Implementation status of error disclosure standards reported by Swiss hospitals

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Summary

QUESTION UNDER STUDY: To establish at what stage Swiss hospitals are in implementing an internal standard concerning communication with patients and families after an error that resulted in harm.

METHODS: Hospitals were identified via the Swiss Hospital Association's website. An anonymous questionnaire was sent during September and October 2011 to 379 hospitals in German, French or Italian. Hospitals were asked to specify their hospital type and the implementation status of an internal hospital standard that decrees that patients or their relatives are to be promptly informed about medical errors that result in harm.

RESULTS: Responses from a total of 205 hospitals were received, a response rate of 54%. Most responding hospitals (62%) had an error disclosure standard or planned to implement one within 12 months. The majority of responding university and acute care (75%) hospitals had introduced a disclosure standard or were planning to do so. In contrast, the majority of responding psychiatric, rehabilitation and specialty (53%) clinics had not introduced a standard.

CONCLUSION: It appears that Swiss hospitals are in a promising state in providing institutional support for practitioners disclosing medical errors to patients. This has been shown internationally to be one important factor in encouraging the disclosure of medical errors. However, many hospitals, in particular psychiatric, rehabilitation and specialty clinics, have not implemented an error disclosure policy. Further research is needed to explore the underlying reasons.

Key words: truth disclosure; medical errors; Switzerland

Introduction

Over the last decade, there has been a dramatic change in the approach to medical errors internationally, with a new ethic of transparency replacing the traditional customs of secrecy and denial. The requirement to disclose errors is increasingly incorporated into national and state laws, accreditation requirements and consensus statements in various countries, including Sweden, Canada, Australia, New Zealand, the United Kingdom, and the USA [1–5].

The disclosure of errors has evolved internationally from a strategic response to rising legal costs focusing on organisational risk minimisation, to an ethical practice seeking to re-establish trust by meeting patients' needs and expectations after an incident. Studies conducted internationally have indicated that patients are virtually unanimous in wanting all harmful errors disclosed and seek information about what happened, why the error happened, how the consequences of the error will be addressed and how recurrences will be prevented [6–7]. Patients often consider that error disclosure "would enhance their trust in their physicians' honesty and would reassure them that they were receiving complete information about their overall care" [6]. Although empirical data relating to error disclosure in Switzerland is limited, a 2006 study examining patient assessments of hypothetical medical errors supported international findings; patients wanted medical errors disclosed and perceived the nondisclosure of errors negatively [8].

There remains, however, a large "disclosure gap" between expected practice and what is actually being done [9]. While health professionals typically endorse disclosure in principle, they often do not share information in practice, with international studies suggesting that as few as 30% of harmful errors are disclosed to patients [10]. A Swiss study published in 2011, which examined patients' experiences and perceptions of safety in eight Swiss hospitals, found that only 25.3% of patients who had experienced a "safety-related event" (e.g. infection or medication error) talked to healthcare staff about this event [11].

International studies examining professionals' views regarding error disclosure have consistently found a number of barriers that contribute to nondisclosure [12]. The most pervasive barrier identified is professionals' legal fears; this is the case even in very different legal settings [13]. Other barriers identified include a professional and organisational culture of secrecy and blame, practitioners lacking confidence in their communication skills, practitioners fearing that patients will experience distress, and doubt

about the efficacy and effectiveness of disclosure [12]. In Switzerland, a recent study confirmed that professionals described psychological issues when involved in an error and a common blame culture among colleagues [14].

Various measures have been put in place in a number of countries to mitigate these barriers and create a more supportive environment for practitioners to disclosure errors, including governmental and organisational standards to promote a clear and consistent approach to error communication, specific "disclosure laws" which mandate disclosure in certain circumstances, "apology laws" to protect the contents of disclosure from being used in a legal action as proof of a professional's negligence, and professional organisations' ethics standards explicitly endorsing error disclosure [15]. International research suggests that some of these measures are having a positive impact. Rick Iedema and his team, for instance, have found that the disclosure of incidents is becoming more frequent in Australia and that one of the driving forces behind this change has been state and health organisations error disclosure policies, along with the increase in numbers of specially trained staff [16].

In Switzerland, patient safety has become a central issue ever since the year 2000, when alarming international statistics on medical errors and associated deaths were published [17]. As a result, the Swiss Patient Safety Foundation (http://www.patientensicherheit.ch) was founded by the Ministries of Health and Social Security, several professional associations and the Swiss Academy of Medical Sciences in 2003. All of the Foundation's activities are designed to help improve patient safety and reduce errors in health care, and it has led the way in drawing attention to the issue of error communication in Switzerland. In December 2006, the Foundation translated the Massachusetts Coalition for the Prevention of Medical Errors' "When Things Go Wrong" into German "Wenn etwas schief geht". This has been widely distributed and has helped bring awareness of this issue in Switzerland. The Patient Safety Foundation also offers interactive and practical workshops for practitioners concerning error communication; this has also been supported by university hospitals increasingly offering courses on error communication. The issue of error disclosure in Switzerland has also been recently pushed forward by the Institute of Communication and Health at the University of Lugano (http://www.ich.com.usi.ch/), founded in 2007.

The Swiss Academy of Medical Sciences (SAMW) has not issued any guidelines specifically on error communication, but supports educational efforts in relation to the issue. For instance, in its recommendations "Aus- und Weiterbildung in Patientensicherheit und Fehlerkultur" the SAMW specifically states that practitioners must openly debate medical errors and obtain the skills required for communicating errors with patients and peers [18]. The SAMW's guidelines on medical ethics also state that practitioners should be honest and transparent [19].

Quality improvement efforts have also found their way into federal law with the recent revision of the health insurance law (KVG-Revision 2007) and the introduction of the DRG-system on 1 January 2012. The so called transparency regulations in Article 49(8) of the KVG require hospitals not only to specify medical costs, but also to publish data on certain quality criteria [20]. Quality measures include infection rates associated with certain interventions, potentially preventable reoperations and rehospitalisation, falls and pressure sores, as well as patient surveys performed by the National Association for Quality Development in Hospitals and Clinics (ANQ). In many cantons, hospitals which are on the cantonal hospital list are obliged under their contracts to perform these ANQ measurements.

Internal hospital standards on error communication are not yet part of the federal quality improvement efforts in Switzerland. In a number of countries, however, they are part of an accreditation requirement for hospitals, for instance in the USA through the Joint Commission of the Accreditation of Hospitals (JCAHO). As Swiss hospitals are under no such obligation, no data are available on how many Swiss hospitals have currently implemented an internal error communication standard. Given that a lack of institutional support can be a significant barrier to error communication, and that organisational standards have been shown internationally to be an important factor in encouraging error disclosure, this study seeks to establish at what stage Swiss hospitals currently are in implementing an internal standard concerning error communication. This overview will contribute to our understanding of error communication in Switzerland and will assist efforts to advance the issue of error disclosure.

Methods

To obtain an overview of the implementation status of error disclosure standards, a short survey was sent to Swiss hospitals asking the hospitals' implementation status of an internal standard that requires patients or their relatives to be promptly informed about medical errors that result in harm. To assess the maturity of disclosure policies at Swiss hospitals, three different stages were defined. In stage 1, hospitals have not yet examined the possibility of disclosure policies or do not have plans to implement one; in stage 2, implementation has been examined and is planned in the next 12 months; and in stage 3 a policy has already been implemented (adapted from Briner et al. [21]). Thus, the survey question asked: "Does an internal hospital standard exist which requires that patients or their relatives are to be promptly informed about medical errors that result in harm?" offering the following answering options: "yes; no; implementation planned within the next 12 months". This was a slightly modified version of a question included in the University of Bonn's Institute for Patient Safety 2010 national survey concerning the implementation status of clinical risk management in German hospitals [9]. The question used in Germany had in addition: "Does an internal hospital standard exist which provides that patients or their relatives are to be promptly informed about medical errors that result in harm *and receive an offer of support*?" The survey also required the specification of hospital type in accordance with the following categories: university hospital, acute care hospital, psychiatric clinic, rehabilitation clinic and specialty clinic.

Hospitals were identified in August 2011 via the Swiss Hospital Association's website (www.hplus.ch/), where hospital members are listed by canton. There were 383 list-

ings in total. After deleting one invalid address and duplicates (three), 379 valid addresses were included. The anonymous questionnaire was sent to hospitals in German, French or Italian, depending on the language used in the hospital. The questionnaires were translated by native speakers. The questionnaire was addressed to the hospital director and included a postage-paid return envelope. The majority of hospitals were located in the German-speaking part of Switzerland (273), 84 were located in the French-speaking part and 22 were located in the Italian-speaking part.

Results from returned questionnaires were entered into, and analysed with, SPSS v20. Data were compared using chi-square statistics. For the comparison between hospital types, hospitals who indicated more than one or no type were excluded (n = 22). For the comparison between hospital types, two groups were defined: university and acute care hospitals versus all others (psychiatric, rehabilitation and specialty clinics).

Results

Responses were received from a total of 205 hospitals, which translates into a response rate of 54%. Almost half (46%) of the responding Swiss hospitals reported an implemented error disclosure standard. Sixteen percent of the hospitals reported that they are planning to implement one in the next 12 months. Thus, 62% of all Swiss hospitals were using an error disclosure standard or were planning a timely implementation at the time of the survey. More than a third (38%) had not implemented an error disclosure standard and were not planning to do so.

When split into language region, significant differences existed between the German-speaking and Latin (French- and Italian-speaking) regions (table 1). Although in all regions the largest group were hospitals that had reported the implementation of an error disclosure standard (German 48%, Latin 42%), hospitals in the different language regions varied in their status as "no implementation" versus "planned implementation in the next 12 months". A total of 41% of German-speaking hospitals answered no, compared with 30% of hospitals from Latin regions, whereas the percentage of hospitals that reported planning implementation in the next 12 months was higher in the Latin region (28%) than in the German speaking region (11%); χ^2 (2, n = 205) = 9.7, p = 0.008.

The results were also analysed according to hospital type (table 2). There was a significant association between hospital type and the implementation of an error disclosure standard or planned implementation of a standard within the next 12 months. Most university and acute care (75%) hospitals that returned the survey had introduced an error disclosure standard or were planning to do so in the next 12 months. In contrast, psychiatric, rehabilitation and specialty clinics had significantly more often no error disclosure standard (53%) than university and acute care hospitals (25%); χ^2 (1, n = 183) = 15.55, p <0.001.

The results were also compared with the results of a similar survey conducted in Germany by the University of Bonn's Institute for Patient Safety in 2010 (table 3). Whereas the Swiss survey only asked about the implementation status of an error disclosure standard requiring that patients and their relatives are promptly informed about medical errors that result in harm, the German survey question also asked whether they also receive an offer of support. The response rate of the German survey was lower (26%) than the Swiss survey (54%). The comparison shows that while a majority of responding Swiss hospitals (62%) have implemented an error disclosure standard or plan to, only 43% of responding German hospitals had implemented or were planning to.

Owing to rounding, total percentages in all tables can exceed or fall below 100%.

Discussion

It appears that Swiss hospitals are in a promising state in terms of providing institutional support for practitioners disclosing medical errors to patients, as the majority of hospitals already have a standard regarding medical error disclosure or are intending to implement one in the near future. There may be several explanations for why the hospitals from German-speaking regions reported significantly more often no implementation than hospitals from Latin regions. Instead of answering "no", a higher percentage of the latter than the former indicated they planned implementation within the next 12 months. The results could indicate that hospitals from the German speaking regions are more adamant in not implementing standards than Latin hospitals or, alternatively, are influenced by a culturally varying interpretation of the certainty with which the implementation had to be planned within the next 12 months. Certain types of hospitals in Switzerland seem to be somewhat less advanced in dealing with this issue. In particular, psychiatric and rehabilitation clinics appear to be less likely to have error disclosure standards than university and acute care hospitals. The differences among hospital types in Switzerland may reflect the variable visibility of pa-

Table 1: Swiss hospital survey results by language type*.			
	n (%)		
Hospital language	**Yes**	**Planned**	**No**
Any 205 (100)[†]	94 (46)	33 (16)	78 (38)
German 145 (71)	69 (48)	16 (11)	60 (41)
Latin: French/Italian 60 (29)	25 (42)	17 (28)	18 (30)
* Hospitals were asked about the implementation status of an internal hospital standard that requires patients or their relatives to be promptly informed about medical errors that result in harm. [†] The survey was sent to a total of 379 hospitals. 205 responses were received (54% response rate).			

tients asking for investigation of suspected errors. Indeed, the number of requested FMH expert evaluations varied according to medical discipline [23]. Our results may also reflect differences in both the type of care provided and the amount of attention medical errors have received in these settings in the media and in the international literature. Since the Institute of Medicine's landmark report "To err is human" was published in 2000 [17], important research has been conducted on the nature, impact and causes of medical errors [24–29]. However, the majority of research has been conducted in hospital settings and has consistently excluded patients with mental disorders [30]. Indeed, psychiatry has had a "late arrival on the medical error scene" and very little empirical research has been conducted regarding medical errors in this field, possibly because psychiatric practice is intensely private and personal, and because psychiatric patient characteristics and psychiatry do not involve the types of invasive procedures that have gained so much attention in the media when they go wrong [30]. We are also not aware of any study that has examined medical errors in rehabilitation clinics. Consequently, further research is needed to explore the unique aspects of psychiatric and rehabilitation clinics regarding medical errors and the reasons why these hospitals do not have error disclosure standards.

Further research is also needed to explore how the disclosure standards are actually implemented in Swiss hospitals and whether hospital staff adhere to the established standard. In the USA for instance, where patient safety standards from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) have required hospitals to disclose to patients all unexpected outcomes of care since 1 July 2001 [31], a 2005 study of hospital CEOs found that 85% had a written policy that recommended disclosure of unanticipated outcomes to patients [32]. However, although most hospitals have a disclosure standard, a 2006 national survey of risk managers in the USA found that risk managers estimated that 25% of serious errors are not disclosed to patients, and for minor errors 38% disagreed that they are disclosed effectively [33].

In 2007/2008 and in 2010 Swiss hospitals were asked to take part in a voluntary national survey intended to assess the maturity of hospitals' implementation of critical risk management (CRM) strategies [34]. Although the survey contained a section on "Communication and information", which included the question "Are there guidelines to ensure that patients are openly and proactively informed of critical incidents or errors that occurred during their treatment?", the communication of errors has not been a focus of any of the resulting articles, nor have the results from this particular question been published. In contrast, all of the results of the study conducted in Germany in 2010 have been published [22]. When comparing the error disclosure standard results of our 2011 survey with the study conducted in Germany in 2010, we observed that a higher percentage of Swiss hospitals had introduced or planned to introduce error disclosure standards. However, whether the observed differences in percentages between the results of this study and the study conducted in Germany are statistically meaningful and reflect real differences in the prevalence of hospital error disclosure standards in the two countries, or are a result of differences in the wording of the question, is unclear. Although the process of error disclosure consists of more than just the provision of information, it was felt that the wording used in the German survey combined two distinct elements that should be separated, as some hospitals may offer one element but not the other. What constitutes "support" is also rather ambiguous. Therefore, it was decided to drop the second part of the question used in Germany in order to keep the questionnaire simple and clear. Given that the question used in Germany combined two different elements, error disclosure *and* an offer of support, it might be expected that the

Table 2: Swiss hospital survey results by hospital type*.

Hospital type	n (%)		
	Yes	Planned	No[‡]
Any 183 (100)[†]	83 (45)	30 (16)	70 (38)
University and acute care 94 (52)	53 (56)	18 (19)	23 (25)
Psychiatric, rehabilitation and specialty 89 (48)	30 (34)	12 (14)	47 (53)

* Hospitals were asked about the implementation status of an internal hospital standard that requires patients or their relatives to be promptly informed about medical errors that result in harm.
[†] The survey was sent to a total of 379 hospitals and 205 responses were received. Hospitals who indicated more than one or no type were excluded (n = 22).
[‡] No implementation vs implementation or planned implementation: χ^2 (1, n= 183) = 15.55, *p* <0.001 (university and acute care hospitals vs all other hospitals).

Table 3: Comparison of Switzerland and Germany survey results*.

	n (%)		
	Yes	Planned	No
Switzerland 205 (100)	94 (46)	33 (16)	78 (38)
Germany 476 (100)	103 (22)	100 (21)	273 (57)

* Comparison of the overall results of the hospital survey conducted in Germany in 2010 by the University of Bonn's Institute for Patient Safety. The question used in Germany had in addition to the question used in Switzerland: "Is there an internal hospital standard which requires that patients or their relatives be promptly informed about medical errors that result in harm *and receive an offer of support*." The Swiss survey achieved a 54% response rate (205/379), whereas the German survey achieved a 26% response rate (476/1820).

Swiss results would be higher than the German results, as the question used only included the first element.

Information on error communication to patients is not yet part of the transparency regulation in Switzerland, although we believe it should be regarded as an equally important part of patient safety improvement efforts. Whether errors have been communicated to patients is an important quality indicator of medical outcomes and thus should be introduced into the quality measure of the ANQ as part of the patient surveys. Publicly available information on the frequency of disclosure to patients may provide hospitals with an advantage in the new regulatory environment. The introduction of free Switzerland-wide basic healthcare treatment for patients in 2012, in combination with the new ANQ measurements, will in the future most likely lead to patients evaluating different hospitals before choosing where to undergo treatment. Communication about safety and disclosure practices in a certain hospital could be a valuable decision criterion.

Patients come to hospital specifically for help in staying or getting well, and trust that the healthcare setting is one in which their health and well-being will be promoted, and not endangered by the very people whom they trust to help them. For those affected, a harm-causing error can be a violation of trust and can cause a loss of confidence in health professionals and hospitals. This situation is exacerbated when errors are not acknowledged or are intentionally concealed, or when only partial or "edited" explanations are provided [35]. Patients want to be informed of any medical error immediately and have full disclosure of the extent of the error [36]. Studies have also found that disclosure of adverse events to patients, even when patients had suffered harm, doubled the odds for allocating high ratings regarding the quality of care received [37].

Furthermore, there is an ethical responsibility to maintain honest communication with patients and their families, even when things go wrong [3]. Truth-telling is central to the healthcare relationship, where evident and ineradicable imbalances of power, knowledge and vulnerability are found. The provision of full and accurate information not only allows patients to make informed choices about their healthcare and other aspects of their lives, but is also important in establishing, maintaining and restoring trust in the healthcare relationship. This is particularly important after a harm-causing error [35].

The finding that a majority of hospitals were aware of the issue of communicating medical errors and had already taken active steps to establish a culture of dealing with them is promising. Furthermore, the implementation of standards across cultures and languages in Switzerland, a country with an emphasis on decentralisation, shows that changes in the medical system towards more transparency and open communication with patients are being recognised as universally needed. However, Swiss hospitals need to take further actions regarding this issue. The fact that more than one-third of the hospitals reported not having an internal standard should be examined further in order to find explanations and identify obstacles that keep those institutions from implementing one.

Although error disclosure is a complex issue requiring a number of different measures to change practice, the im-

plementation of error disclosure standards has been shown internationally to be one important factor in encouraging the disclosure of medical errors. Such standards are, of course, no panacea; there remains the challenge of translating statements of principle into practice. However, such measures can play an important role in influencing professional, national and organisational cultures, which have a significant effect on the practice, values and individual attitudes in a workplace. While these cultures are dynamic, they also have considerable inertia that requires both strong interventions and time to change [38]. External pressure from regulation, such as the addition of error disclosure frequencies to the ANQ measurements, could provide the necessary force to induce the required change of practice. However, as international examples also show, other factors such as the training of staff also need to be considered.

Fewer than 50% of respondents reported having an internal standard concerning error disclosure. As respondents are likely to be those more interested in the topic, this fact should be taken seriously. Since results are self-reported, the over-reporting of socially desirable activities can also not be excluded. Thus it is possible that the percentage of hospitals without an error disclosure policy is even higher than indicated. Both limitations point in the same direction and underline the importance of our findings in Switzerland.

The study has some limitations. We can only refer to answers reported by hospitals. Perceived social desirability of answers might have caused a bias towards over-reporting of implementation of planned implementation. Since the questionnaire was anonymous, hospitals would not fear being tracked down and asked actually to prove the existence of their standards. However, we believe that the answers "no implementation" should be taken seriously because they are likely to indicate honest reporting that error disclosure standards are neither in existence nor planned within the foreseeable future of the next 12 months. It is also noteworthy that this bias is not likely to affect the comparison between Germany and Switzerland, because results in both countries rely on self-reporting and would be subject to a similar reporting bias.

With the response rate being less than 60% (205/379; 54%) a generalisation of the results for all hospitals in Switzerland is not possible. However, it could be argued that the response rate in this study was above average. A study in 2008 that analysed 1,607 studies published in the years 2000 and 2005 in 17 refereed academic journals found that the average response rate for studies that utilised data collected from organisations was 35.7% [39]. Furthermore, we do not know what hospital error disclosure standards look like in detail and if they are comparable between hospitals. We received 11 questionnaires in which more than one hospital type was indicated. Although in some cases overlap in the categories was evident (a university psychiatric hospital or university acute hospital), we cannot exclude the possibility that in other cases one answer was sent that referred in fact to more than one hospital. One of the 11 responses provided contact details and we were able to find out that in this case the questionnaire was filled out for seven hospitals of three different types. However, we do not have reason to

believe that this way of filling out the questionnaires was frequent enough to have caused a bias. First of all, we contacted single hospitals so that it seems unlikely that many would have felt inclined to answer for more than their own hospital. Moreover, the large majority of respondents indicated one single hospital type, and the results do not change if we include all 205 or only the 183 hospitals that indicated a single hospital type. Indeed, if in a few questionnaires the answers might refer to more than one hospital this is likely to have occurred independently of different language regions and independently of implementation of error disclosure standards. On the contrary, this indicated that we might have slightly underestimated the number of hospitals that responded and therefore our study might even extend to a slightly higher number of responding hospitals than the calculated 54% response rate.

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