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ADR in the medical setting

A mediation model for the disclosure of adverse events in a hospital setting

Melinda Shirley and **Tina Cockburn**

There is currently a high level of interest and activity in Australian health care around the management of adverse events. Ethical obligations, legal duties and practical guidelines have emerged requiring the open disclosure of adverse events to improve the quality of health care provision and to increase patient safety.[1]

An 'adverse event' has been defined as 'an incident in which unintended harm resulted to a person receiving health care'[2] and open disclosure as 'the open discussion of incidents that result in harm to a patient while receiving health care'.[3]

The primary goals of the open disclosure movement are to ensure that patients are made aware of medical errors (to enable proper treatment and compensation), to identify systemic problems and to minimise litigation.

Routine disclosure is inevitable

The elements of open disclosure are an expression of regret, a factual explanation of what happened, an explanation of the potential consequences and the steps being taken to manage the event and prevent recurrence.[4]

Given that the Australian system of accident compensation is fault based and focuses on the individual responsibility of health care providers — as opposed to attributing responsibility to the system within which they operate[5] — a significant barrier to compliance with requirements to report error and disclose harm to patients appears to be the fear of increased litigation, although there is little evidence to support this view.

This fear persists even though many Australian jurisdictions have enacted legislation conferring some statutory protection for those who apologise or express regret to patients following an adverse event or outcome. Unfortunately the legislation is not uniform, and, except in New South Wales and the Australian Capital Territory, there is no statutory protection for apologies which include an admission of fault.

Implementing disclosure is difficult — a mediation model may be the way forward …

The mediation model of open disclosure is a template which encourages 'physicians, hospital administrators, and other health care providers to communicate more effectively with patients following an adverse event or medical error, learn from mistakes, respond to the needs and concerns of patients and families after an adverse event, and reach a fair and cost-effective resolution of valid claims'.[6]

Mediation theory suggests that the advantages of a mediation model of disclosure in this context should include:

- the promotion of interest based solutions to meet the immediate needs of the affected patient and their family;
- the sharing of information at an early stage to promote discovery of systemic problems and to prevent recurrence;
- reduced anger and punishment behaviour;[7]
- reduced litigation; and
- maintenance and protection of the physician–patient relationship after an adverse event.

A pilot project for this model, suggests that while doctors have experience in delivering bad news and discussing hard choices with patients, these skills need to be supplemented with active listening and conflict resolution skills in the disclosure conversation to achieve optimal outcomes. ●

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The full version of the paper that this article is based on discusses the ethical and legal foundations for disclosure of adverse events in Australia, the current status of the law governing apologies and their impact on the litigation of these cases, the potential benefits of an early intervention/mediation disclosure model and recommendations in relation to the way it should be implemented by health professionals in Australia. it will be available from the NADRAC website at <www.nadrac.gov.au> shortly.

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Endnotes

1. For a discussion see B Madden and T Cockburn 'Bundaberg and beyond: duty to disclose adverse events to patients' (2007) 14(4) May *Journal of Law and Medicine* 501–27.

2. Australian Council for Safety and Quality in Health Care (ACSQHC), *Open Disclosure Standard* (2003) <www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/F87404B9B00D8E6CCA2571C60000F049/$File/OpenDisclosure_web.pdf> at 12 April 2007, at 3 (Key Terms) at p 6. For a summary of definitions of other key terms in this field, see W Runciman, 'Shared meanings: preferred terms and definitions for safety and quality concepts' (2006) 184(10) *Medical Journal of Australia* 41, available online at <www.mja.com.au/public/issues/184_10_150506/run11055_fm.html> 21 April 2007.

3. ACSQHC, *Open Disclosure Standard* above note 2 at 1.

4. ACSQHC, National Open Disclosure Standard Fact Sheet, <www.safetyandquality.org/internet/safety/publishing.nsf/Content/6A2AB719D72945A4CA2571C5001E5610/$File/opendisclfact.pdf> 12 April 2007.

5. This issue was considered by B Walker, Special Commissioner, *Final Report of the Special Commission of Inquiry into Campbelltown and Camden Hospitals* 30 July 2004 online at<www.lawlink.nsw.gov.au/lawlink/Corporate/ll_corporate.nsf/pages/sci_final_reportUTH> (last accessed December 2004). As to the question of systemic versus individual accountability, Walker SC concluded that this was a false dichotomy — and that both forms of accountability are essential and can co-exist. This issue is discussed by J Gilmour, *Patient Safety, Medical Error and Tort Law: An International Comparison*, final report prepared for the Health Policy Research Program, Health Canada (May, 2006), <www.yorku.ca/osgoode/faculty/documents/FinalReport_Full.pdf> 12 April 2007.

6. C Liebman and C Hyman 'A mediation skills model to manage disclosure of errors and adverse events to patients' (2004) 23(4) *Health Affairs*, 22–32.

7. An explanation (emphasising that the cause of negative behaviour was external or uncontrollable) reduces anger and punishment behaviour see: RJ Bies, and DL Shapiro, 'Interactional fairness judgments: the influence of causal accounts' (1987) 1 *Social Justice Research* 199–218.