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Open Disclosure Involves More Than Patient Rights -A New Zealand Experience

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Abstract. *This article explores the concept of open disclosure in healthcare, emphasizing that it encompasses more than just patient rights. Drawing on the New Zealand experience, it examines the legal, ethical, and practical dimensions of open disclosure policies within the healthcare system. By analyzing the framework established by the Health and Disability Commissioner, the article highlights how transparency in medical mishaps can enhance patient safety, trust, and quality of care. It discusses the responsibilities of healthcare providers to communicate openly with patients about adverse events, the impact of such disclosures on clinical practice, and the cultural shifts required to foster an environment supportive of open communication. Through qualitative research, including interviews with healthcare professionals and patients, the findings reveal key challenges and opportunities in implementing effective open disclosure strategies. The article ultimately argues for a holistic approach to open disclosure that considers the rights of patients, the responsibilities of healthcare providers, and the implications for healthcare governance, aiming to create a safer and more accountable healthcare system in New Zealand.*

Keywords: *Healthcare governance; New Zealand; Open disclosure; Patient rights; Transparency*

1. INTRODUCTION

Open disclosure is the term used to describe responses to patients affected by adverse events in hospitals. I shall propose that rather than being confined to communicating with patients, it should be extended to the creation of a culture of open disclosure to better meet their expectations within changing patterns of health service delivery. In describing the establishment of such a culture at Hutt Hospital, I shall emphasize its much wider potential for benefit beyond just the affected individuals.

2. BACKGROUND

Disclosure to patients by doctors has traditionally been part of good clinical practice, though the degree of openness has varied. Risks of adverse events in hospital admissions of up to 18% despite advancing technology, reflect an environment which includes new and increasingly complex systems of treatment involving numbers of different clinicians. The majority of adverse events are due to the breakdown of safety nets in both clinical and organization systems - often identified by simply asking “could the same mishap have occurred with another clinician?” Expectations of greater openness by patients are often thwarted by unclear accountability for adverse events resulting in responses which are delayed and fail to address their concerns.

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Despite increasing recognition of the needs and rights of patients there is still hesitancy and often resistance to open disclosure. Persisting hierarchical traditions in the health system foster a culture of low trust and high tolerance of error with defensive attitudes to challenges or questioning. Fears about open disclosure, particularly of its impact on the reputation of doctors, masked by responses such as the need to avoid "upsetting patients" lead to patient perceptions of avoidance and secrecy. These sensitivities extend to the organizations within which they work, though in New Zealand financial risks are usually minimal because of the unique compensation for injury provided under legislation by the Accident Compensation Corporation.

Different Approaches To Open Disclosure

The focus of the legal approach to disclosure is on defending or proving liability for a particular incident whilst that of the New Zealand Health and Disability Commissioner is largely on the rights of individual patients. Both are narrow and give little or no attention to the potential for improving safety for future patients. Protocols for open disclosure developed by hospitals tend to reflect the influence of lawyers and to avoid explicit recognition of organizational accountability.

The Hutt Hospital Approach

Hutt Hospital is developing a culture of open disclosure being "what we do" to meet the rights of patients – both the injured and future patients. This is most evident in the obstetric service reflecting its central focus on the rights of women but less so to varying degrees in other services.

The stimulus for promoting a culture of open disclosure was an adverse event in which a patient died during surgery as the result of undue delays in access and diagnosis. In leading a process of open disclosure, subsequently acknowledged by the coroner, senior management and professional leaders recognized the limitations of fault-finding for adverse events and identified the responsibilities of the organization as a whole since the majority are of systemic origin. The organization, therefore, has accountability not only for both for the majority of adverse events but also how open disclosure is conducted. This protects and supports individual clinicians and also allows them freedom to advocate for their patients.

By aiming to put things right including acknowledging and addressing emotional consequences of adverse events, staff have become less defensive and more proactive. Whilst a culture change requires time and an initial level of trust, particularly between clinicians and

managers, it has been our experience that its further enhancement has contributed to improving quality and safety of services through more open questioning and challenging of inappropriate behaviour, an often unrecognized risk to patient safety, by both clinical and non-clinical staff.

Acceptance that adverse events are inevitable rather than unforeseen catastrophic happenings leads to a "business as usual" response which, like service delivery, has to be well managed. Managers, therefore, have key roles along with the involved clinicians. Staff do need guidance, support and also reinforcement through positive feedback to develop confidence in entering into what for many is still an uncomfortable experience of open disclosure.

Doctors And Open Disclosure

Resistance from senior doctors was addressed starting with the simple but provocative question "what would you yourself want if you were a patient?" Some had difficulty understanding the differences between fault attributable to a system rather than to individuals and between their perceptions of "openness" compared to those of patients. What impacted most, however, was the recognition that an organizationally driven response to adverse events meant that individual clinicians were protected and supported by the hospital. Reflecting the systemic causes of the case I have described, it was the hospital manager, rather than individual clinicians, who took public accountability on behalf of the hospital.

Occasionally of course, adverse events are clearly the result of individual negligence or incompetence for which the responsible clinician must be held accountable. Where, however, they result from recognised complications of procedures, clinicians working competently should be protected. It has been noticeable following such adverse events that doctors are becoming more proactive and open reflecting the cultural change.

3. CONCLUSION

We have found that creating a culture of open disclosure offers far more than reductionist and often legalistic approaches which can have a damaging impact on all concerned including aggrieved patients. Greater openness not only with patients but between staff is making the hospital a safer and better place to work. By reducing complaints and referral to external bodies such as the Health and Disability Commissioner, time spent in responding to them by clinicians and managers has been greatly reduced. The explicit ultimate accountability taken by the organization as a whole not only for how open disclosure is done but more importantly for the majority of adverse events, has greatly increased the trust and confidence of clinicians. Further development of the culture, however, is ongoing and requires

continual reinforcement in the face of persisting defensive attitudes and a national culture of blame and shame fueled by the media.

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