Interest in the practice of open disclosure (OD) — candid communication between health professionals and patients following adverse events in health care — has exploded internationally in the past decade.1 2 Australia has emerged as an international leader in this area. A national Open Disclosure Standard (“the Standard”), designed to facilitate open communication about adverse events, was endorsed by the health ministers in 2003.6 A recent evaluation of the Standard’s implementation in 21 pilot sites demonstrated a reasonable degree of enthusiasm for OD among both patients and clinicians.7

However, legal concerns were apparent. A number of health professionals voiced uncertainty about the implications of OD for medicolegal risk and liability insurance coverage.7 In addition, the Standard’s rollout was initially stalled by concerns from state government insurers about the fiscal and litigation consequences of offering expressions of regret to patients who had been harmed. Survey research in the United States has identified fear of increased liability as one of the main reasons doctors are reluctant to embrace OD.4 8 9 but no previous research has addressed this question in Australia.

We surveyed a sample of health professionals at the forefront of OD practice in Australia. Our main objective was to gauge the perceived importance of medicolegal fears as a barrier to OD. Because some existing state laws — chiefly, apology and qualified privilege laws — may protect information conveyed in OD from subsequent use in legal proceedings, the survey also elicited views on the extent to which such laws supported OD practice.

METHODS

Sample

OD processes are a relatively new feature of health care delivery systems. We expected limited knowledge of laws related to them within any random sample of health professionals. We therefore targeted the survey at a small group of recognised experts — individuals with direct experience with actual OD communications. In addition, because laws that bear on OD practice are chiefly state laws, we sought to include in the sample participants from all eight states and territories, roughly in proportion to population size.

Participants were identified in three principal ways. First, staff from the Australian Commission on Safety and Quality in Health Care (ACSQHC) provided names of OD leaders from across the country. Second, we contacted directors of patient safety and quality in state departments of health and requested names of people recognised as leaders of OD practice in that state. Third, we used snowball sampling: at the completion of each survey, we asked participants whether they knew of counterparts at other health care institutions who were knowledgeable about and experienced with OD. Our target sample size was 50 participants.

Survey instrument

The instrument asked participants to rate the importance of 11 potential barriers to OD on a four-point Likert scale (from “not a barrier” to “major barrier”). A barrier termed “fears about medicolegal risks” was presented midway down the list.

Next, participants rated their views about the extent to which apology laws and qualified privilege laws, respectively, made health professionals “more willing to conduct full and frank open disclosure”. Apology laws were defined as “laws that protect apologies or expressions of regret from later use in legal proceedings”. Qualified privilege laws were defined as “laws that protect certain types of information related to quality improvement efforts, such as information that comes out of the work of a hospital’s quality assurance committee and incident reports, from use in legal proceedings”. Participants rated their willingness on a five-point Likert scale (from “not at all” to “much more willing”). These questions probed participants’ general views on the effectiveness of apology and qualified privilege laws, untethered to the legal situation in any given jurisdiction. Subsequent questions ascertained participants’ knowledge of prevailing laws in their own jurisdiction.

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Finally, the instrument elicited participants’ opinions about whether legal reforms are needed to “help ensure the free flow of information between providers and patients about adverse events”, and if so, what those reforms should be. Law reform recommendations were recorded as free text. We pilot-tested a draft version of the instrument on three people who met the sampling criteria.

**Survey administration**

One of us (D P) administered the survey by telephone between April and June 2009. Completion times varied in duration from 14 minutes to 65 minutes, with a median of 25 minutes.

We approached a total of 83 people, of whom 20 did not have direct experience with OD practice and thus were ineligible to participate. Of the rest, nine did not respond to telephone and email requests to be surveyed and three refused. The remaining 51 people agreed to participate and completed the survey (a response rate of 81% [51/63] among eligible participants).

**Analysis**

Our analysis was descriptive. For closed-ended questions, we calculated simple counts (categorical responses) and means (Likert scales). For analysis of the free text responses to the question about law reforms, we used standard coding techniques for qualitative data. Two of us (D P and D M S) reviewed the responses and independently generated a list of candidate categories. We then compared the two sets of candidate categories, agreed on a final set of seven categories and six subcategories, and sorted each reform into those categories and subcategories.

**Ethics approval**

Our study was approved by the Human Research Ethics Committee of the University of Melbourne.

**RESULTS**

**Sample characteristics**

A profile of participants is shown in Box 1. About half (24/51) were doctors and about a third (16/51) were nurses. Participants most commonly held positions as hospital risk managers (14/51), directors of clinical governance (7/51) or clinical services (7/51), managers of consumer services (6/51) or patient safety officers (5/51).

**Barriers**

Two perceived barriers to OD stood out (Box 2): most participants cited fears about medicolegal risks (45/51) and inadequate education and training in OD (43/51) as major or moderate barriers. With mean Likert scores of 3.2 and 3.4, respectively (“3” representing a moderate barrier and “4” a major barrier), the perceived importance of each of these barriers was significantly greater than any of the other barriers posed (P < 0.001).

Four other factors were cited as a major or moderate barrier by about a third of participants: time constraints (18/51), fear of scaring patients (18/51), advice from liability insurers (18/51) and advice from clinical leaders (16/51). Only six participants viewed cost as a major or moderate barrier.

**Perceived efficacy of legal protections**

Opinion was mixed over the efficacy of apology laws and qualified privilege laws as tools for promoting OD (Box 3). With respect to apology laws, participants were roughly equally divided as to whether they made participants much more or more willing to conduct OD (19/51); somewhat more willing (14/51); or not more willing (18/51). Among those in the third group, a majority (14/18) indicated that lack of awareness of apology laws was the key inhibiting factor.

With respect to qualified privilege laws, 30 participants viewed them as having limited or no effect on OD. The leading reason (12/30) given for lack of effect was that the laws did not cover situations or types of information pertinent to OD activities. As one participant put it, “I don’t think they have any bearing on open disclosure”; another said, “We have not tied in qualified privilege with the open disclosure process at all. So for our hospital the impact has been nil, not positive or negative.”

**Knowledge of legal protections**

Although all states have apology laws that may apply to OD communications, knowledge of that fact was limited, except among participants from New South Wales and the Australian Capital Territory (Box 4). Unlike the general questions about perceived efficacy described above, this set of questions elicited knowledge of the laws actually in force in the participants’ jurisdiction. A majority of participants in four states and
Not much more willing/not at all willing 18 30
Lack of awareness of law 14/18 3/30
Lack of confidence in law’s protective value 2/18 5/30
Don’t know, no experience with them* 0/18 4/30
Insufficient connection to OD 0/18 12/30
Other reason 2/18 6/30
* These responses came from four participants in the Northern Territory, where qualified privilege laws exist but there are currently no health care entities designated under the legislation to enjoy this privilege.

3 Perceived effect of existing qualified privilege and apology laws on health professionals’ willingness to conduct full and frank open disclosure (OD) (n = 51)

Law reforms
All but four participants recommended law reforms. The most frequent recommendations pertained to bolstering existing protections by strengthening or clarifying them (23/47), particularly qualified privilege laws (Box 5). The other leading recommendations were: improving education and awareness of existing laws (11/47); fundamental reform of the medical negligence system (8/47), including introduction of no-fault compensation for medical injuries (6/47); and better alignment of the activities of various legal actors, such as coroners and health

4 Participants’ responses regarding whether their jurisdiction has a law that protects apologies made in open disclosure

Discussion
Our survey of health professionals detected considerable apprehension about the liability implications of engaging in OD. Fear of medicolegal consequences, alongside inadequate education and training, was perceived as the leading barrier to OD. More than two-thirds of participants rejected, or only tepidly supported, the proposition that the willingness of health professionals to conduct OD is enhanced by existing laws that protect the information from use in legal proceedings.

Our findings resonate with those from previous US studies that have highlighted concerns about ODs medicolegal repercussions as a major obstacle to its uptake. In theory, health professionals’ fears about the legal consequences of OD could be mitigated by laws that prohibit use of the information for inculpatory purposes. To the extent that such protections exist in Australia, apology laws and qualified privilege laws are the main sources. In practice, however, several factors may undercut the ability of such laws to promote OD. First, the laws may have limited applicability in the OD context. Second, whatever protections they provide may be too weak to assuage medicolegal concerns. Third, health professionals may not understand or be aware of legal protections. Responses to our survey suggest that all three factors are at work.

Ignorance about protective laws was evident in responses to questions about apology laws. Among the third of participants who said that apology laws were not an effective way of encouraging OD, the leading reason given was “lack of awareness” of these protections. Even more compelling was the finding that participants themselves, despite being leaders of OD in Australia, displayed uncertainty and confusion about the existence of apology laws in their own jurisdictions. Every state and territory has an apology law that should cover expressions

Complaints commissioners, with the objectives and culture of OD (6/47).
of regret made in OD communications. Knowledge of this was excellent among participants from Victoria and Queensland, and poor among participants from the other states and territories.

Many participants were sceptical about the relevance and applicability of qualified privilege laws to OD. A majority (30/51) said that such laws do not encourage OD, and the leading reason given for this lack of effect was that the laws had little or no applicability to OD conversations. The analysis of OD-related laws in the previous issue of the Journal suggests this view is correct; according to the legal analysis, an accurate picture of protections under existing laws will be cold comfort. Eight participants said that radical reform of the current negligence system was needed; their concern was that an environment conducive to OD is unattainable against the backdrop of the current adversarial system. This argument joins others for "no blame" systems of compensation for medical injury. Ironically, the main findings of our study — that medicolegal fears and lack of appropriate OD training are at the top of the list of perceived barriers to OD in Australia — should give OD proponents cause for optimism, as both obstacles should be at least partly fixable. Legal regimes can be reformed to reassure health professionals who are open with patients about adverse events that their forthrightness will not be turned against them. With such reforms in place, educational efforts could then emphasise both the skills needed to conduct OD effectively and the strength of prevailing legal protections.

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COMPETING INTERESTS

David Studdert is the chief investigator of an Australian Research Council (ARC) linkage grant in which he is partnering with the Health Services Commissioner of Victoria and Avant Mutual to study complaints and claims regarding informed consent. Most of the project costs are met by the ARC, but Avant Mutual also contributes to the project budget. Donella Piper was contracted by the ACSQHC in 2008 to advise on the development of a consumer engagement strategy, and received reimbursement from the ACSQHC for related travel costs. Rick Iedema was paid consultancy fees by the ACSQHC for three research projects relating to OD.

AUTHOR DETAILS

David M Studdert, LLB, ScD, MPH, Professor and Federation Fellow
Donella Piper, LLB, PhD, LLM, Research Fellow
Rick Iedema, PhD, Professor of Organisational Communication, and Director

REFERENCES

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