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Professional liability insurance and medical error disclosure

Stuart McLennan[a], David Shaw[a], Agnes Leu[a, b], Bernice Elger[a]

[a] Institute for Biomedical Ethics, University of Basel, Switzerland
[b] Careum Research, Kalaidos University of Applied Sciences, Department Health, Zürich, Switzerland

Summary

QUESTION UNDER STUDY: To examine medicolegal stakeholders' views about the impact of professional liability insurance in Switzerland on medical error disclosure.
METHODS: Purposive sample of 23 key medicolegal stakeholders in Switzerland from a range of fields between October 2012 and February 2013. Data were collected via individual, face-to-face interviews using a researcher-developed semi-structured interview guide. Interviews were transcribed and analysed using conventional content analysis.
RESULTS: Participants, particularly those with a legal or quality background, reported that concerns relating to professional liability insurance often inhibited communication with patients after a medical error. Healthcare providers were reported to be particularly concerned about losing their liability insurance cover for apologising to harmed patients. It was reported that the attempt to limit the exchange of information and communication could lead to a conflict with patient rights law. Participants reported that hospitals could, and in some case are, moving towards self-insurance approaches, which could increase flexibility regarding error communication
CONCLUSION: The reported current practice of at least some liability insurance companies in Switzerland of inhibiting communication with harmed patients after an error is concerning and requires further investigation. With a new ethic of transparency regarding medical errors now prevailing internationally, this approach is increasingly being perceived to be misguided. A move away from hospitals relying solely on liability insurance may allow greater transparency after errors. Legalisation preventing the loss of liability insurance coverage for apologising to harmed patients should also be considered.

Key words: *liability insurance; medical errors; truth disclosure*

Introduction

Despite clinicians being widely considered internationally to have an ethical, professional and legal obligation to disclose medical errors to patients [1–4], there remains a large "disclosure gap" between expected practice and what is actually being done [5]. Clinicians' legal fears have been identified internationally as the most pervasive barrier to disclosure [6]. One fear in particular is the risk of losing professional liability insurance coverage if too much or the wrong thing is said, owing to the so-called "cooperation clauses" found in many insurance policies, which releases the insurance companies from their obligation to pay costs if liability is admitted without prior consent [7–8]. However, professional liability insurance can be critical to both parties in cases of harm causing errors; the most stringent liability rules do not help a claimant if the clinician is unable to pay damages.

In Switzerland, liability law differentiates between self-employed and employed clinicians. Since 2007, it has been obligatory for self-employed clinicians to have professional liability insurance (Federal Law on Medical Professions, MedBG). However, the MedBG does not apply to employed clinicians. If employed clinicians are working for a public hospital, their liability for medical treatment complies with the liability law (LS 170.1, Zürich). In this case, it is not the hospital liability insurance which is liable to be sued (no direct legal claim), but – depending on the hospital's funding body – the state, the independent public institute, the administration union or the municipality. During the damage assessment, which is carried out by the insurers in accordance with the liability law, certain formal responsibilities remain with the hospital's funding body. Accordingly, their involvement in the resolution of the case is to a certain extent mandatory.

Every hospital is obligated to cover their third-party liability risk in the appropriate form, independently from their legal structure – whether they are run by the Canton, the municipality or by a private company, and whether they receive subsidies (see § 36 Abs. 2 in connection with § 12 Abs. 2 general health law for the canton Zurich [GesG, LS 810.1]). It is the hospital's responsibility to cover this risk, whether they guarantee the coverage through liability insurance, by creating accruals or through a combination of accruals and liability insurance.

As a part of a broader study into medical error communication in Switzerland, key medicolegal stakeholders were interviewed to explore their general attitudes towards med-

ical errors, perceived barriers to error communication and potential ways of improving the situation. One major theme to emerge from these discussions was the issue of liability insurance. The aim of this paper is to examine medicolegal stakeholders' views about the impact of professional liability insurance on medical error disclosure in Switzerland. It will also evaluate this reported impact in light of international trends and ethical considerations.

Methods

The study was approved by Professor A Perruchoud, Chairperson of the Ethics Committee of Basel, on 6 January 2012. Informed consent was implied by returning the survey. The methods of the study are presented in accordance with the "Consolidated criteria for reporting qualitative research" (COREQ) [9].

Research team and reflexivity

Interviews were conducted by S.M., a male PhD student in biomedical ethics, who had previous training and experience in qualitative research [10]. No relationship was established between S.M. and the participants prior to the study and participants received limited information about S.M. There was no hierarchical relationship between SM and the study participants and we are not aware of any particular biases of S.M. concerning the research topic. D.S. has been involved in several qualitative publications [11–13]. A.L. has several years of experience with qualitative studies [14–16]. B.E. has a longstanding experience with qualitative studies [17–19].

Study design

The theoretical framework employed in this study was conventional content analysis [20]. We primarily selected participants through purposive sampling, in order to ensure that participants were from different backgrounds and to capture a variety of experiences. Possible interview partners were identified through discussions with collaborators and wider contacts. Key medicolegal stakeholders included the quality heads at large public teaching hospitals, a quality practitioner from a private federation, law professors specialising in medical law and criminal law, a university hospital lawyer, a chief of surgery, chiefs of anaesthesia, a university hospital medical director, a former Dean of Medicine, representatives of a liability insurer, a private sickness fund, a physician association, a patient safety organisation, and an academy of medical sciences.

Stakeholders were contacted by email and suitable dates for an interview were found with those willing to participate. A total of 23 stakeholders agreed to participate in the study. One stakeholder declined to participate because of their workload. Interviews were held between October 2012 and February 2013. One interview was conducted via a Skype video call; all others were conducted in person at a venue of the participant's choosing, typically his or her private office. Only the participant and the researcher were present during the interview. As the interviewer (S.M.) was a non-native German and French speaker, all interviewees were given the option to have a translator present. This offer was not taken up and all interviews were conducted in English.

A semi-structured interview guide about stakeholders' attitudes and experiences with error disclosure and perceived barriers was developed. Questions used to prompt discussion included: Are errors a serious problem in healthcare? What do you see as the main barriers to the communication of medical errors (to patients/colleagues/hospitals) in Switzerland? What measures could promote medical error communication in Switzerland? Based on the first two interviews, which did not show any problems, we decided that no further piloting or adaptation of the interview guide was necessary. No repeat interviews were carried out. Interviews were audio recorded, no field notes were taken. Interviews lasted an average of 52 minutes. After 23 interviews the question of data saturation arose and was discussed by the research team. It was agreed that, concerning the main themes, saturation was reached and that no new major discrepancies were coming up during the interviews. In sum, the research team concluded that saturation was reached in the content and attitudes expressed by the participants on the main themes and no other major issues regarding error disclosure were not at least broached. Transcriptions of the interviews were not returned to the participants.

Analysis and findings

Using the interview transcriptions, S.M. performed conventional content analysis [20], focusing on themes common across participants as well as those unique to individuals that may offer insight into differences in perspectives and discrepancies in practice. Initial themes discovered in the interviews were labelled using a process of open coding (i.e., no specific preconceived codes were identified or used; rather, codes emerged directly from the data). The other investigators (S.M., D.S., A.L., B.E.) reviewed the initial analysis to clarify and refine codes, and conversations among the investigators continued until coding differences were resolved and consensus was achieved.

Results

The impact of liability insurance on error communication

Whereas all 23 participants were asked about liability insurance, the most in-depth responses regarding this issue came from a minority of participants with a legal or quality background. The other participants, particularly those who were clinicians, had generally not experienced or were not aware of any interference from liability insurers in terms of open communication with the patients after an error, but the participants with a legal or quality background reported a significant negative impact on communication.

In general, it was reported that liability insurance contracts generally prohibit hospitals and physicians from making statements concerning liability before discussing the matter with the insurance company. It is also the insurance company's responsibility to handle the claim and communicate with the patient in relation to this process:

> *"I think that is a general provision that not only in medical situations but in general that before giving any statements concerning the liability or even the coverage they need to register the case and talk with us and finally it's our business to do the claims handling. Well, that's in general." P18*

It was acknowledged, however, that communication with the patient regarding the case would often be put on hold while information and expert advice was gathered. In complex cases, this process could take many years.

However, a number of participants reported that the impact of liability insurance contracts on communication between the hospital or doctor and the patient was often much greater in practice than simply not making statements concerning liability. Participants reported that all communication with the patient was often stopped once a claim was made as a result of instructions given by insurance companies' lawyers, or hospitals and doctors being overly cautious:

> *"As soon as a case is announced to the insurance company, usually a lawyer from the insurance company comes and says we take it over, don't say anything to the patient to the patient's lawyer, not even excuses. Now you have to shut your mouth." P12*

Indeed, a number of participants reported that hospitals and doctors are particularly concerned about losing their liability insurance cover for apologising to harmed patients because of the fear that it will be seen as an admission of fault. There was general agreement among these participants that whereas liability insurers would not allow apologies that include an acknowledgement of responsibility to be given to patients, expressions of sympathy for what has occurred were not dangerous. However, owing to the anxiety about losing liability insurance cover, healthcare providers are often unwilling to apologise to patients at all:

> *"There is no debate about the fact you should express regrets from the institution, regrets about what happened, but there is some consensus on the fact that third party liability insurers would not currently cover any hospitals that would plain and bluntly say I'm sorry, and not that I'm sorry for what happened, but I'm sorry for my mistake for instance, there would be no coverage for a hospital where a professional would say something like that. So that's where the caution comes into account." P1*

However, some of these participants felt that inhibiting apologies, and communication in general, after a patient was harmed was unnecessary and has potentially negative outcomes for all involved.

Liability law vs patient rights law

One participant felt that in terms of communication after an error there could be a meeting of "two different worlds" which often conflicted: liability law and patient rights law. To illustrate his point, the participant described a recent case where he was representing an injured patient and was confronted by a hospital's liability insurance lawyer, who was trying to limit the exchange of information and communication. The participant reported that he bypassed this by using patient rights and went directly to the physician, who was reluctant to speak about (and apologise for) what happened because of the instructions he had received:

> *"He received a message from the hospital – you will not speak because there is the liability insurance lawyer taking care of the case. But the law gives my client the right to be in the room and ask to see the doctor. And the doctor received a message from their lawyer, don't speak. So I had to twist the arm behind because the system was not built in a way that they could actually have an open discussion, and that was no good. You see, I think you can have a physiological or sociological analysis, but it's true in a pure legal point of view we had two different worlds meeting, one coming from liability law and one coming from patient rights law." P15*

Increasing flexibility regarding error communication

Participants identified two different self-insurance approaches that could be taken by hospitals to increase flexibility regarding error communication. Firstly, participants suggested that hospitals could raise their current self-insured retained limits, under which liability insurance does not cover and must be paid for by the insured. This would provide hospitals with more freedom to communicate with harmed patients and resolve the matter directly with them. Participants reported that some hospitals have implemented this approach and are experimenting with how much they can cover themselves.

Second, participants reported that some large public hospitals have decided to move to full self-insurance and not have liability insurance at all.

> *"I know of a few hospitals who now have decided not to keep the insurance but to be their own insurer, and to save money every year and to create a fund, and then they pay damages out of their own money. Because they had the feeling that they had more control over the whole process. What they could say to the patient, what they could really discuss…So I know that in a number of public hospitals there is a big discussion now, should we keep civil liability insurance or should we move to another system where we insure ourselves." P12*

Representatives of one of these hospitals reported that this was done primarily for financial considerations. However, they also noted that this approach also gives them more flexibility in de-escalating patients' demands in the context of civil claims.

Discussion

The results of this qualitative study suggest that a conflict exists in Swiss hospitals between the requirements of liability insurance and communication with patients following medical errors. Legal concerns about insurance may be preventing doctors from communicating transparently with patients, which in turn implies that patient rights legislation is not being followed.

With a new ethic of transparency regarding medical errors now prevailing internationally, the nondisclosure of errors is increasingly being perceived to be misguided, being more concerned "about our liability than our humanity" [21], As Lucian Leape has noted: "We have long known that a serious medical mishap is devastating for the patient, imposing an immense emotional burden on top of the physical suffering and fracturing the trust that is the cornerstone

of the doctor-patient relationship. And we know that honesty, transparency and apology are essential to ease that burden and rebuild that trust …" [21]. It is also known that medical errors can have a significant impact on clinicians and it is thought that their distress can be exacerbated by nondisclosure [21].

However, the advice to avoid open communication and apology has not always been completely unwelcomed by clinicians: "It fed into their fears of shame and disgrace and provided cover for avoiding the painful discussion with the patient and the revelation of fallibility" [21]. Indeed, it would be mistaken to think that clinicians' legal fears are the only reason for errors not being disclosed. While legal fears may surely be a factor in clinicians' reluctance to disclose and apologise for errors, the true reasons are usually more complex, including a professional and organizational culture of secrecy and blame, clinicians lacking confidence in their communication skills, and the shame and humiliation associated with acknowledging a harm causing mistake – to oneself, one's patient, and one's peers [6]. Indeed, research published in 2006 involving US and Canadian physicians suggest that the legal environment may have a more limited impact on physicians' communication attitudes and practices regarding adverse events than often believed, and that the culture of medicine itself may be a more important barrier [22].

Nevertheless, it is clear that communication after an error is often inhibited by liability insurance companies due to fears that it will increase litigation and costs. However, the experience of a number of organisations internationally indicates that adoption of disclosure and apology practices may in fact markedly reduce litigation and legal costs [23–24]. However, it is difficult to know how much of the success achieved at these organisations "is related to the practice of open disclosure and how much might be related to their proactive approach of offering early compensation" [21]. Indeed, it remains unclear what the overall impact of wide-spread disclosure and apology practices would be on malpractice litigation. Some researchers have referred to "the great unlitigated reservoir" and have warned that such practices may actually significantly increase lawsuits and costs [25].

It is widely agreed, however, that disclosing medical errors and apologising to harmed patients is the ethical thing to do, regardless of whether it decreases or increases the incidence of litigation [3]. Indeed, the disclosure of errors has evolved over the past two decades 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 following an error.

While disclosure cannot be done in isolation and has to be integrated into risk management and liability insurance programmes [21], the reported current practice of at least some liability insurance companies in Switzerland of inhibiting hospitals and clinicians from communicating with harmed patients after an error is concerning and requires further investigation.

Participants identified two different self-insurance approaches that could be taken by hospitals to increase flexibility regarding error communication: (1) hospitals could raise their current self-insured retained limits, or (2) hospitals could move to full self-insurance and not have liability insurance at all. The fact that some large public hospitals have decided to not have liability insurance, and others are currently considering this option, may suggest that there is dissatisfaction among some Swiss hospitals with the service liability insurance companies are currently providing. Indeed, an article in the May 2011 issue of *Gesundheitstipp* entitled "Hospital liability: Little benefit – despite high premiums" noted that "the satisfaction of the hospitals [regarding liability insurance] is crumbling. The Lausanne Universitätsspital Chuv terminated its liability insurance three years ago" [26]. Furthermore, it was reported that as insurance companies usually only pay when there is no alternative, patients are often forced to go to court, though few can afford this. Margrit Kessler, President of the Stiftung SPO Patientenschutz, therefore felt that the move away from liability insurance was not only better for hospitals as it saved them money, but also for patients: "Although the Canton of Vaud no longer has liability insurance, the compensation of patients works better there than in other Cantons. In the case of an error, the Chuv pays for follow ups as well as compensation without any grumbling" [26]. Both of the options identified by participants may therefore not only save hospitals money on insurance premiums, but also improve the situation for patients by allowing hospitals to pursue disclosure and apology programs, and early compensation programs. It remains to be seen, however, if the majority of Swiss hospitals have the desire, and courage, to pursue such programmes. However, it should be noted that even if hospitals move away from liability insurance, physicians in the private sector will still be under an obligation on to have their own liability insurance, owing to Article 40h of the Swiss Medical Professions Law.

It is therefore interesting to note that, internationally, legislation has been widely enacted in the United States (36 states and the District of Columbia), Australia (all 8 states and territories), and Canada (8 out of 10 provinces and 2 out of 3 territories) to prevent "apologies" given after an "incident" from being used in various legal processes [26–29]. A number of these apology laws also specifically address the issue of liability insurance. For instance, legislation in Canada states that an apology "does not, despite any wording to the contrary in any contract of insurance and despite any other enactment, void, impair or otherwise affect any insurance coverage that is available, or that would, but for the apology, be available, to the person in connection with that matter" [30]. While some international legal scholars have questioned the need for apology laws in general, they have acknowledged that these particular provisions regarding liability insurance may be a good idea if these fears are found to be justified [31].

An example that may be more relevant for Switzerland is the 2008 addition in Germany of section 105 of the Insurance Contract Law Act (Versicherungsvertragsgesetz), which provides that insurance agreements that include "cooperation clauses" are now invalid. In principle, German clinicians are now free to speak to patients about the incident, give them a report of the facts, and express regret, and may also accept liability without losing their insurance

cover [32]. Further research is needed in Switzerland to establish whether the loss of liability insurance coverage for apologising to harmed patients is a significant enough issue to warrant the implementation of such legal protection.

Limitations

This was a qualitative study that did not aim at collecting statistically representative data. It was carried out in one European country. However, given the international network of liability insurances, it is likely that a similar influence on medical error communication exists in other European countries. Although we have no proof that our interviewees have correctly described the reality there is no particular reason to doubt that their perceptions describe a significant part of the reality in Switzerland. Indeed, the fact that we interviewed experts from different fields that have experience with medical errors makes it likely that we captured at least some part of the reality viewed from different sides. A bias might exist towards the reporting of socially desirable attitudes. Given our results that are rather critical of current practice, we believe that such a bias is unlikely to be of significant size. The fact that many medical interviewees were not aware of any influence of liability insurance on the communication of medical errors can be interpreted as a limitation. At the same time, this is an important finding and should motivate further studies in this field.

Contribution statement: S.M. and B.E. conceived the idea for the study. S.M. designed the study and carried out data collection, analysis and interpretation. D.S., A.L., and B.E. co-analysed and interpreted the data. S.M. wrote the first draft of the manuscript and D.S., A.L., and B.E. critically revised it. All authors approved the final draft of the paper.

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Correspondence: *Stuart McLennan, Institute for Biomedical Ethics, Universität Basel, Bernoullistrasse 28, CH-4056 Basel, Switzerland, s.mclennan[at]unibas.ch*

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