HONG KONG ACADEMY OF MEDICINE
香 港 醫 學 專 科 學 院

BEST PRACTICE GUIDELINES ON DISCLOSURE, APOLOGY AND ALTERNATIVE DISPUTE RESOLUTION

Hong Kong Academy of Medicine
Professionalism and Ethics Committee
Disclosure, Apology and Alternative Dispute Resolution Task Force

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Foreword

To further promote medical professionalism and ethical practice among Fellows and specialist trainees, the Hong Kong Academy of Medicine established the Professionalism and Ethics Committee in March 2019. The Committee has set up six task forces to cover specific areas and develop relevant best practice guidelines where appropriate, from the perspectives of professionalism and ethical clinical practice for medical and dental practitioners.

While prevention of medical errors is always the goal of medical practitioners, adverse events and disputes between patients and doctors do occur. Understandably doctors fear that making an apology or disclosing information about an unanticipated outcome inappropriately may result in litigation. The Apology Ordinance (Cap. 631) was enacted in Hong Kong in December 2017. It covers a wide range of applicable proceedings and encourages the making of apologies with a view to preventing the escalation of disputes. Alternative dispute resolution is an effective means of resolving disputes without going through the process of litigation. Mediation has the additional benefits of encouraging disclosure, lowering legal costs, reducing the time consumed and ensuring confidentiality. It can be conducted in a friendly atmosphere and the parties have full control of the process and the outcome. The Professionalism and Ethics Committee recognises the importance of these new developments and established a Task Force on Disclosure, Apology and Alternative Dispute Resolution, which has compiled this set of guidelines aiming at providing relevant guidance and advice to medical and dental practitioners.

The present document will be subject to regular review and update. Your input will be most valued and welcomed.

Professor Gilberto Leung
Co-Chairman
Professionalism and Ethics Committee
Hong Kong Academy of Medicine

Dr. James Chiu
Co-Chairman
Professionalism and Ethics Committee
Hong Kong Academy of Medicine

Preface

Disclosure, Apology and Alternative Dispute Resolution (ADR) are crucial means in tackling conflicts arising from medical disputes. The three aspects correlate to each other and contribute together to maintain good doctor-patient relationship when adverse events or medical errors occur. The culture of open disclosure derives from an apology offered to a patient when a patient considers that treatment or care is not provided at the level that it should have been. The apology goes hand in hand with disclosure which is a vital part of the process, helping the patient understand what has happened as accurately as possible. When disputes occur, alternative dispute resolution and mediation are helpful tools to consider.

It takes time to promote a new culture in these aspects. The enactment of the Apology Ordinance in Hong Kong since 2017 has been an important enabler, and the publication of these Best Practice Guidelines on Disclosure, Apology and Alternative Dispute Resolution aims to provide some useful guidance and practical tips for healthcare practitioners to refer to, so that they can gain confidence when making apology or open disclosure, or considering alternative dispute resolution or mediation as appropriate whenever such need arises at work.

Thank you to all Task Force members' valuable inputs in the compilation of these guidelines, particularly to Prof. Gavin Joynt, Prof. Gilberto Leung, and Dr. James Chiu for their key contributions in drafting the guidelines. Special thanks should go to Dr. James Chiu for his leadership in the set-up and initial stage of this task force since 2019.

I hope you will benefit from the views and suggestions given in these guidelines and find them useful in your daily work.

Professor Paul Lai
Convenor, Task Force on Disclosure, Apology and Alternative Dispute Resolution
Professionalism and Ethics Committee
Hong Kong Academy of Medicine

About this Document

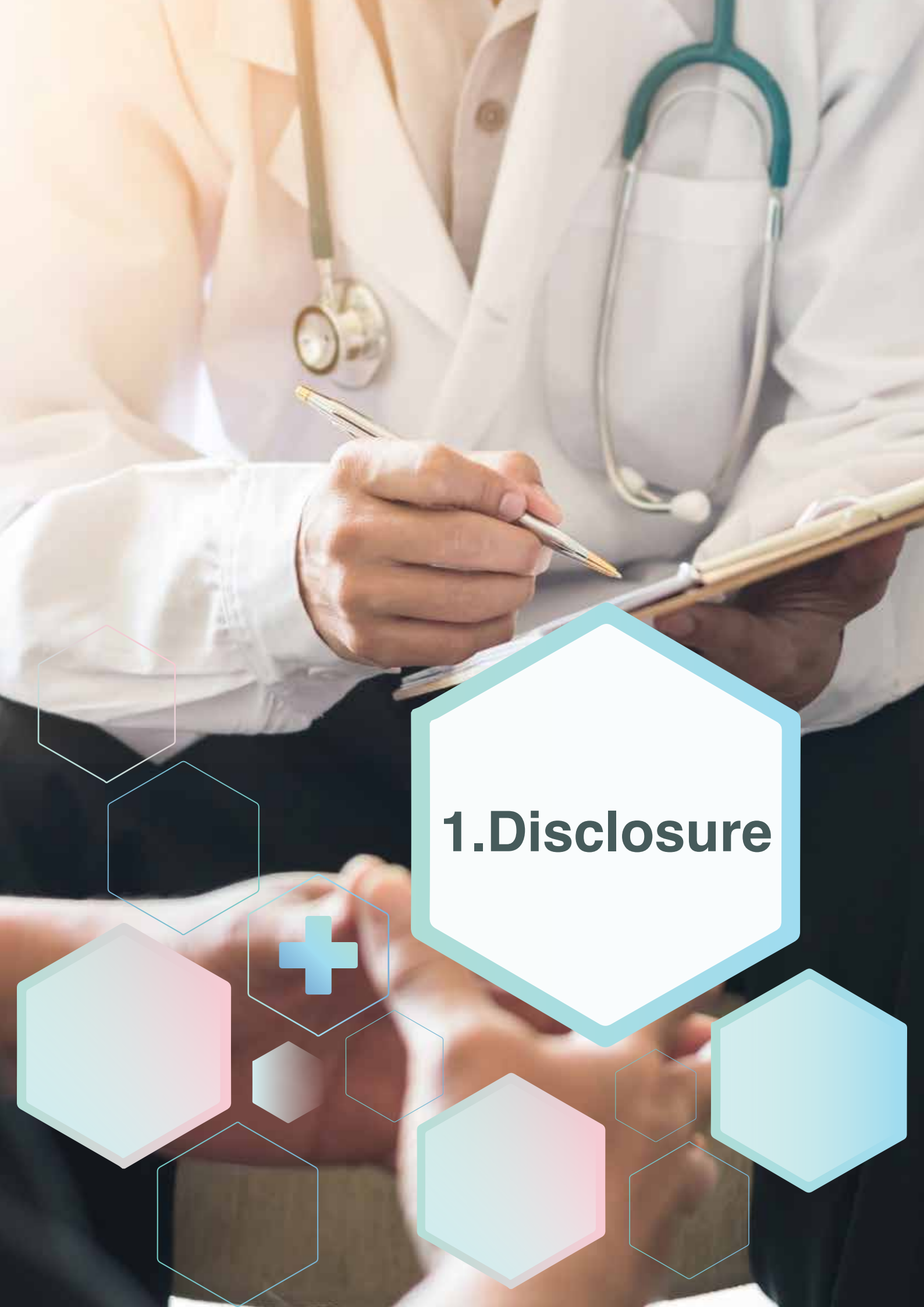
The information contained within this document is for guidance only and is not intended to be prescriptive. The guidelines are developed from the perspectives of professionalism and ethics, on the basis of which medical and dental practitioners should exercise their clinical judgment, with regard to all clinical and other circumstances.

This document is compiled by the Task Force on Disclosure, Apology and Alternative Dispute Resolution established under the Professionalism and Ethics Committee of the Hong Kong Academy of Medicine, with the following membership:

Convenor
Prof. Paul Bo-san Lai (Vice-President (Education and Examinations), Hong Kong Academy of Medicine)

Members
Dr. James Shing-ping Chiu (Co-Chairman, Professionalism and Ethics Committee, Hong Kong Academy of Medicine)
Prof. Gilberto Ka-kit Leung (President and Co-Chairman, Professionalism and Ethics Committee, Hong Kong Academy of Medicine)
Dr. Hing-yu So (The Hong Kong College of Anaesthesiologists)
Prof. Gavin Matthew Joynt (The Chinese University of Hong Kong)
Dr. Yolanda Yee-hung Law (The College of Dental Surgeons of Hong Kong)
Dr. Eric Ming-tung Hui (The Hong Kong College of Family Physicians)
Dr. Wing-wa Go (The Hong Kong College of Obstetricians and Gynaecologists)
Dr. Nancy Shi-yin Yuen (The College of Ophthalmologists of Hong Kong)
Dr. Ping-tak Chan (The Hong Kong College of Orthopaedic Surgeons)
Dr. Alan King-woon So (Hong Kong College of Paediatricians)
Dr. Phyllis Kwok-ling Chan (The Hong Kong College of Psychiatrists)
Prof. George Kwok-chu Wong (The College of Surgeons of Hong Kong)

Advisor
Mr. Woody Chang (Honorary Legal Advisor, Hong Kong Academy of Medicine)



1.Disclosure

1. Disclosure

1.1 Introduction

1.1.1 What is a patient safety incident?

A patient safety incident occurs when an event or circumstance results in, or could result in, unnecessary harm to the patient.[1] A patient safety incident that causes harm to the patient is designated a *harmful incident*. If no harm occurs it is termed a *no harm incident*. A patient safety incident that is recognised, but is prevented from reaching the patient, either by design or chance, is termed a *near miss*.

It is worth noting that key to the definition is "unnecessary harm", and therefore known complications that may occur as a result of appropriately indicated and correctly performed procedures are not considered "unnecessary harm".

1.1.2 Why is open disclosure required?

It is a fundamental aim of healthcare to provide safe treatments for our patients. When a patient safety incident causes harm – or potentially causes harm – it creates communication challenges. To achieve a consistent culture of patient safety, it is necessary that our Fellows and trainees maintain honest and effective communication with patients and their families or representatives, especially after a patient safety incident.

In particular, we should always recognise:

- The ethical and professional duty of trust, which is based on honesty and transparency in the doctor-patient relationship
- The need to demonstrate respect and empathy
- The patient's right to know what has happened, to allow their active involvement in future therapeutic decision-making (respecting their autonomy)
- The responsibility to learn from patient safety incidents and to improve both personal and organisational performance as a result; this learning process frequently involves system improvements that result in systemic safety enhancements
- The expectations of patients and families, who may be more understanding of incidents following open disclosure; although factors leading to litigation are complex, effective communication and provision of care following a patient safety incident are factors that may influence a patient/family decision to take legal action[2-6]

1.1.3 What do patients generally expect from the disclosure process?

- To be informed of the facts of a patient safety incident within a reasonable time frame after the event

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- That an appropriate response (including treatments) to minimise the harm are immediately explained and implemented
- For a comprehensive investigation to confirm the facts and to be completed within a reasonable time frame
- For an honest and comprehensive disclosure of the facts within an appropriate time
- That accountability is acknowledged appropriately
- To receive a sincere apology
- That, when necessary, the investigation report is shared with appropriate individuals and supervisory/regulatory bodies, particularly to ensure that future similar incidents are averted
- To receive fair compensation within a reasonable time frame, when appropriate

1.1.4 What are the common concerns preventing open disclosure by healthcare professionals?

- Uncertainty about the relationship between error and outcome
- Fear of punishment
- Culture of perfection, loss of self-esteem, fear negative peer judgment
- Lack of knowledge of responsibility, or lack of training

1.1.5 Objectives of this guidance

- To help Fellows and trainees understand the professional requirements relating to open disclosure
- To provide Fellows and trainees with guidance in order to promote the consistent practice of open disclosure
- To encourage individuals and organisations to learn from the circumstances of patient safety incidents
- To encourage individuals and organisations to provide support for healthcare workers who have been involved in a patient safety incident

1.2 Professional requirements of open disclosure

Open disclosure is a process that may vary markedly in nature and duration depending on the seriousness of the patient safety incident, and/or the degree of harm the patient suffers, if any. Generally, the more serious the incident, and/or the more harm suffered, the more detailed and prolonged the disclosure process is likely to be. Correspondingly, additional parties representing both sides are likely to become involved. For example, a simple medication error resulting in minimal harm may be effectively dealt with by the person involved in one brief disclosure

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interview. However, a fatal anaphylaxis resulting from a medication error may require an initial disclosure interview with the person and family/ other significant representative involved being supported by multiple parties, followed by a process of multiple interviews as the investigation progresses and personal, compensation and legal matters are progressively resolved. The following section provides brief guidance on key questions related to the open disclosure process.

1.2.1 When is open disclosure required?

Open disclosure should always follow a patient safety incident that has resulted in harm (harmful incident).

Open disclosure should usually follow a patient safety incident that has potentially resulted in harm (no harm incident), particularly in circumstances when it is likely that a reasonable person would want to know.

Open disclosure is usually not required when a patient safety incident has not reached the patient (near miss), unless the near miss has ongoing safety implications, or the patient is aware of the event.

1.2.2 How much information should be disclosed?

The known facts relevant to the incident should be described. At the initial disclosure, all details may not yet be available and therefore only those facts that have been ascertained (and agreed by the involved parties of the involved healthcare workers) should be discussed. When necessary, a statement should be made to the effect that all important facts will be disclosed once an investigation is completed.

The likely short- and long-term effects of what has happened should be explained to the patient, or where appropriate, the patient's family/other significant representative.

An appropriate apology should be made (see Section 2.4).

Additional agreed facts and implications for the patient's future well-being should be disclosure during follow-up meetings, and if necessary, a post-investigation disclosure meeting.

1.2.3 Who should disclose the information?

During the initial disclosure interview, there are two recommended approaches:

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- The individual, or individuals most involved in the incident may lead the interview, with senior medical administrative support, if necessary. For Fellows in individual practice, consideration may be given to seeking the support of a senior colleague.
- Senior medical and/or administrative support staff may lead the interview, with input from the person(s) most involved with the incident.

Subsequent disclosure interviews may be conducted by the individual(s) involved, and/or senior medical or administrative staff, with the responsibility for leadership of the interview decided by factors such as the severity of the incident, psychological state of the individuals involved, the emotional response of the injured stakeholders, and practical constraints.

For incidents with substantial implications or harm, it is advisable that senior medical and/or administrative support staff should lead the interviews, with input from the person/s most involved with the incident.

1.2.4 When should the disclosure be communicated?

An initial disclosure interview should usually take place within 1-2 days after the incident, if possible.

1.2.5 To whom should the information be disclosed?

- The patient, or where appropriate, the patient's family/other significant representative
- Employer and supervisor/s of the implicated healthcare worker/s to facilitate the provision of support for the disclosure process, and to allow for appropriate review and investigation, if justified; this encourages a learning culture that responds to adverse incidents with improved processes
- Professional organisations and regulatory bodies, if considered necessary
- Other relevant stakeholders such as colleagues, when their interests may be affected

1.2.6 How should individuals and organisations learn from a patient safety incident?

Individuals and organisations are encouraged to function within a "just culture".

Patient care should be safe, transparent and honest communication valued, and continuous learning from patient safety incidents encouraged. This requires the following:

- Encourage disclosure by involved healthcare workers in a safe environment, i.e., a process that formal, fair, focused on system improvement, and follows clear policy and legal requirements.

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- Provide healthcare workers with education and training that prepares them for disclosure, investigation and subsequent system improvement processes.
- Develop robust disclosure, investigation and subsequent system improvement processes to ensure there is potential to learn from all patient safety incidents.
- Keep families informed of positive system outcomes of initially harmful incidents.

1.2.7 What support should be offered to the patient/family?

- Appropriate remedial treatment, when possible, including additional medical treatments
- Follow-up meetings if desired by the patient/family
- A contact person for the patient/family, who will deal with ongoing queries and support matters
- Psychological support to help the patient/family, when appropriate
- Physical support measures, e.g., extended visiting hours
- An explanation of system improvements, if any, that have resulted from the internal review/investigation

1.2.8 What support should be offered to the healthcare staff involved in the harmful incident?

Healthcare workers involved in a patient safety incident may suffer from feelings of regret, guilt, sadness, and loss of self-esteem.[5]

It is being increasingly recognised that healthcare workers involved in a patient safety incident receive little formalised emotional, psychological or practical support. Colleges and the Academy are encouraged to develop support structures to assist Fellows involved in patient safety incidents, especially when the individual practitioner is working independently.

A process of disclosure, and apology, may assist emotional healing.[7] Organisations are encouraged to support the emotional well-being of healthcare workers by the following:

- Consider appointing an individual with experience and/or training to support affected healthcare workers.
- Consider instituting a formalised debriefing process to help those involved to express the emotional impact of the event, share issues related to the event with other relevant parties so as to minimise feelings of isolation, and receive advice on how to cope with evolving challenges.
- Consider offering a leave period for substantially traumatised individuals to recover.
- Consider appointing an individual with experience and/or training to provide follow-up support for affected healthcare workers.

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- Provide educational opportunities and disclosure training to healthcare workers, as well as junior trainees so they are better prepared to deal with disclosure processes.
- Acknowledge the contribution of systems as contributory causes of incidents, so that individual responsibility is appropriately apportioned, and opportunities for system improvement realised.
- Establish fair and transparent systems for incident investigation, and establishing accountability.

1.2.9 What should be documented?

- Date, time and place of interview
- Names and positions of those present
- A summary of the facts presented, questions raised and answers given
- Treatment plans, as appropriate to the incident and the patient's condition
- Date and time of follow-up interviews, if planned

1.2.10 What are the legal implications of an open disclosure?

The possible legal implications of an open disclosure depend on the specific facts of each case. Nevertheless, there are some general points that should be considered when making an open disclosure.

The Apology Ordinance, which will be discussed later, protects any apology (including statements of fact) from being admitted as evidence to determine fault or liability. There may be a concern that information disclosed during an open disclosure might prompt the patient to conduct further investigations into whether there was indeed any fault on the part of the healthcare provider (for example, request medical records or obtain expert evidence). Such investigations could potentially lead to civil, criminal and/or disciplinary proceedings. However, non-disclosure will not guarantee that such proceedings are avoided. Generally speaking, open disclosure may help minimise hostility and establish a good rapport, and a good rapport might lower the chances of any further action by a patient.

A deliberate concealment of important facts might affect the credibility of the healthcare provider, especially if there subsequently turned out to be legal and/or disciplinary proceedings. The defence case may be jeopardised if the credibility of witnesses is at stake. In some cases, if and when fault is established through criminal or disciplinary proceedings, the fact that an early open disclosure was made could be a useful mitigating factor in support of a more lenient sentence or penalty.

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1.3 Special circumstances

1.3.1 Paediatric patients

Disclosure to children and their parents may present some specific challenges. Children who are capable of sufficient understanding to be involved in autonomous decision making regarding their healthcare should generally be entitled to disclosure as well. The additional challenge is to provide appropriate information, in keeping with their age, ability to comprehend, and emotional maturity. Both children and their parents may require extra emotional support.

1.3.2 Patients with mental health problems

Special consideration as to how to disclose information sensitively and with appropriate detail and clarity. The guardian and/or family/ other significant representative, have a right to be informed of a health safety incident, and may be able to assist in the disclosure process with the patient. Adequate psychological and physical support should always be made available.

1.3.3 Multi-provider disclosure

Patients may receive medical care from more than one provider. The health safety incident may be discovered in the current place of care but may have resulted from care provided in a different place or by a provider not part of the current care team. Basic principles should apply, and if possible, the provider responsible for the incident should lead the disclosure, with supportive collaboration by the current care team. Effective collegiate communication between healthcare providers, and the establishment of agreed facts after an honest transfer of information should form the basis of the disclosure process.

1.3.4 The institutional employer and the individual practitioner/s involved have conflicting views on the nature or manner of disclosure required

Both the individual practitioner and the institution should be bound by the same professional moral code when in the role of delivering patient care. Thus, open disclosure should follow the recommendations provided in the current guideline. Where there is disagreement, and the disagreement or conflict cannot be resolved by discussion, and where the individual practitioner/s believes his/her professional responsibilities are being compromised by institutional employer demands, they may seek advice from their respective College, the Academy, and/or obtain formal legal opinion through their professional indemnity insurers.

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1.4 Recommended practice guidelines

1.4.1 Preparation for the disclosure interview

- Gather available facts and develop a consensus among the relevant healthcare providers about how the details of the incident will be delivered.
- Review the seriousness of the incident, anticipate the likely emotional impact on the patient and involved healthcare workers, and prepare proportionate responses.
- Decide who will be present at the meeting:
  - Person to lead disclosure (usually most involved healthcare staff)
  - Supporting team leader and/or administrator (or a senior colleague for Fellows in individual practice,), if required
  - Contact person for family
  - Patient and/or family members/other significant representatives
  - Support personnel (spiritual or psychological) for patient/family, or friends, if required
- Agree on a time for the interview with all relevant parties.
- Choose an appropriate location that is private and comfortable.

1.4.2 Physical environment

- Choose a convenient time, and if possible, location, to meet the patient's/family in person.
- The location should be comfortable and private.
- External noise or interruptions should be avoided.

1.4.3 Disclosure interview

- Ensure identification of all participants by clear introduction.
- Aim for clear communication, avoid medical jargon and demonstrate empathy and sincerity. Avoid speculation.
- Describe the facts as known and how the patient has been affected.
- Describe the future care plan, and how it may change, if appropriate, and facilitate ongoing care.
- Describe how the incident will be further investigated, if necessary, and that the patient/family will be informed of developments.
- Apologise, where appropriate (see Section 2.4).
- Allow sufficient time for family questions and invite them to express their feelings about the incident.
- If necessary, offer to arrange follow-up meetings.
- Consider offering support, both emotional and practical, such as:
  - Social work service
  - Spiritual or religious support
  - Counselling
  - Facilitate access to the hospital, room to rest

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1.4.4 After the interview

- Maintain appropriate documentation and record:
  - Date, time and place of interview
  - Names and positions of those present
  - Brief summary of facts presented, questions raised, answers given, assistance provided, and follow-up plans

1.4.5 Follow-up interview(s)

- Disclose further factual information as it arises, and correct previously provided information if required.
- Acknowledge responsibility if appropriate.
- Apologise again, where appropriate (see Section 2.4).
- Ensure the support offered to the patient/family has been provided and is sufficient.
- Provide the patient/family with information related to any investigation and resulting system improvements, if appropriate.

2.Apology

2. Apology

2.1 Why apologise?

To say "sorry" after one has committed a wrong or a mistake to the detriment or the disappointment of another is common decency. To apologise to a patient and his or her family following a medical error is widely considered an ethical and professional duty of healthcare professionals. The clinician-patient relationship is primarily founded on trust and respect for patients' rights, and it is only apt that patients are duly informed when something has gone wrong with their treatment and care, especially where it has caused harm.

Previous studies found that most affected patients would desire and expect an apology for a medical error, together with an explanation of what had gone wrong, why things had gone wrong, what would happen to them, and what can be done to help them to recover and to prevent the same error from happening to others in future.[8]

A proper apology demonstrates respect and empathy, reduces emotional distress, and promote a strong sense of partnership. It is an important signal that all parties are on the same side, to "move on", to minimise harm, and to achieve the best possible outcome despite what had happened.

Conversely, the failure for clinicians to apologise and to assume responsibility for their own errors may compound distress, erode trust, and engender anger, if not animosity, in the victims who may then see complaint and lawsuit as the only way for them to obtain an explanation, to deter future malpractice, and to seek redress or even revenge.

From the clinician's perspective, a proper apology could improve patient satisfaction, avoid disputes and facilitate settlement through the use of alternative dispute resolution without recourse to litigation. Such openness about one's mistake or imperfection can be liberating as compared to the burden of having to conjure up explanations and alternative facts that in the end might be all but debunked. It is also a sign of confidence, maturity, and integrity in the eyes of professional peers, the public, and those with regulatory powers.

2.2 Common concerns and legal protection

Some clinicians, however, are concerned that apologies may invite troubles rather than solutions, thinking that open disclosure of error could trigger complaint and legal action that might otherwise not materialise, that an apology equates an admission of fault and liability, and that statements of facts contained within an apology would invariably be used against them in the courts or disciplinary proceedings. While available evidence in this connection remains controversial, fears for

2. Apology

reputational, financial, psychological and career-related consequences have led many to refrain from making apologies where warranted. Loss of self-esteem, the sense of guilt, embarrassment and uncertainty, and the lack of training and experience in making apologies are some other reasons, with the result that patients are often deprived of the explanations and apologies they want and deserve.

In response, many countries have implemented legislation that aims to encourage apology-making by preventing an apology from amounting to an admission of fault or liability.[9] The level of protection varies, with some apology laws prohibiting all kinds of apologies from being used as evidence, while others would only protect some kinds of apologies. (For example, some but not all jurisdictions in Australia would protect an admission of fault, i.e., a "full" apology.[10]) The Apology Ordinance in Hong Kong is the only apology law in the world that expressly protects statements of facts. The applicable proceedings (e.g., civil litigation versus professional disciplinary proceeding), the effect of an apology on professional indemnity cover, and even the definition of apology may differ among jurisdictions. It is therefore not surprising that apology laws have yet to uniformly achieve their intended goals around the world, leaving many clinicians in the perpetual, unfortunate, but perhaps understandable, belief that saying "sorry" after a medical incident is not a good idea after all. Such notions, however, may not ring true in Hong Kong.

2.3 Apology protection in Hong Kong

The Government of the Hong Kong Special Administrative Region implemented the Apology Ordinance (Cap. 631)[11] in 2017. Having learnt from overseas experiences and considered advice from a wide spectrum of stakeholders, the Apology Ordinance is designed to confer a comprehensive apology protection.[12]

What distinguishes the Apology Ordinance from other apology laws is that its definition of apology is the broadest so far. It covers all kinds of apologies from an expression of regret, sympathy or benevolence, to an admission of fault and liability and a statement of fact.[13] Under the Apology Ordinance, none of these can be admitted as evidence in civil disputes, arbitration, disciplinary proceedings or regulatory proceedings to determine fault or liability (criminal proceedings and death inquests are not applicable proceedings); nor would an apology void or affect any insurance cover, compensation or other benefits. It is only under exceptional circumstances, such as when there is no other evidence available for determining the issue at hand, that a statement of fact in an apology may be admitted as evidence at the discretion of the decision-maker. A decision-

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maker, as defined in the Apology Ordinance, means the person (whether a court, a tribunal, an arbitrator, or any other body or individual) having the authority to hear, receive and examine evidence in the applicable proceeding.[13]

The level of legal protection now available in Hong Kong would mean that under normal circumstances, all kinds of apologies are protected in applicable proceedings. Clinicians should not have unnecessary worry about any backfiring of their apologies. They should have confidence in knowing that any information and apologies given to patients would serve to fulfil their ethical and professional duties, to minimise misunderstanding, to diffuse tension and hostility, hopefully to avoid complaint and litigation, and, ultimately, to promote healing and recovery.

2.4 How to apologise?

Once a clinician realises that something has gone wrong with a patient's condition, they should speak to the patient or the affected family as soon as possible without being prompted to do so. There is no need, or any advantage, in postponing the process of communication until the outcomes of all investigations are available although one should adhere to what has been established. It is a delicate process of communication, and the way in which it should be conducted varies from case to case. Nevertheless, a quiet and private environment, an appropriate seating arrangement, the presence of someone who can provide support to the affected parties, and a compassionate and empathetic dialogue using terms and a language that the patient can understand are always helpful.

The substance of an apology is critical in determining its impact.[14] There are different kinds of apologies. Which kind of apology would be appropriate depends on the circumstances of each case. A "full" apology is one that contains an expression of regret or sympathy, an admission of fault or liability, an explanation of what had happened, and a plan for rectifying harm and for preventing future occurrence. By contrast, a "partial" apology contains only an expression of regret, sympathy or benevolence. It is more prone to be perceived as insincere and evasive, and which could in fact invite or exacerbate disputes. However, a "partial" apology is preferable before all the facts are identified and the presence of a fault is confirmed.

The following example illustrates the differences between "full" apology and "partial" apology.

Example 1

You prescribed antibiotics to which your patient was known to be allergic. The patient developed an adverse reaction after taking it.

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A “full” apology with a statement of fact would say:

“I am sorry that you have developed this skin rash after taking the antibiotics I gave you. Your record did state that you are allergic to it, but I had failed to check it. It was my fault. Fortunately, this kind of allergic reaction is often mild and will go away after a few days of discontinuing the antibiotics and taking the remedial medications I am giving you. I will take care of it and do what I can to make it up to you, and I have updated my computer record system to make sure that the same will not happen again to you or other patients. ”

A “partial” apology (or a non-apology) may read something like:

“I am sorry to see that you have this nasty skin rash. I was not expecting that.”

“The antibiotics you took had probably caused this skin rash. I am so sorry. Some people have this kind of reaction and it is not easy to tell.”

“Perhaps you should not have been given that antibiotics. You seem to be allergic to it. I am so sorry.”

Or even worse is:

“I am sorry about the rash. But you already had itchiness after you took the first dose, why did you continue to take it?”

Below is another example to further illustrate how a “full” apology or a “partial” apology can be applied.

Example 2

You omitted to do an intra-operative cholangiogram during a cholecystectomy. The patient developed serious complications afterwards. Post-operative imaging studies showed that the common bile duct had been ligated.

A “full” apology with statement of fact would be:

“I am sorry that I wrongly tied off a major bile duct when trying to remove your gallbladder which then caused these severe complications. An additional imaging procedure during surgery would have enabled me to prevent this. I should have done one, but I regret that I did not because there was another patient waiting to be seen by me. It was really my fault. You will need another operation to deal with the problem, and I have requested the Chief of Service to be the surgeon

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this time. I shall explain the details to you. It is likely that you will have to stay in hospital for a while for some complex treatments, but I promise I shall do my best to help you recover, and to make sure that the same will not happen again to any other patient in future. ”

A “partial” apology (or an non-apology) may say:

“I am sorry to tell you that your common bile duct seems to be blocked. It does happen sometimes though.”

“The operation somehow caused a bit of a narrowing of your bile duct. Usually an X-ray during surgery can tell, but I did not think it was necessary. Sorry!”

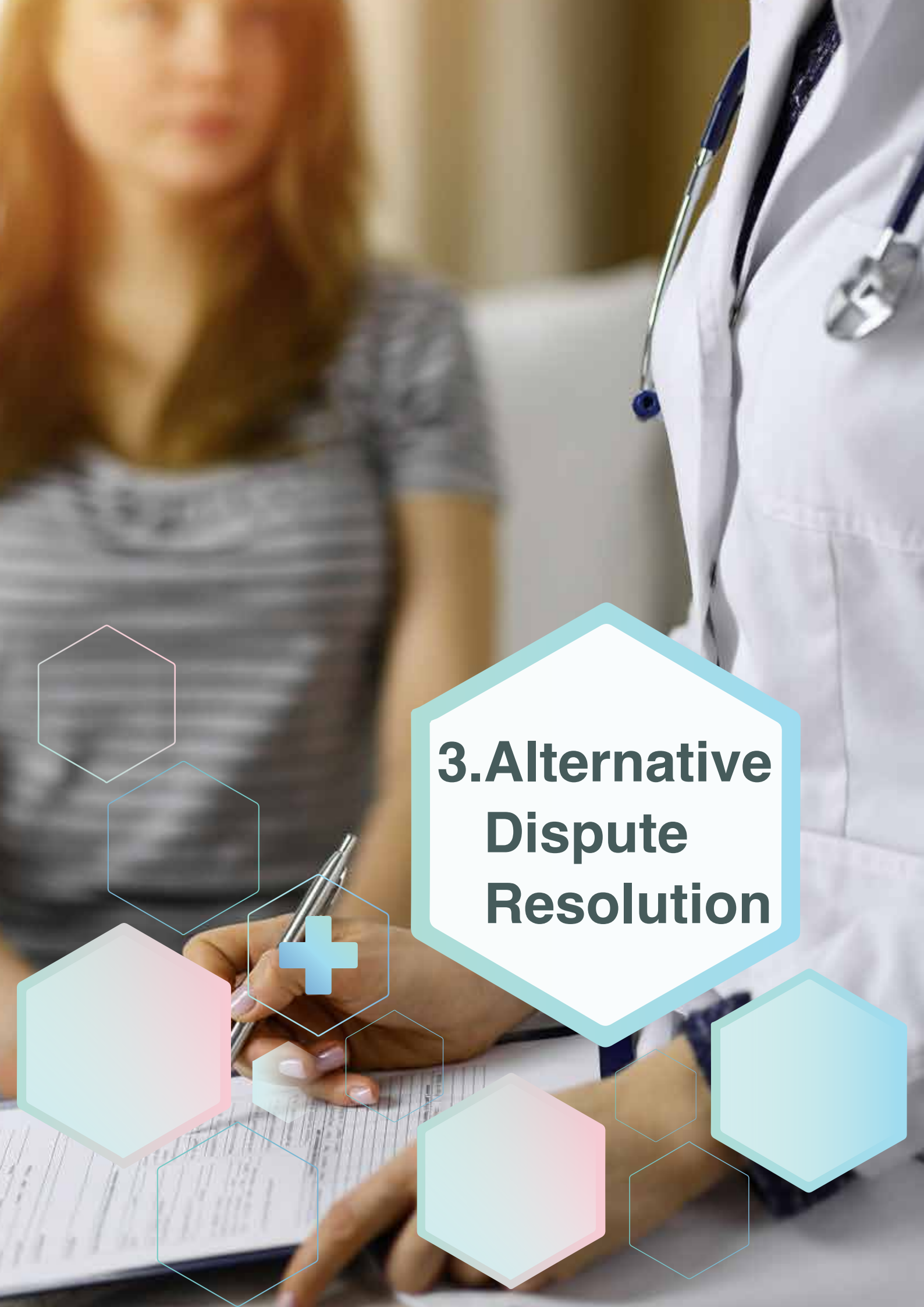
“I have some bad news for you. Your common bile duct is not working well. Maybe I should have done an X-ray to check earlier on. Sorry about that.”

Patients are more likely to respond positively if they receive an honest and factual explanation from someone who is prepared to assume responsibilities and to take positive steps to address the problem. It is not always necessary for the apology-maker to take full, personal responsibilities, especially where other factors such as a system failure are involved.

Notwithstanding, a personalised apology in such cases (e.g., “I am sorry…”) is preferred to a non-specific expression of regret about the incident on behalf of the organisation or someone else.

The patient or the relatives should be given time to ask questions and to have them answered in a truthful and empathetic manner. For those who refuse to hear more about the incident (e.g., due to psychological distress), their wishes should be respected, while making it clear that they can receive more information later if they so wish. In such cases, the clinician should try hard to make good what went wrong and help the patient to have a speedy recovery. In any event, clear and impartial documentation of the process is crucial, so as to ensure consistency in future communications. Information about counselling and support services should be provided.

In summary, patients deserve and desire an apology following a medical incident. Such apologies, when properly constructed and delivered, are conducive to patient well-being and hopefully the settlement of the dispute. The Apology Ordinance in Hong Kong provides robust legal protection, and clinicians should feel encouraged and empowered to apologise and take responsibility for their mistakes. It is an important clinical skill that can be acquired and improved through training and experience.[15]



3.Alternative Dispute Resolution

3. Alternative dispute resolution

3.1 Complaints and claims

Each year, thousands of complaints are made against healthcare services and professionals in Hong Kong. The number has risen rapidly in recent years. Some of the complaints may lead to disputes, which may be resolved by disclosure with or without apologies, and settlement negotiation between the parties. A small percentage of the disputes may result in claims for compensation. Some of these cases will settle with or without the help of lawyers, and others by means of alternative dispute resolution (ADR). The remaining cases will end up in courts.

3.2 What are ADR and mediation?

ADR means an alternative process, other than litigation, whereby both parties agree to appoint a third party to assist them to resolve their dispute and reach a settlement. A common mode of ADR is mediation.

Mediation for healthcare disputes has been practised in Hong Kong for about 20 years. The Dental Association first conducted mediation in 2003, followed by the Medical Association in 2006. As defined in the Mediation Ordinance (Cap. 620)[16], it is a structured process comprising one or more sessions in which one or more impartial individuals, without adjudicating a dispute or any aspect of it, assist the parties to the dispute to do any or all of the following:

- identify the issues in dispute;
- explore and generate options;
- communicate with one another; and
- reach an agreement regarding the resolution of the whole, or part, of the dispute.

As in litigation, the parties in mediation may be accompanied by lawyers and adduce expert witness reports, if they wish. The advantages of mediation are that it can be conducted in a friendly atmosphere and the parties can negotiate the terms of settlement (including compensation, if any), instead of these being imposed on them by judges or arbitrators. Mediation is also much less time-consuming and much less expensive than litigation and arbitration.

Other means of ADR, such as arbitration and collaborative practice, have been proposed to resolve healthcare disputes but have not yet been practised in Hong Kong.

3.3 Duties of the Courts

An underlying objective of the Rules of the High Court and the District Court is to facilitate the settlement of disputes. The Courts have a duty to further that objective by encouraging the parties to use ADR. The Courts also have the duty of helping the parties to settle their cases.

3. Alternative dispute resolution

3.4 Practice Directions

To assist the Courts in discharging the duty, the Chief Justice issued relevant Practice Directions (e.g., PD 31[17] and Part D of PD 18.1[18]) on mediation. Legal representatives should advise their clients of the possibility of the Courts making an adverse costs order where a party unreasonably fails to engage in mediation. This means that if a party refuses to participate in mediation proposed by the other party without a reason acceptable by the Court, they may not recover costs from the other party even if they win the case.

3.5 Mediation Ordinance

The Mediation Ordinance[16] became effective on 1 January 2013. One of its objects is to promote, encourage and facilitate the resolution of disputes by mediation. Although the Mediation Ordinance does not make mediation mandatory before litigation, legal representatives and parties have to bear in mind the consequences of a possible adverse cost order. They also have the duty of assisting the Court to discharge the Court's duties. Thus, most civil disputes, including healthcare disputes, have to go through the process of mediation first, with the exception where the parties can resolve their disputes by negotiation. These disputes will proceed to full-blown trials only if mediation fails.

3.6 Concerns about the legal consequences of mediation

3.6.1 Confidentiality

Mediation is conducted behind closed doors and not in open courts. Confidentiality is one of the key features of mediation. It is advantageous to patients, healthcare practitioners and hospitals. Its importance is acknowledged in the Courts[19], the Practice Directions and the Mediation Ordinance.

3.6.2 Liability

Whilst liability is often an issue in healthcare claims, mediation can be conducted successfully on a 'without admission of liability' basis.

3.6.3 Enforceability of a mediated settlement agreement

A Settlement Agreement duly signed by the parties in mediation is a legal contract enforceable by law. The Courts will not normally interfere with the settlement terms agreed between the parties in mediation. There are exceptions such as those claims involving minors or mentally incapacitated persons, where the settlement must be approved by the Courts.

3. Alternative dispute resolution

3.7 Process of Mediation

Simplified version of the mediation process

First Joint Session

- Mediator starts with an Opening Statement.
- *Party A* presents his perceived facts, interest and needs to resolve the disputes.
- *Party B* presents his perceived facts, interest and needs to resolve the disputes.
- Mediator helps the *Parties* to set an Agenda with or without Common Ground.
- Mediator facilitates the *Parties* to discuss the Agenda issues one by one in an orderly manner.

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Separate Sessions

- Mediator explores the issues further with the *Parties* in private, one after the other, until some workable options which may be acceptable to the *Parties*, are generated. (These sessions often take more than one round.)

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Final Joint Session

- Mediator facilitates the *Parties* to discuss and negotiate over the options generated in the Separate Sessions, and ensure that they are workable. *Parties* are reminded to seek legal advice if they have lawyers.
- If an agreement is reached, Mediator will facilitate the *Parties* to fine-tune and check the details of the terms of the agreement.
- A Settlement Agreement will be drafted for the *Parties* to sign.

3. Alternative dispute resolution

3.8 DOs and DON'Ts in mediation

DOs

- Remember that mediation is a voluntary process involving two or more parties.
- Remember that the parties have to agree on the choice of the mediator(s).
- Remember that your active and voluntary participation is essential for a successful mediation.
- Participate with an open mind and friendly attitude, and aim to solve the problems and issues with the other party.
- Create new options which are acceptable to both you and the other party in order to achieve a win-win resolution and settlement of the dispute.
- Remember that the outcome of court rulings is out of your control, but parties can retain control of the process and outcome in mediation.

DON'Ts

- Believe that the Courts will always be on your side.
- Believe that you will be able to claim every cent of your legal costs from the other side.
- Think that, because legal proceedings have started and lawyers are already involved, it is too late to start mediation. When the parties agree to mediation, they may apply to the Courts for an interim stay of the proceedings.
- Think that whoever proposes mediation first is the weaker side.
- Think that the other side will not agree to mediation, without asking them first.
- Think that your case is not suitable for mediation, without first trying to understand what mediation is.
- Be confrontational or positional during mediation.

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