Open Disclosure from an MDO Perspective

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What is Open Disclosure?

Open disclosure is the open discussion of incidents that result in harm to a patient while receiving health care.

The elements of open disclosure are:

- an expression of regret
- a factual explanation of what happened
- the potential consequences and
- the steps being taken to manage the event and prevent recurrence.

What is Open Disclosure?

The open disclosure process commences with the recognition that the patient has suffered unintended harm or an adverse outcome during their treatment.

It includes a discussion about what has happened, why it happened and what is being done to prevent it from happening again.

Why Open Disclosure?

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.

Trust and understanding must continue after an adverse event to your patient

Why Open Disclosure?

Following an adverse event, open, honest and prompt explanation of what happened may assist to:

- further mitigate adverse clinical outcome
- ensure the patient is fully informed of the issues and options available
- prevent or dissipate patient anger
- reduce the potential of a complaint and claim
- reduce the desire of the patient to consult a solicitor

These are obviously good outcomes for you, your patient and your MDO.

Why Open Disclosure?

Open disclosure can identify and enhance clinical outcomes in terms of

- lessons from losses
- quality assurance
- improved patient safety
- identifying skill deficiencies & further training opportunities

It should also assist clinicians in the reduction of personal stress and anxiety.

Let the MDO manage the medico legal consequences

Why Open Disclosure?

Failure to engage in open disclosure may be seen as :

- the clinician/practice ‘going to ground’ or ‘covering up’
- the clinician/practice being callous and unsympathetic to the injured patient

This not the impression that you, your practice or your MDO want to give to your patient, or even before a registration board or even in court if you find yourself defending your position.

Why Open Disclosure?

Australian Medical Council –
Code of Conduct 3.10 Adverse Events

When adverse events occur, you have a responsibility to be open and honest in your communication with your patient, to review what has occurred and to report appropriately. When something goes wrong, good medical practice involves:

1. Recognising what has happened
2. Acting immediately to rectify the problem, if possible, including seeking any assistance and advice

Why Open Disclosure?

3. Explaining to the patient as promptly and fully as possible what has happened and the anticipated short term and long term consequences
4. Acknowledging any patient distress and providing appropriate support
5. Complying with any relevant policies, procedures and reporting requirements, subject to advice from your MDO/insurer
6. Reviewing adverse events and implementing changes to reduce the risk of recurrence

Why Open Disclosure?

7. Reporting adverse events to the relevant authority (including employers), as necessary
8. Ensuring patients have access to information about the process for making a complaint (for example, through the relevant health care complaints commission or medical board)

Open disclosure is not easy

- Success and benefits rest on a doctors ability to discuss/disclose/explain – it can be emotional and difficult
- Do your research - be prepared and empathetic
- Show genuine empathy but do not admit liability, blame or fault – speak to your MDO for assistance in advance
- Maintain ongoing lines of communication – do not distance yourself from the incident – deal with it
- You can/will improve the system
- Keep your patient’s trust – keep your patient

The NSW Health Care Complaints Commissioner recently identified his top 10 tips for a successful apology

- Consider what the patient/their family want to know and the most appropriate way to communicate this to them
- Provide a neutral and supportive environment and language assistance if necessary
- State the relevant facts; what happened and/or what went wrong
- Stay calm, and explain in a way the patient and/or their family understand
- Clarify the degree of responsibility and apologise where appropriate

The NSW Health Care Complaints Commissioner recently identified his top 10 tips for a successful apology

- Listen to the patient's reactions – don't be defensive
- Offer a solution where available, and support and assistance
- Be open, honest and take responsibility for your actions
- Respect the patient's perspective
- Consider the complexity of the case and adjust the communication, people involved and follow-up actions accordingly.

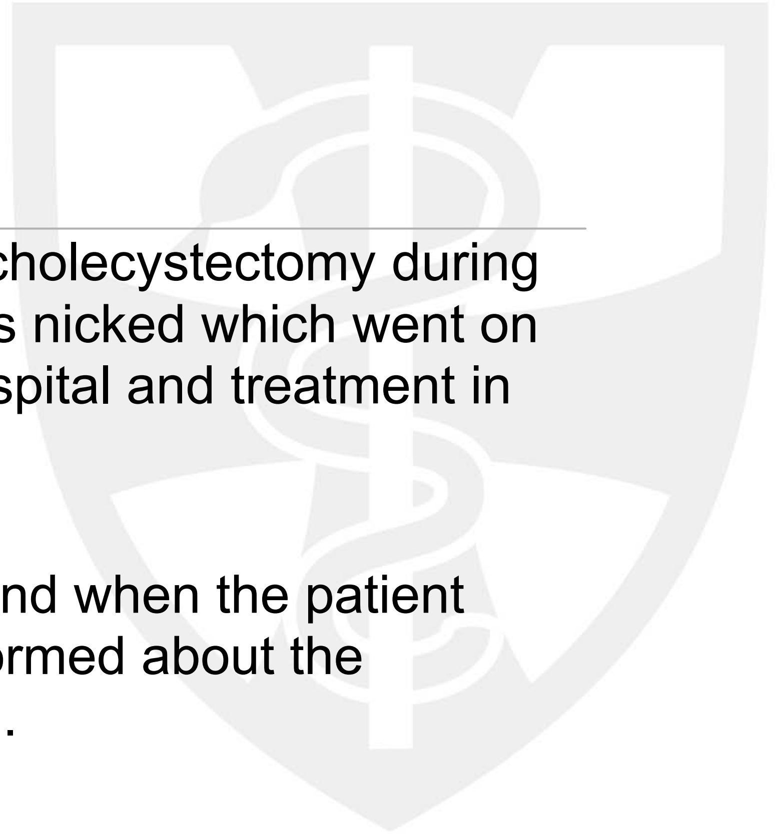
Case study 1

A 75 year old patient taking warfarin had a recent INR reading of 5.4. The GP did not read the results at the time they were received but planned to do so in his forthcoming holidays.

The patient suffered a fatal cerebral haemorrhage and the patient's son rang the practice to discuss the situation when the GP returned from holidays.

The GP ignored the calls, which led to the bereaved son feeling abandoned and ignored. He decided to engage solicitors to investigate the situation for him.

Case study 2



A patient underwent a laparoscopic cholecystectomy during which time the common bile duct was nicked which went on to peritonitis, an extended stay in hospital and treatment in intensive care.

The family were kept well informed and when the patient regained consciousness, he was informed about the complications and management plan.

The patient was accepting of the incident, no complaint or claim was ever made and a hospital review of the incident led to improved protocols where such surgery might be problematic.

Case study 3

A patient was to be contacted by the GP on return of her pathology test results. The results were received by the practice, but not passed on to the GP for 5 weeks.

The GP then contacted the patient and apologised sincerely for the unacceptable management of her results. He assured her that system improvements had now been made.

By that time, the patient had sought alternative medical advice confirming negative test results.

Whilst annoyed at the practices mismanagement , she appreciated the GPs candour and apology and suggested she would continue to utilise his services.

Case study 4

A baby was delivered by LUSCS. Post op bleeding was not noticed for 2 hours. The patient underwent emergency surgery to stop the haemorrhage, resulting in a further three weeks in hospital.

Scenario 1

The patient is given no explanation of the what occurred, why or how. She has nightmares and is stressed. She also incurs additional unbudgeted costs. As a result, she requests her medical records and engages a solicitors to act on her behalf to investigate what happened and look at the potential to claim expenses and damages.

Case study 4

Scenario 2

The day after the incident when the patient was well enough the consultant advised her and her husband that a registrar had taken too long to realise she had the post op bleeding and sincerely apologised on the hospital's behalf.

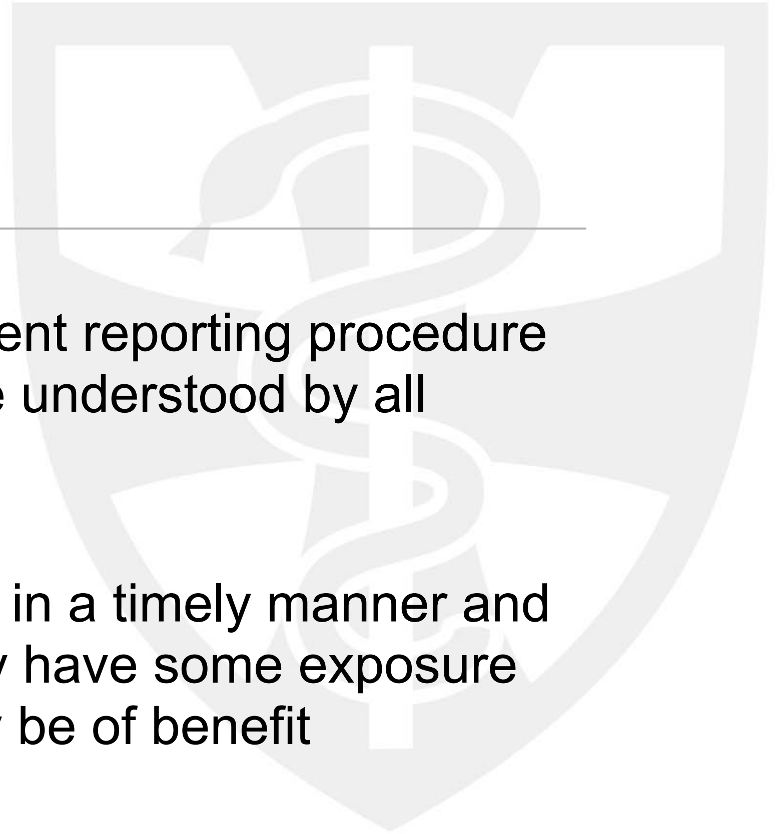
The couple were upset but relieved to know what happened, the good prognosis, the management plan and and delighted with their first child, who was fortunately healthy and well.

What was the best outcome for all concerned?

Recent Australian Evaluation of Open Disclosure

- Open disclosure has generally been met with approval and relief by consumers and health professionals
- Some uncertainty still exists amongst practitioners as to when to engage in it, but it is becoming better understood and accepted.
- Open disclosure is very much a work in progress – junior doctors are extremely important to the development and success of open disclosure in Australia

Summary



- You should have a practice incident reporting procedure in place, and protocols should be understood by all practice staff
- Advise your MDO of all incidents in a timely manner and discuss where you think you may have some exposure and believe open disclosure may be of benefit
- MIPS is highly supportive of the Open Disclosure concept/process given the potential benefits to patients, clinicians, and the broader health system.