costs are payable by the unsuccessful defendant/s. Litigation does not have disciplinary consequences. If made public, however, it may well have adverse reputational and business consequences.

Depending on the severity of the medical adverse outcome (eg patient injury or the circumstances of how it was managed), one or more of these processes may occur.

For example: the case of the Late Vanessa Anderson – death at RNSH in 2005 after she had been hit in the head by a golf ball – monitoring & medication issues.

This involved RCA & OD, Coronial Inquest, and then legal proceedings. (I understand that it also involved a complaint to and investigation by the HCCC as well).

The Health Care Complaints Commission NSW – the complaints management framework:

The first step when a complaint is received about a healthcare organisation or provider, is for it to be ASSESSED.

Possible outcomes of assessment include:

- Referral to the relevant professional Council
- Discontinuance – with or without comments
- Resolution by way of the complainant being satisfied with the explanation provided by the healthcare provider
- Facilitation of a meeting between the two
- Formal investigation – (which includes obtaining an external medical opinion) re the care being consistent with or a departure from appropriate standards

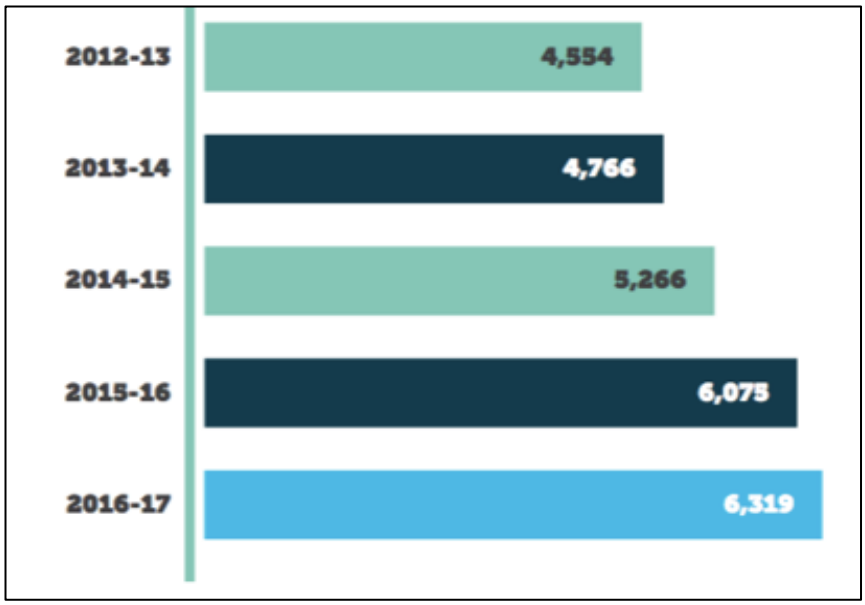
Outcomes of investigation may include:

- Referral to the relevant professional Council to address poor performance or health issues;
- Consideration for prosecution before a Disciplinary Body, having regard to the risk to the public, the seriousness of the allegation and the merits of the prosecution
- Issue a public warning
- Make comments to the healthcare provider
- Prosecution before a Professional Standards Committee or before the NCAT – NSW Civil and Administrative Tribunal
- Prosecution can result in: reprimand, fine or imposed conditions; only NCAT can suspend or cancel registration

Complaints are on the rise.

In the HCCC Annual Report 2016 / 2017, Commissioner Sue Dawson commented that:

> "Nationally and internationally, and also in NSW, health care complaints are increasing in number. In NSW there were 6,319 complaints in 2016/2017, which represents 53.0% growth over the last five years and a 132.1% growth over the last decade."



"Research indicates that this common pattern of growth is attributable to many different factors:

- An increasing population
- An ageing population, who are more likely to be using the healthcare system
- Increasing consumer choices and expectations
- Greater services offered with the developments in medical research and technology
- Expanding use of allied healthcare services
- Greater awareness of complaint management bodies
- Impacts of mandatory reporting requirements.

> "Consumers are rightly empowered and enabled to ask questions and seek solutions when things go wrong or when they do not understand aspects of their treatment and care.
>
> Where serious and complex issues are involved, consumers consistently say that they value the ability to rely on an independent body to consider and determine whether there are deficiencies in their health care."

My Own Experience:

As a plaintiff lawyer practising exclusively in the area of health law – from the mid 1990's and for the first 10 years of my legal career, this is consistently what I heard at the first consultation:

1. When there was a complication with their medical treatment, no explanation was provided and no opportunity to ask questions.

2. The patient felt they had no where else to turn for answers, (or explanations that weren't perceived to be self-serving because of the attitude that came with them), for understanding or for assistance

3. The patient feels "let down" by their healthcare provider; vulnerable – because they trusted them and often on top of this: No apology or expression of empathy or regret, was offered.

4. The patient and their family do not want the same event to happen to anyone else – they want to see to it that positive system changes are made to prevent the same outcome occurring again.

5. The patient's complications of treatment have caused a serious adverse impact on their life, including their livelihood, earning capacity and enjoyment of life and they require financial support in respect of this.

In all but the last example, effective communication (which may or may not be facilitated by the "Open Disclosure" process) where any medical complication has occurred, should be able to achieve an effective resolution of issues, if performed in a professional and genuine way.

WHAT MY INITIAL CLIENT CONSULTATION WOULD LOOK LIKE:

- I would actually meet with the client
- Plaintiff lawyers act on a "no win / no fee" basis and selection of matters was a paramount to running a successful business
- I would LISTEN to their story. I'd block at least 2 hours – knowing that they would take a good 1 hour talking and usually a lot of emotion would be involved.
- I would then ask: why have you come to see me? What are you wanting to achieve?

- This enabled 2 very important things: 1: the client felt HEARD. 2: It helped me to "screen" them. This would enable me to size them up, assess the seriousness of their claim, how the adverse medical outcome had impacted their life, what it might be worth, assessment of witness credit issues, whether the client is likely to accept and follow legal advice, what is motivating them and essentially, whether you are prepared to take the case on.

- The next hour: I would explain what it is I CAN and CANNOT achieve for them – and their options.
- For example: notions of justice – obtaining an apology, effecting discipline: I'd say that I would not be able to achieve any of those things.
- I'd explain about monetary compensation – that's all I can achieve.
- Then explain the steps involved, and the RISKS.
- And they'd listen to me because I had listened to them. The first consult was always a really important way of establishing trust, mutual respect and a functional client relationship.

It's interesting to me that as a mediator a key theme of the training was on the emphasis on the importance of being and feeling HEARD – and I expect our next speaker, Rachel King will elaborate on the science behind this.
(RachelKing.com.au)

I would also explain to my client at the first consultation, that a legal investigation involves the following:

- Steps: - investigation – gathering records, preparing a statement, analysing it – obtaining an independent expert opinion that they would have to pay for so that they have some "skin in the game" – and that this process would take at least 3-6 months. Ie no quick fix

- RISKS: if you lose the case you have to pay the other side's costs. If clients weren't concerned about that, you'd have to be careful in acting for them.

Why am I telling you this?

Because in many cases I would often explain to my client why litigation may not be the answer for them: where there was not serious adverse health consequences warranting the trouble, expense and risk. And I found that the client would most often be satisfied with that – perhaps because I had listened to their story, and they were then content in the knowledge of the prohibitive expense & risk of an investigation – not to proceed.

They might be content for the matter to NOT go beyond the investigation stage – once they had received an independent expert opinion providing a comprehensive explanation of what occurred. They might (only) make a complaint, or not make one at all.

Also explained to the client at the first consultation: That a Litigated Claim for Compensation involves proving ALL elements of the legal cause of action – most usually Negligence.

Negligence:

1. Duty of Care
2. Establishing the Standard of Care and Breach of duty – *Section 5O Civil Liability Act*
3. Establishing injury / damage

4. Proving that damage was caused by the breach of duty
5. The result was reasonably foreseeable

These elements were essentially codified in the Civil Liability Act NSW in 2001.

5O Standard of care for professionals:

(1) A person practising a profession (**a professional**) does not incur a liability in negligence arising from the provision of a professional service if it is established that the professional acted in a manner that (at the time the service was provided) was widely accepted in Australia by peer professional opinion as competent professional practice.

(2) However, peer professional opinion cannot be relied on for the purposes of this section if the court considers that the opinion is irrational.

(3) The fact that there are differing peer professional opinions widely accepted in Australia concerning a matter does not prevent any one or more (or all) of those opinions being relied on for the purposes of this section.

(4)Peer professional opinion does not have to be universally accepted to be considered widely accepted.

(NB: Sparks v Hobson; Gray v Hobson – NSWCA decision 2018)

And I'd warn my client about the risks of litigation:

Litigation – 12 to 18 months +

- ALL legal elements to be proven
- Plaintiff bears the onus of proof to the balance of probabilities
- If not successful, the Plaintiff is required to pay the Defendant's legal costs

(Most claims are resolved before Trial, eg mediation)

A salient point to think about in these different times of mass advertising and greater consumer awareness / ease of access to legal advice & services:

There are a lot more "medical" lawyers out there these days who don't take that approach – they operate more on volume of instructions. Now more than ever before – is the importance of being able to prevent a patient being disgruntled enough to make a complaint or see a lawyer. **Such a large proportion of complaints have poor communication at their core.**

Back to the HCCC Complaints Data reported in the 2016/2017 Annual Report:

Issues raised in complaints:

A single complaint will often raise a number of issues. In 2016-17, 6,319 **complaints received raised** 11,694 issues – an average of **1.9 issues per complaint**, which is consistent with the previous year.

In 2016-17, the three most common issue categories were:

- treatment (41.5%; 2015-16: 42.3%),
- the professional conduct of the health service provider (16.4%; 2015-16: 14.9%) and
- communication (15.9%; 2015-16: 17.2%).

This is the first year that the number of complaints regarding professional conduct issues have surpassed those regarding communication issues. This is not unexpected as the Commission has observed a gradual but clear year on year increase in the number and proportion of complaints received regarding professional conduct issues.

Complaints about treatment:

The most common issues raised in the treatment category were inadequate treatment (30.5%), diagnosis (11.9%) and inadequate care (10.7%;).

Other common treatment-related issues were unexpected outcome (10.3%), wrong/inappropriate treatment (8.7%;), delay in treatment (7.2%;), inadequate or inappropriate consultation (6.6%;) and coordination of treatment or follow up of results (3.8%).

Some National Statistics for Medico's:

"Identification of doctors at risk of recurrent complaints:
A national study of healthcare complaints in Australia".
By Bismark, Spittal, Gurrin, Ward & Studdert

- 2000 to 2011
- 19,000 complaints against 11,000 doctors
- 3% of medicos accounted for 49% of complaints
- 1% accounted for 49% of complaints
- RE: Clinical care: 61% / Communication: 39%

This is the title of the paper that was the focus of the October 2017 presentation at the Law Society NSW[1]. It looked at the study by Marie Bismark, Matthew Spittal, Lyle Gurrin, Michael Ward & David Studdert.

This was taken from a national sample of nearly 19,000 formal healthcare complaints lodged against doctors nationally (excluding SA) between 2000 and 2011, and drawing from all HCCC bodies, AHPRA & MDO data.

The study found that:

- 61% of Complaints re Clinical care: - comprising treatment 41% / diagnosis 15% / medication issues 8%

- 39% Communication issues: - with the breakdown of concerns re the attitude or manner at: 15% / quality or amount of information provided: 6%

- 79% complaint subjects were male / 47% were GP's / 14% were surgeons

[1] "Complaint Patterns for Medical and Legal Practitioners: Panel Discussion and Latest Research", paper presented on Monday 16 October 2017 and published by the NSW Law

Also see:

"Identification of doctors at risk of recurrent complaints: a national study of healthcare complaints in Australia", By Bismark, Spittal, Gurrin, Ward & Studdert, BMJ Quality and safety in Healthcare; 2013; 0:1-9

"Characteristics of Lawyers Who are Subject to Complaints and Misconduct Findings", by Sklar, Tara and Touk, Yamna and Studdert, Spittal, Matthew, Paterson and Bismark, (September 15,2017), https://ssrn.com/abstract=2988411

"Why do Surgeons Receive More Complaints Than Their Physician Peers?",

Likewise, in the 16/17 annual report, the HCCC: found that Some of the key issues and drivers for complaints referred for investigation were:

- a small number of practitioners who are the focus of multiple investigations, and
- complaints about one particular private health facility and its practitioners resulting in 10 investigations.

And with respect to the Legal Profession: Effective and respectful communication is a non-negotiable.

Legal Services Commissioner John McKenzie said that 4% of lawyers accounted for 58% of complaints and that 28% of complaints were against sole practitioners.

The importance of communication for lawyers was also a feature of the Legal Services Commissioner Annual Report 2016/2017, which noted that the most commonly made complaint was negligence, followed by poor communication and then overcharging.

> As has been the case for a number of years, more complaints were lodged in relation to family and de-facto law matters in this reporting year than any other area of law. Complaints in relation to personal injuries, and probate, wills or family provision claims are also common.
>
> The most commonly made complaint was negligence, followed by poor communication and then overcharging. (P6)…
>
> **Our role**
>
> In many cases this year our Mediation and Investigation Officers were able to supply additional information to complainants that had not previously been made available to them by their lawyers. Whilst the provision of additional information may not always resolve all of the complainant's concerns, it can assist their understanding of why events may have occurred.
>
> As noted above, again this year a not insignificant number of consumer matters related to a perceived failure of communication. In some instances a client may have unreasonable expectations of the level of contact they will have with their lawyer, in other instances lawyers fail to provide a basic level of communication or fail to properly explain events to their clients. (P9)

LawCover's 2017 Annual Report re Notifications data is also notable in relation to litigated matters:

It is interesting and perhaps not surprising that most notifications to LawCover for 2016/2017 (22%) were with respect to litigated matters. I think it serves to emphasize the importance of good communication and managing client expectations – and particularly "the gamble of litigation" itself.

That is, an adverse litigious outcome may be "par for the course" and not indicative per se, of solicitor negligence. After all, there are so many factors outside the parties' control when a litigated matter proceeds to hearing.

If a substantial portion of notifications and complaints in litigated matters have COMMUNICATION issues rather than NEGLIGENCE at the heart of it – then this is something that:

- Should have been preventable; and

- May well occur again if the solicitor in issue has an approach to communication that is lacking.

Percentage of notifications – area of practice

The following table presents the percentage of notifications by area of practice for the 2016–17 year with comparisons to prior years.

Area of Practice	% of Total notifications 2016–17	% of Total notifications 2015–16	% of Total notifications 2014–15
General Commercial	11	9	9
Sale & Purchase of Business	2	3	2
Conveyancing	25	21	21
Leases	5	3	4
Mortgages & Commercial Borrowing	3	4	6
Tort & Workers Compensation	5	4	4
Out of Time Personal Injury	3	6	5
Out of Time - Other	2	2	2
Litigation	22	19	21
Matrimonial	7	10	9
Probate and Wills	9	10	10
Others*	6	9	8
	100%	100%	100%

**Includes criminal, immigration, defamation and revenue*

We continue to monitor emerging trends in claims and circumstances and, where appropriate, target areas of concern through risk analysis and targeted claims prevention strategies.

(LawCover Annual Report 2017 at page 14)

And back to the NSW HCCC findings in 2016/17:

HCCC – 15.9% Communication:

"The Commission is acutely aware that sound communication between a health care provider and consumers is instrumental to quality treatment. Many complaints can be prevented by a practitioner making the effort to discuss treatment options and decisions, obtain and record informed consent and ensure that no ambiguity remains. This message will continue to be the cornerstone of our advice to health service providers."

- Attitude and Manner: 48.8%
- Inadequate Information: 32.4%
- Incorrect / Misleading Information: 17.6%

Complaints about communication

Nearly half of communication and information-related issues concerned the attitude and manner of the health practitioner. This is a decreased proportion compared to the previous year (48.8%; 2015-16: 57.6%).

Other issues in this category related to inadequate information (32.4%; 2015-16: 31.2%) or incorrect/misleading information (17.6%; 2015-16: 9.9%) from the health service provider.

The increases in these two categories may reflect health consumer's greater access to health information and a desire to receive fuller information from the provider on treatment options and risk.

In a small number of cases (1.2%; 2015-16: 1.3%), the complaint was about the failure to accommodate the special needs of a patient.

Complaints about professional conduct – 16.4%

Where the complaint related to professional conduct, most complaints related to a practitioner possibly suffering from:

- an impairment (19.3%; 2015-16: 14.2%),
- a breach of guidelines or law (15.8%; 2015-16: 19.1%) or
- illegal practice (15.0%; 2015-16: 12.6%).
- The practitioner's competence accounted for 13.8% of complaints in this category (2015-16: 17.8%), followed by
- sexual misconduct (7.1%; 2015-16: 6.9%).
- Other professional conduct-related issues (such as misrepresentation of qualifications, inappropriate disclosure of patient information, boundary violations

and financial fraud) accounted for 29.0% of all complaints raising a professional conduct concern.

The Commission receives a proportion of complaints about impairment, which may negatively impact upon a health practitioner's ability to carry out their professional duties. In most of these cases, unless there is also evidence of departures in conduct and/or a significant risk of harm the complaint would be referred to the relevant professional council which can assist these practitioners through their Health Program, to ensure they receive the necessary treatment and support.

Impairment is also an alarmingly common issue amongst lawyers:

The Tristan Jepson Memorial Foundation is an independent, charitable organisation. The Foundation's objective is to decrease work related psychological ill-health in the legal community and to promote workplace psychological health and safety. It's research has found that:

- 33% of lawyers and 20% of barristers suffer disability and distress due to depression.
- They do not seek help and self medicate with alcohol.
- High rate of suicide and suicidal ideation among lawyers.
- 80% of disciplinary matters associated with underlying mental health issues.

"Healthy people think better and make better decisions."
Tristan Jepson Memorial Foundation - (tjmf.org.au)

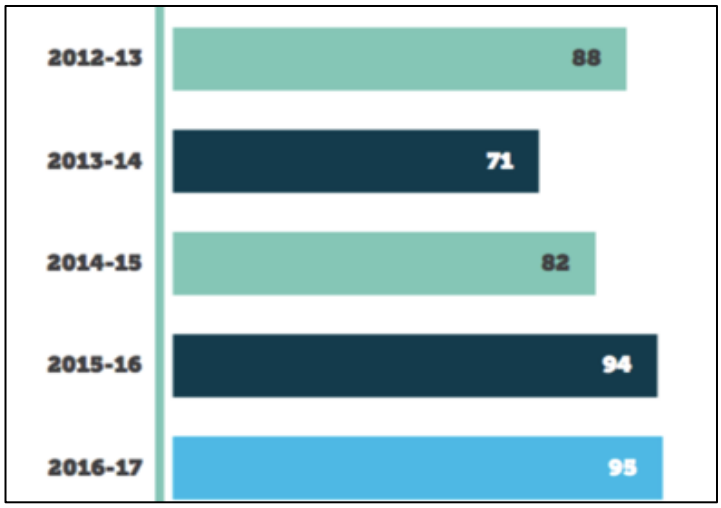
HCCC Figures continued.....RE Prosecuting complaints:

The Commission referred 198 investigations to its Legal Division, compared with 139 in the previous year. This is an increase of 42.4%.

As shown in the Chart (below), the Legal Division finalised 95 matters in 2016-17.

The overall success rate of prosecutions before Professional Standards Committees and NCAT was 96.2%.

In 2016-17, the registration of 38 health practitioners was cancelled or disqualified. Three practitioners were suspended and had conditions placed on their registration. A further 31 health practitioners had conditions placed on their registration and were reprimanded or cautioned.



In 2016-17, the Commission received a total of 4,102 complaints about individual registered and non-registered health practitioners, a 4.8% increase on the previous year.

Medical practitioners, nurses and midwives, dental practitioners, pharmacists and psychologists were the health professions most commonly complained about. Complaints about these professions accounted for 94.2% of all complaints received about individual practitioners in 2016-17.

Again, Complaints about medical practitioners continue to be the most common.

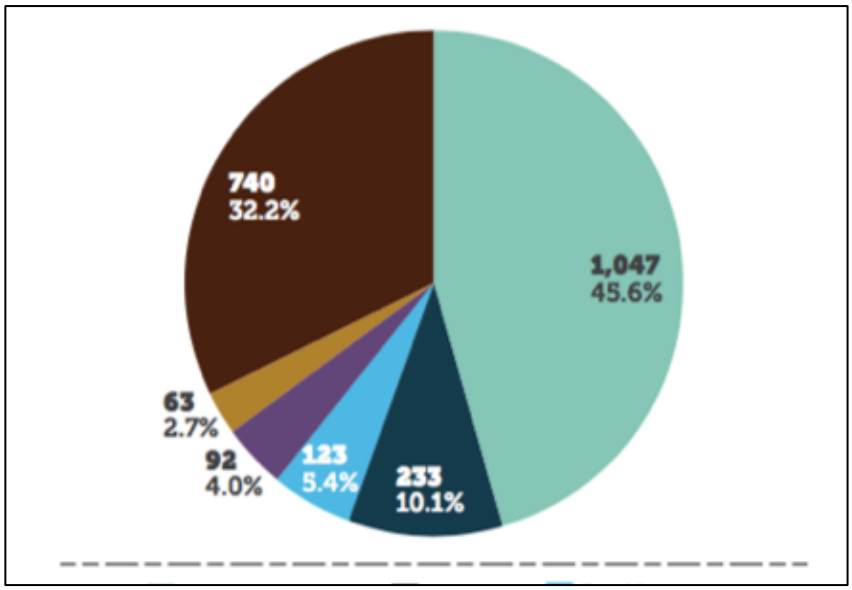
In 2016-17, the Commission received 2,298 complaints about medical practitioners, a 7.7% increase on the 2,134 received in the previous year. Complaints about medical practitioners made up 56.0% of all complaints about health practitioners in 2016-17.

As shown in Chart below, in 2016-17, complaints about medical practitioners most commonly related to those in the service areas of:

- general medicine (45.6%; 2015-16: 38.8%),
- surgery (10.1%; 2015-16: 12.0%),
- psychiatry (5.4%; 2015-16: 3.4%),
- mental health care (4.0%; 2015- 16: 5.4%) and
- emergency medicine (2.7%; 2015-16: 4.4%).

Complaints about these areas accounted for 67.8% (2015-16: 64.1%) of all complaints received about medical practitioners during the year. The remaining 32.2% of complaints were across a wide range of service areas such as oncology, obstetrics, anaesthesia, aged care, cardiology and drug and alcohol.

The high proportion of complaints relating to general medicine should be seen in the context of the number of patient-practitioner interactions in the primary health care sector – Medicare Australia reported close to 40 million GP attendances in NSW in 2016-17.



Open Disclosure is a response to incidents of patient harm by the individual healthcare provider and/or the organisation involved, the elements of which include:

- a frank and open discussion with the patient / carer / family around what happened;
- acknowledging the incident and its impact on the patient & family and providing them with an opportunity to ask questions;
- discussing the potential consequences of the incident;
- expression of sympathy, empathy, regret and/or an apology as relevant and appropriate in the circumstances;
- explaining the steps being taken to manage the incident and prevent recurrence;
- internal analysis around what happened, how, and recommended steps to be taken to prevent the same type of incident occurring again, with communication of this to the patient; and
- providing support to the patient and to the healthcare providers involved, to assist them to manage the physical & psychological consequences of what happened.

Open Disclosure was introduced in 2003 with all Health Ministers in Australia endorsing the National Open Disclosure Standard, prepared by the ACSQHC – Australian Council for Quality and Safety in Healthcare.

The National Standard was revised in 2013 and there are various papers and reviews on the issue, with some key sources referred to below.[2]

The RCA Process has a statutory privilege afforded to it – so that it can be completely transparent and a useful tool for identifying error and where system improvement is required.

This has been questioned as being at odds with the Open Disclosure process. For example, the HCCC made a submission in 2009 that privilege should not attach:

> ***HCCC submission re RCA Statutory Privilege and the Investigation of complaints arising from the death of Vanessa Anderson***
>
> Following Vanessa Anderson's death at Royal North Shore Hospital in 2005, the Anderson family made a complaint about the adequacy of Vanessa's care and treatment at the hospital.
>
> The circumstances leading to Vanessa's death were the subject of an RCA investigation. After being provided with the RCA team's findings and its recommendations for a number of systemic improvements at Royal North Shore Hospital, the family made a further complaint – that the hospital had failed to give them adequate information about the events that had led to Vanessa's death.
>
> The Commission's investigation report found that the RCA report was:

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[2] Resources:

Australian Commission on Safety and Quality in Health Care – Open Disclosure and the Open Disclosure Framework:
URL: https://www.safetyandquality.gov.au/our-work/open-disclosure
URL: https://www.safetyandquality.gov.au/our-work/open-disclosure/the-open-disclosure-framework/

NSW Health - Clinical Excellence Commission – Open Disclosure Process, including: - a very helpful "Flowchart of the Open Disclosure Process"; and
- Frequently Asked Legal and Insurance Questions
URL: https://www.cec.health.nsw.gov.au/incident-management/open-disclosure-process

"Legal Aspects of Open Disclosure II: Attitudes of Health Professionals – Findings from a National Survey", by Studdert, Piper & Idemea, *The Medical Journal of Australia 2010*; 193(6): 351-355
URL: https://www.mja.com.au/journal/2010/193/6/legal-aspects-open-disclosure-II

> *… framed at a very general level and provided little meaningful information. Its limited admissions did nothing to enlighten [the Anderson family] as to what had occurred and raised yet further questions for them.*
>
> As a result, the family remained very concerned about almost every aspect of Vanessa's care and treatment.
>
> Significantly, the Commission's investigation of the complaint required a careful consideration of the tensions between the privilege conferred on the information obtained by the RCA team and the need for open disclosure. The Commission's report on the matter concluded that the privilege:
>
> *… has the effect of compromising the effectiveness of open disclosure. Failure to resolve the tension between the privilege for information obtained by an RCA and open disclosure is likely to leave patients and bereaved [people] in a state similar to the position of the Anderson family … adding to their grief, distress and suspicion, rather than assisting them to understand what happened and begin to cope with their tragic loss.*
>
> ***NSW Health Discussion Paper – "Statutory privilege for root cause analysis and quality assurance committees – Submission by the HCCC 24 July 2009"***

I am a great believer in the genuine good sense and utility of Open Disclosure to all participants and stakeholders.

My recent observations as a participant in the Open Disclosure process:

I sincerely hope that the comments and suggestions I make here will help to improve the technique and awareness of those involved. I give that qualifier because I was a recent witness to the process performed with good intent but unfortunately: it was productive of additional emotional distress and mistrust on the part of the deceased patient's family, who I was assisting on a pro-bono basis.

DO: Explain the OD concept and process at the outset, so that the patient understands and knows what to expect.

DON'T: Leave it until a few meetings down the track to then provide the patient with the organisation's generic written material about the process.

DO: Provide a copy of the clinical records (if requested) without making this step fraught with logistical difficulties, delay and red tape.

DON'T: Provide an incomplete set of records! Yes, the records need to be gathered from various places to form a complete set. Make sure that is done before being provided to the patient. Beware clerical errors. Missing

records (particularly obvious and important records) do nothing to quell a patient's sense of mistrust or questioning of a "cover-up".

DO: Give careful consideration to who should attend the OD meeting/s and why. If a particular senior clinician or key stakeholder must attend, ensure that they are appropriately trained, including with respect to the "soft skills" of emotional intelligence, and the need to be empathic.

DON'T: Assume that attendance by a particular figurehead is going to help the patient to understand better or improve the relationship. Attendance by the "boss" who arrives late, says nothing other than to introduce him/herself, sits in the room with arms crossed, checks his/her phone constantly, looks frustrated/hostile, and then leaves the meeting early – only serves to undermine the process.

This is particularly so when that same individual essentially repeats that behavior at the next meeting but when they do speak, it is to aggressively assert that the patient's care was standard practice, as though the meeting were a courtroom.

DO: Ensure that at least 1 person attending the meeting/s is familiar with the patient's care and/or the clinical records, so that they can answer basic factual questions about what happened. This is a very important part of OD process; patients want to know and they will ask basic, specific questions that are reasonable to expect an answer to.

DON'T: Assume that the patient only wants to recount their experience and vent any grievances, such that familiarity with the factual events and content of the clinical records isn't necessary from the outset. It can be a significant source of frustration and distress on the part of the patient if their questions are constantly met with an answer along the lines of:

> "*I don't know, I wasn't actually involved in this patient's care. But the standard of care provided was very good. No-one could have predicted this outcome*."

DO: Take notes of what questions and concerns the patient is expressing, so that these can be addressed (later if necessary). Do offer to have a further meeting so that the answers can be provided on the next occasion, with opportunity for the patient to have further dialogue if desired.

DON'T: Undertake to provide a response to the patient's questions at the next meeting and then conduct the next meeting with no record or recollection of the issues that the patient specifically requested answers about. Having to re-visit everything that was painfully addressed at the first meeting is usually not what any of the participants want.

Worse: the patient feels like they have not been listened to and causes them to question the bona fides of the healthcare providers involved.

DO: Ask for the patient's version of events and opinions or concerns about what went wrong, and at least consider these to be included in any investigation report or internal review process. Frequently, there are omissions or frank errors in the medical records which mean that a fulsome understanding of events cannot be gleaned from the records or from healthcare provider witness evidence alone.
The patient and their family often have a different account or additional information that is factually important. For an analysis to be truly transparent, this should be take into account.

DON'T: Provide an investigation report to the patient that excludes the patient's version of events, and assert that the report is a transparent analysis. Don't do this and assert that the analysis and its findings are reliable for the purposes of concluding that there was no error, or that an adverse outcome was not reasonably foreseeable, etc.
If healthcare providers truly wish to improve their practices and systems with the benefit of hindsight and lessons learned, an acknowledgement of additional witness evidence from the patient that is not included in the contemporaneous medical records, is very important here.

Do these suggestions seem too critical? Do they seem too obvious? It is a great shame that this Open Disclosure process was undermined by these factors, because save for the one senior participant, the rest of the Open Disclosure team were kind, empathic, genuine, and appeared to be trying to do their utmost in their respective roles.

The unfortunate experience referred to above all added to the patient's confusion and very real sense of having been let down by the hospital care.

After an experience like that, I'd say there would be a high likelihood that a patient in a similar situation would be likely to go on to make a complaint to the HCCC – being an external body.

If the Open Disclosure process left the patient and their family satisfied with the explanation, with steps identified for system improvement, and with genuine empathy expressed – I believe this would be enough to finalise any potential complaint issues.

Likewise, in pushing for an Inquest into a patient death – noting that the Coroner will have regard to the wishes of the family in deciding on whether to conduct an Inquest as opposed to a written report following investigation.

The importance of an apology
- or expression of empathy, or regret as appropriate in the circumstances

Just as good and empathetic communication is important in resolving a problem – there is also a very real IMPORTANCE to an injured patient, OF AN APOLOGY.

It is safeguarded in legislation not to constitute an admission of liability, and it matters to plaintiffs.

One of the greatest advantages of mediation compared to a public trial is privacy. The rules of confidentiality that attach to mediation allow the parties to negotiate in an open, safe, and honest environment as there is no public scrutiny. This is conducive to parties being prepared and able to provide confidential apologies and concessions.

Lawyers should not underscore the importance of a genuine and constructively - conveyed acknowledgment of suffering, apology, and/or any other concession, on the attitude of the parties to the dispute and in turn, their attitude to the negotiations.

In my experience as a lawyer on both sides and now as a mediator – the vast majority of litigated matters settle at mediation.

At the end of a mediation I would inevitably hear my client say: "And I still never got an apology". Don't think it doesn't matter to them.

In that sense, defendant healthcare providers and their lawyers should not underscore the importance of a genuine and well made acknowledgment of suffering, apology, and/or any other concession, on the attitude of the parties to the negotiations.

And referring back to my observations re why a patient sees a lawyer in the first place: *they want to know what changes have been made*.

Mediation is an ideal forum for this. Why not communicate these issues at the start – rather than leaving them to the end or not at all. Don't think the mediation is only about a monetary negotiation. It isn't!

One further interesting point that I've found in the MEDIATOR role: I spend a lot of time with the injured plaintiff, listening to their story. In cases where there isn't much or indeed any real contact between the parties, I've found that it does seem to be enough that the P is telling me. That is – once they've told me – their demeanour improves. There isn't necessarily the need for the Patient / Plaintiff to communicate their story to the other side.

The need to be heard... it's very powerful.

It is helpful if the plaintiff's lawyer obtains from their client beforehand, regarding whether such an acknowledgement is desired or indeed expected during the course of the mediation, as well as the specifics of how that acknowledgement should be conveyed.

Likewise, it is helpful if the defendant's lawyer explores with their client in advance of the mediation:

- the willingness to offer an apology or acknowledgment of suffering, including the nature and substance of any such proposal and the outcome that the client anticipates to achieve in making it;

- offers support and advice on the specific content of how an apology may be conveyed without the risk of being regarded as an admission of liability (unless appropriate to do so);

- discusses with the client who is the most appropriate person to convey that apology or acknowledgement; and

- assists the client to convey the same at mediation in a constructive way, including consideration of "who, what, when and where" – to ensure as far as possible that the expectations of the client (and the anticipated expectations of the plaintiff) correspond and coincide.

This will avoid the perilous situation whereby one party offers an apology that is deemed wholly inadequate, or which fails properly to address the relevant issues, or is in relation to an issue which was not that anticipated by the other.

As mentioned previously, it is also VERY constructive for the plaintiff to be informed, in the course of any expression of regret, the steps that have been or are being taken to prevent a recurrence of the subject incident. For defendants: keep in mind that this is important information within the knowledge of the defendant party but not necessarily known to the plaintiff.

Apologies – not an admission of liability.

Every legal jurisdiction in Australia has laws to prohibit the conveyance of an apology from being used against the defendant healthcare provider in civil legal proceedings.

For example: NSW Civil Liability Act: defines an "apology" at S. 68 as:

> An expression of sympathy or regret, or a general sense of benevolence or compassion, in connection with any matter whether or not the apology admits or implies an admission of fault in connection with the matter.

Section 69 states that:

> An apology does not constitute an admission of fault or liability, is not relevant to the determination by the Court of liability – and evidence of an apology or anything said in that regard is not admissible in court proceedings as evidence of liability.

There are corresponding provisions in every state and territory in Australia.

Also:

In the vast majority of cases, liability cannot be established (or conceded) without **expert evidence** addressing each of the legal elements of the case required to be proven.

Despite every legal jurisdiction in Australia having laws to prohibit the conveyance of an apology from being used against the defendant healthcare provider in civil legal proceedings, a 2009 study of healthcare professionals involved in Open Disclosure nationally found that[3]:

- 88% (45/51) felt that medico-legal risk was a moderate to major barrier to Open Disclosure;

- 35% (18/51) said that advice from liability insurers was a moderate to major barrier to Open Disclosure; and

- Many participants were not even aware that there are legal protections around the expression of an apology, (whether associated with a formal OD process or not).

This is disappointing, because from anecdotal evidence that I am aware of and from what I've observed myself, insurers in this space are in fact supportive of Open Disclosure and it is part of what insurers do to respond quickly when adverse incidents arise – to assist their insureds through the process in a timely manner. Perhaps things have improved quite a bit in this regard since 2009 when this study was conducted.

Further, I genuinely believe that many disciplinary complaints to NSW HCCC and to AHPRA, as well as many litigated claims could be avoided if all healthcare providers and stakeholders were to embrace Open Disclosure. That includes to invest the resources and training necessary for those who undertake the process to do it effectively and successfully.

[3] "Legal Aspects of Open Disclosure II: Attitudes of Health Professionals – Findings from a National Survey", by Studdert, Piper and Iedema; Medical Journal of Australia 2010; 19396): 351-355

"Improving reconciliation following medical injury: - A qualitative study of responses to patient safety incidents in NZ", by Moore & Mello, 2016[4]

This was a study published in the British Medical Journal, with the premise being that "Healthcare providers are keenly interested in non-litigious approaches to resolving incidents of malpractice."

Here, the authors interviewed:

- 62 patients injured by healthcare in NZ (100 were invited)
- Administrators of 12 public hospitals(20 were invited)
- 5 lawyers specialising in Accident Compensation and 3 ACC staff – (who had extensive experience assisting injured patients)

The results showed these 5 important elements:

1. Ask, rather than assume what patients and families need from the process **– so important for the basic human need for autonomy – no less so with any patient** - and recognise that, for many patients, BEING HEARD is important and should occur EARLY in the reconciliation process.

2. Support timely, sincere, culturally appropriate and meaningful apologies – avoiding forced or tokenistic quasi-apologies.

3. Choose words that promote reconciliation.

4. Include the people who patients want involved in the reconciliation discussion, including practitioners involved in the harm event; and

5. Engage the support of lawyers and patient relations staff as appropriate.

Whilst an apology should not be seen as a substitute for other remedial actions – use flexible guidelines in relation to promoting a best practice communication policy. Don't expect to be able to prescribe a "one size fits all" communication approach.

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[4] "Improving reconciliation following medical injury: - A qualitative study of responses to patient safety incidents in NZ", by Moore & Mello, BMJ Quality and Safety; 26:788-798; 2016

Also see:

"Patients' Experiences with Communication-and-Resolution Programs After Medical Injury", by Moore, Bismark & Mello; JAMA Internal Medicine published online October 9, 2017

"The Failure of Sorry: An Empirical Evaluation of Apology Laws, Healthcare and Medical Malpractice", by Benjamin Michael, August 16, 2017

"It's absolutely, fundamentally about being heard and being able to look at the health professionals in the eyes, tell your story – and for them to look you in the eyes, an actually register."

"...It takes a lot of time to listen properly, but you'll save a lot of time if you do that early on".

And these issues don't just apply to the healthcare profession:

I deliver talks to lawyers about managing client expectations and what is interesting are the synergies here, in relation to high percentage of complaints that have COMMUNICATION as a driver, as well as impairment issues associated with many of the respondents.

Be mindful of the following key drivers of social behavior, relevant to all communications, particularly in difficult situations:

- Status
- Certainty
- Autonomy
- Familiarity / a sense of belonging
- Fairness

This is the sort of common sense advice I give to lawyers and it would seem to apply equally to the healthcare provider / patient relationship:

To get the best outcome:

Manage client expectations from the very first point of contact.

Conduct yourself with empathy and professionalism, so that your earn and maintain their confidence and respect.

Be mindful of your own health and wellbeing.

At the end of the day, as lawyers at least, (and particularly plaintiff lawyers) we all want our clients to:

- Value you and respect your advice
- Follow your advice – which you need them to do even when it is not what they want to hear

- They will feel their own autonomy in the process and be accepting / content / happy with the outcome

- They won't complain about you or challenge your fees

- You will feel in control of your life and your career and get pride & satisfaction from it – we all want to feel like we are good at what we do and to get the feedback from our clients that we have genuinely helped them. And at the end of the day: this is a job and you also need to "have a life" because if your job becomes your life – it can be a slippery slope to maintaining a healthy mental wellbeing and outlook.

Because we all want out clients to feel supported, and not scared, vulnerable and distrusting because of the way we treat and communicate with them.