

## Patient and Family Involvement

# What Prevents Incident Disclosure, and What Can Be Done to Promote It?

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Policies regarding the disclosure of adverse-event incidents promote openness between clinicians and patients following unexpected clinical outcomes. On the strength of emerging data showing its effectiveness as risk management and service improvement approach, as well as its potential to enhance the quality of care,<sup>1,2</sup> incident-disclosure policies are being formally adopted across a range of countries, including Canada, Australia, New Zealand, the United Kingdom (U.K.), and the United States.<sup>3-5</sup> Other developments that confirm continued interest in incident disclosure include the 2009 relaunch of the U.K.'s "Being Open" policy<sup>6</sup> and the Institute for Health Improvement's 2010 white paper on managing serious clinical adverse events.<sup>7</sup>

As an emerging domain of policy and practice, disclosure has been subjected to systematic inquiry for less than a decade.<sup>8,9</sup> This means that disclosure has advanced as a major policy initiative without much knowledge about the policy's impact on day-to-day practice and relationships.<sup>10</sup> The studies that form the basis of this have begun to address this gap by probing how clinicians and patients are experiencing disclosure and what they regard as preventing disclosure from being effective.

Following a literature review summarizing research into clinicians' enactment and patients' experience of disclosure, this article reports on concerns expressed by a total of 289 interviewees (147 clinicians and 142 patients/family members) about current approaches to and effects of incident disclosure.

### Existing Knowledge of Barriers to Clinicians' Implementing Open Disclosure

Studies that have investigated practitioners' views of disclosure have revealed a relatively stable set of factors that contribute to clinicians' favoring nondisclosure (Table 1, page 410). The barrier that is most often mentioned in this context is professionals' fear of litigation.<sup>11-14</sup> This fear is so pervasive as to transcend not just national boundaries but also legally distinct environments.<sup>15</sup> Some commentators interpret clinicians' legal fear as a justifica-

### Article-at-a-Glance

**Background:** Adverse-event incident disclosure is gaining international attention as being central to incident management, practice improvement, and public engagement, but those charged with its execution are experiencing barriers. Findings have emerged from two large studies: an evaluation of the 2006–2008 Australian Open Disclosure Pilot, and a 2009–2010 study of patients' and relatives' views on actual disclosures. Clinicians and patients interviewed in depth suggest that open disclosure communication has been prevented by a range of uncertainties, fears, and doubts.

**Methods:** Across Australia, 147 clinical staff were interviewed (mostly over the phone), and 142 patients and relatives were interviewed in their homes or over the phone. Interviews were recorded, transcribed, and analysed by three independent investigators. Transcription analyses yielded thematic domains, each with a range of ancillary issues.

**Results:** Analysis of interview transcripts revealed several important barriers to disclosure: uncertainty among clinicians about what patients and family members regard as requiring disclosure; clinicians' assumption that those harmed are intent on blaming individuals and not interested in or capable of understanding the full complexity of clinical failures; concerns on the part of clinicians about how to interact with (angry or distressed) patients and family members; uncertainties about how to guide colleagues through disclosure; and doubts surrounding how to manage disclosure in the context of suspected litigation risk, qualified-privilege constraints, and risk-averse approaches adopted by insurers.

**Conclusions:** Disclosure practices appear to be inhibited by a wide range of barriers, only some of which have been previously reported. Strategies to overcome them are put forward for frontline clinicians, managerial staff, patient advocates, and policy agencies.

Table 1. Known Barrier Domains and Specific Barriers: What Prevents Incident Disclosure?

Known Barrier Domains	Specific Barriers	Relevant Studies (Reference Number in References List)
1. Clinicians experience legal fears	a. fear of litigation	Christensen et al. 1992 (13); Kalra et al. 2005 (12); Novack et al. 1989 (11); Schwappach & Koeck 2004 (14); Gallagher et al. 2006 (15); Studdert et al. 2010 (10)
	b. apprehension of reputation damage	Gallagher et al. 2006 (15)
	c. fear of loss of privileges	Mazor et al. 2004, 2006;* Kaldjian et al. 2006 (26)
2. Health service culture of secrecy and/or blame	a. professional groups protect their own interests	Walshe & Shortell 2004 (16); Bosk 2003 (17); Institute of Medicine 1999 <sup>†</sup>
	b. incident management responsibilities are fragmented	Walshe & Shortell 2004 (16); Institute of Medicine 1999 <sup>†</sup>
	c. clinicians and health care services deny the occurrence of incidents and practice self-deception	Walshe & Shortell 2004 (26); Institute of Medicine 1999
	d. clinicians experience shame and self-blame, leading to secrecy	Ofri 2010 (23); Delbanco & Bell 2007 (24)
3. Clinicians lack confidence in communication skills		Gallagher et al. 2003 (19); Gallagher et al. 2006 (15); White et al. 2009 (18)
4. Clinicians fear patients will experience distress (nondisclosure as benevolent act)	a. distress can result for patients and families	Fallowfield & Jenkins 2004 (21)
	b. distress can result for clinicians	Gallagher et al. 2003 (19)
	c. distress can harm patients	Iedema et al. 2008 (27)
5. Doubt about the efficacy and effectiveness of incident disclosure	a. disclosure's ability to increase patients' trust and decrease litigation may be overstated	Gallagher & Lucas 2005 (25)
	b. disclosure may prompt legal action	Studdert et al. 2007 (10)

\* Mazor K.M., Simon, S.R., Gurwitz, J.H.: Communicating with patients about medical errors. *Arch Intern Med* 164:1690–1697, Aug. 9–23, 2004; Mazor K., et al.: Disclosure of medical errors: What factors influence how patients respond? *J Gen Intern Med* 21:704-710, Jul. 2006.

<sup>†</sup> Institute of Medicine: *To Err Is Human: Building a Safer Health System*. Washington, DC: National Academy Press, 1999.

tion for secrecy.<sup>16</sup> This fear is seen to undermine the aims and execution of incident management, practice improvement, and public involvement through disclosure.<sup>16,17</sup>

Other studies have emphasized professionals' apprehension in the face of emotional distress.<sup>18</sup> Clinicians are wary of both their own negative emotional responses and of the distress caused for those to whom the disclosures are made.<sup>19</sup> These apprehensions are exacerbated by low levels of confidence in one's own communication skills<sup>20</sup> and a perceived lack of ability to respond appropriately to others' feelings.<sup>21</sup> It is evident from studies that investigate staff training in disclosure that the emotional dimensions of disclosure conversations are experienced as by far the most challenging.<sup>22</sup>

Finally, practitioners may be ashamed about the incident and therefore hide their knowledge about what went wrong.<sup>23,24</sup> Or they may be unsure or skeptical about disclosure achieving the

desired effect<sup>25</sup> and therefore regard the claims made in favor of disclosure, such as increasing patients' trust and obviating litigation, as overstated.<sup>26</sup> Given fears that disclosure may prompt complaints and litigation rather than avert them, some professionals regard disclosure as risky, personally as well as organizationally<sup>10</sup> (see Table 1 for a summary overview, above).

### Knowledge about Barriers to Disclosure Derived from Two Australian Studies

In Australia, what is known as *open disclosure* operates in a fault-based legal environment where hospitals and salaried clinicians are covered by state-based indemnity arrangements. Contracted medical clinicians who run their own businesses purchase individual practice insurance premiums. An indemnity crisis in 2001–2002 saw the collapse of two major health care insurers and led to, among other things, the Australian Council (now

*Commission*) on Safety and Quality in Health Care's publication of its Open Disclosure Standard.<sup>3</sup>

The Open Disclosure Standard defines open disclosure as follows:

Open disclosure is the open discussion of incidents that result in harm to a patient while receiving health care. The elements of open disclosure are an expression of regret, a factual explanation of what happened, the potential consequences and the steps being taken to manage the event and prevent recurrence.<sup>3</sup>

The policy distinguishes between high- and low-level disclosure—high-level disclosure is reserved for serious incidents involving permanent harm or death. The standard further intimates that both errors and complications (adverse events not due to errors) should be subject to disclosure.

The model generally deployed in Australia for disclosure involves a liaison person (usually the patient safety officer) contacting the victim of an adverse event, gathering data about the incident, convening a meeting for clinical staff to plan the disclosure meeting (and determine its level of formality), facilitating the primary disclosure meeting and maintaining contact with the patient (and/or family) following the initial meeting(s). The barriers described in this article help explain why clinicians may be inclined or encouraged to avoid disclosure. Identifying these barriers is critical to enabling organizations and clinicians struggling with disclosure adopt and devise strategies that render disclosure effective and acceptable for all those affected by an incident.

Since 2006, open disclosure practice in Australia has been evaluated in two ways. First, when piloted across 42 hospitals in Australia in 2006 and 2007, open disclosure was evaluated at 21 of those hospitals by interviewing 131 clinicians and 23 patients.<sup>2</sup> Second, open disclosure was again evaluated in 2009–2010, this time by interviewing an additional 119 patients and family members and 16 clinicians about their experiences of incident disclosure.<sup>28</sup> These two data sets are analyzed here from the perspective of what interviewees thought prevented disclosure.

## Methods

### STUDY RECRUITMENT

Participants were recruited when they had been involved in open disclosure in one capacity or another. Clinicians—which included managers who were not health care providers—were recruited through their health organizations where ethics approval for the study had been obtained. All clinician interviewees vol-

unteered for the study. Patient and family member participants were recruited using a range of strategies to reduce the chance of a single strategy biasing the sample. Across both study periods, health services (producing 59 participants involved in 51 interviews), the national media (56 participants involved in 43 interviews) and two Internet marketing companies (27 participants in interviews) were mobilized to invite members of the public to come forward with accounts of incidents and incident disclosures.

### STUDY SAMPLE

The interviewees (289 total) were recruited from across Australia. Most clinician and patient interviewees were from Queensland (91), underscoring Queensland's progress in promoting disclosure.<sup>29</sup> Some 68 were based in New South Wales, with the remaining 130 recruited from the four other states. Clinician interviewees included 49 frontline medical clinicians, 20 nursing clinicians, and 78 clinicians engaged in quality management roles. Some 44 patients and 88 family members participated in the interviews.

### RESEARCH APPROACH

The study used in-depth, semistructured interviews, which ranged from 20 minutes to 3 hours in duration. In the majority of cases, the clinicians were interviewed over the phone, with the remaining small minority of cases interviewed at their workplaces. Patients and family members were interviewed over the phone (50%) or at home (50%). The question schedule developed for the clinician interviews explored approaches and challenges to disclosure. The question schedule developed for the patient/family member interviews explored experiences and views. The same clinician/patient question schedules were used in both the 2006–2007 and the 2009–2010 data sets.

### DATA ANALYSIS

After the interviews were digitally recorded and transcribed verbatim, three independent investigators [R.I., S.A., R.S.] analyzed them using "open coding."<sup>30</sup> The few major discrepancies in coding results that occurred were resolved by comparing and realigning coding criteria, coding labels, and coding axes (cross-links). The resulting code analyses produced a list of overarching themes, which the investigators cross-checked by relating them back to the relevant sections in the original data transcripts.

## Results

Thematic analyses of the interviews produced four main domains within which barriers to implementing open disclosure

emerged, as follows:

1. Lack of insight among clinicians into what patients and family members regard as requiring disclosure
2. Concerns about how to disclose incident information to patients and family members
3. The challenge of communicating with colleagues about (their) incidents
4. Uncertainty about how to negotiate disclosure in the context of legal and insurance risk.

Quotes that are emblematic of these themes are provided.

### 1. LACK OF INSIGHT AMONG CLINICIANS INTO PATIENTS' AND FAMILY MEMBERS' EXPERIENCE AND UNDERSTANDING OF INCIDENTS

*1a. Insufficient Insight into Patients' and Relatives' Perceptions of What Constitutes a "Disclosable Incident."* Patient and family interviewees commented on clinicians' reluctance or inability to acknowledge the impact of an unexpected outcome on those receiving care. These interviewees make mention of unsuccessful attempts to alert clinicians to what they perceive to be substandard, risky, or unreasonable care. This barrier may derive from clinicians not regarding certain events as being risky, inconvenient, or harmful; not being able to afford the time to probe such events; or not appreciating that the patient has indeed experienced a risk, inconvenience, or harm. All three scenarios may, in their own way, obviate dialogue about what the patient or family regard as warranting an explanation, an improvement, or a disclosure.

I'm floored by the fact that these [clinicians] deal with these [incidents] every day and yet behave this way. I cannot get my head around that. I believe that patient care is all about people, regardless of their journey.—Daughter of a patient who died

*1b. Uncertainty About Patients' and Relatives' Capacity and Willingness to Understand Clinical Complexity, Medical Technicalities, and the Systems Dimensions of Failure.* In cases in which clinicians were able to appreciate the impact on patients of a specific risk, inconvenience, or harm, patient and family interviewees felt that clinicians underestimated their ability or willingness to understand the problem. Clinicians' doubts about patients' and family members' ability or willingness to understand the full complexity of what went wrong led to denied or inadequate disclosure. If disclosure was granted, clinicians treated disclosure as one-way simplified information provision rather than as an opportunity for clinician-patient dialogue addressing the complex organizational and process dimensions of

diagnosis and treatment, particularly those that involved risk, inconvenience, and even harm.

It was when we . . . had the next appointment with the oncologist . . . and we raised the [incident] then and they, well he . . . played it down and . . . washed over it and didn't really ah . . . admit to anything or think it was a problem."  
—Husband of a woman who died

### 2. UNCERTAINTIES ABOUT DISCLOSING INCIDENT INFORMATION

*2a. Uncertainty About How to Deal with Complex Patient-Family Emotions and Dynamics.* Clinicians expressed uncertainty about how the team should handle complex patient/family emotions and dynamics, and about which serious incidents were seen as exacerbating. The family dimension in particular was feared to further inflate the "blame risk": a family member not immediately involved in the day-to-day care of the patient may not appreciate how or why particular things happened and how this played a role in the adverse event, and they therefore could experience higher levels of anger and frustration than the harmed patient.<sup>31</sup> Clinicians' sense of inadequate communicative ability in turn inspired uncertainty about how to prevent disclosure from making matters worse. Interviewees were particularly concerned about "saying the wrong thing."

Oh, you're opening all sorts of emotional cans of worms, and I think that if it's not done carefully and sensitively by people who have a bit of an idea of what they're doing, you can do quite a lot of damage emotionally to the clinicians involved and family members. You're dealing with some pretty raw emotions . . . and you can do a lot of damage if you don't know what you're doing. Certainly you get your buttons pushed, [and] you're going to push them right back.—Medical manager

*2b. Uncertainty About the Cultural Appropriateness of Open Disclosure Communication.* Clinicians expressed uncertainty about how teams should disclose adverse events when (their approach to) disclosure may not be perceived to be culturally appropriate by the patient and their family.<sup>32</sup> Interviewees were clear that dealing with people from diverse cultural and linguistic backgrounds requires special knowledge and additional resources on the part of those disclosing adverse events. The challenge of communicating across cultural boundaries is complicated further when the disclosure involves interpreters and translators. Challenges were also recognized to affect clinicians from non-Australian cultural and linguistic backgrounds having to communicate about incidents. Difficulties became most apparent when the success of these conversations depended on cli-

nicians' ability to respond to detailed questions about and emotional responses to the health care incident.

[We need] cultural awareness. [For example,] a lot of indigenous people will give you eye contact, and this older guy was really annoyed at the nurses because they wouldn't give him eye contact [but we] don't understand the various community groups and their nuances.—Nursing manager

[Name of overseas-trained junior doctor] needed it to be explained to him what was going to happen because it's probably not as common a thing in [his] subcontinent. And most junior clinicians aren't aware of it in the [name of state] system.—Medical manager

### 3. UNCERTAINTIES ABOUT COMMUNICATING WITH COLLEAGUES ABOUT INCIDENTS

*3a. Uncertainty About How to Liaise with Colleagues Who Were Most Closely Involved in the Adverse Event.* Clinicians expressed uncertainty about how to conduct communication about the incident with colleagues originally party to it and how to structure their role in its disclosure. Interviewees commented on the need to gauge colleagues' feelings about the adverse event and to assess the damage that might be incurred by the patient's and family's blaming the colleague(s). The default response was to "distance" junior medical or nursing clinicians from the disclosure, whether or not their presence was requested by the patient or family. This response was justified by pointing out that high-severity incidents rendered blame likely and that junior clinicians had not yet developed the requisite communicative experience or professional maturity to cope with a challenging patient-provider encounter. Interviewees thought that the closer the clinician was to "the sharp end of the incident," the more likely this person was to need support from and work closely with the patient safety officer.

If . . . it's sort of like . . . an obvious sharp end incident . . . where the clinician has directly caused the harm, definitely they need so much more support, than when it's something that's indirect . . . some clinicians will need more support than . . . others. I think it comes down to the actual nature of the incident, the disclosure.—Organizational support personnel

*3b. Doubts About How Disclosure of Unexpected Outcomes Can Contribute to Enhancing One's Professionalism.* Clinician interviewees indicated that their colleagues tended to throw doubts on the notion that formalized incident disclosure may be integral to professionalism. Two problems were identified. First, interviewees felt that their colleagues were insufficiently

accepting of new policies explaining when and how to disclose incident information. This concern was related to these peers' apparent unwillingness to contemplate disclosure's potential for reassuring patients and families of their professional standards and for facilitating personal and organizational learning. Second, interviewees felt that their clinical colleagues tended to overestimate their own familiarity with and skills in communicating disclosure. Lending force to this concern was that patient and family interviewees presented numerous unsatisfactory disclosure experiences.<sup>28</sup>

[T]hat's the feedback: "We already do that well," "We deliver bad news all the time. We do that well," and if you're dealing with someone who already thinks they do things fine . . . I'm finding, they don't see any need for improvement.—Senior support personnel

It is all about having the right people, and I think that there are some people whose manner and interpersonal skills perhaps would be counterproductive in that sort of process.—Medical manager

### 4. UNCERTAINTIES ABOUT THE LEGAL/INSURANCE IMPLICATIONS OF DISCLOSURE

*4a. Communicating Disclosure When Incident Information May Be "Privileged."* Clinician interviewees expressed uncertainty about how to marry the requirement that they disclose and apologize for adverse events with the importance of maintaining "qualified privilege." Qualified privilege protects quality assurance activities and information produced therein from legal proceedings to encourage clinicians to engage in practice improvement.\*

There are two complicating factors here. First, there are a number of lawful pathways in Australia along which the information generated as part of a quality assurance process or quality assurance committee may travel to patients, with qualified privilege ceasing once information is released by the quality assurance committee. These pathways vary across jurisdictions, exacerbating clinicians' doubt about what is required to do and what is permissible to say. Second, in Australia qualified privilege does not apply to disclosure, so a clinician is not legally—but can be organizationally—prevented from apologizing or disclosing information at his or her disposal about what occurred and

\* Qualified privilege protects documents and communications generated as part of a quality assurance process or quality assurance committee from demands to disclose them—typically, demands that emanate from legal proceedings. The principle behind qualified privilege is to encourage clinicians to engage in practice improvement without having to fear being blamed when evidence comes to light of subideal performance. Qualified privilege no longer applies to information once such information is lawfully released by the quality assurance committee.

Table 2. Additional Barrier Domains and Individual Barriers Identified

Barrier Domains	Individual Barriers
1. Lack of insight into patients' and relatives' experience and understanding of incidents	1a. Insufficient insight into patients' and/or relatives' perceptions of what constitutes an incident
	1b. Uncertainty about patients' and/or relatives' capacity to understand clinical complexity, medical technicalities, and the systems dimensions of failure
2. Uncertainties about disclosing incident information	2a. Lack of capacity in dealing with complex patient-family emotions and dynamics
	2b. Doubt about the cultural appropriateness and effectiveness of incident disclosure (for patients and staff)
3. Uncertainties about communicating about incidents with colleagues and the wider organization	3a. The challenge of dealing with resistant and/or distressed colleagues involved in the incident
	3b. Doubts about how the admission of an unexpected outcome can contribute to enhancing one's professionalism
4. Uncertainties about the legal/insurance implications of disclosure	4a. Doubts about how to align disclosure with qualified privilege
	4b. Uncertainty about insurers' stance on incident disclosure

what caused it. This of course burdens the clinician with having to arbitrate between patients' expectation "to be informed about who was responsible" and "to be told everything," on the one hand, and the organization's prerequisite to safeguard privileged information and thereby obviate the waiver of that privilege, on the other hand.

An additional complicating factor is that disclosure policy prescribes what some have called a partial apology<sup>3</sup> (for example, "We are sorry this happened")—a form of apology that enables the clinician to evade taking responsibility for an adverse event. Clinician interviewees were concerned that patients and family members respond negatively to partial apologies. Similarly, clinicians were concerned that patients and family members respond negatively to explanations that avoid framing incident causation as a matter of individual or organizational responsibility and that instead portray incidents as having been brought about purely by "system factors." Clinicians feared that the disclosure meeting may fail when they are not prepared to acknowledge some responsibility for what went wrong and that such failure may exacerbate litigation risk.

No, you cannot admit liability. You can apologize and say . . . we are sorry that this has happened to you, but we cannot turn around and say, yes we can offer you [an explanation] . . . and that is some of the anger, because they keep coming back through the course of the meetings and say "Why don't you just say that you stuffed [screwed] up?"—Nursing clinician

*4b. Uncertainty About Insurers' Stance on Disclosure.* Clinician interviewees expressed the view that in their experience some insurers were not in favor of disclosure. Some insurers may make public statements supporting disclosure but then generally advise individuals involved in incidents "to stop talking." This presents a particularly strong disincentive. Clinicians are concerned that they are put in the position of communicating openly with the victim(s) and potentially risking their own insurance coverage being rendered void.

Obviously when something goes wrong we [the health service] advise our insurer. But they [the clinician involved in the incident] also advise their insurer and they might receive advice on "don't do that" or "don't say this." I do not know what goes on but that got to be respected.—Senior nursing clinician

Table 2 (above) provides an overview of the barriers to implementing open disclosure, as we have identified.

## Discussion

We grouped interviewees' concerns about disclosure into four overarching domains. Barriers arose from clinicians' (1) not appreciating what patients and family members regard as a disclosable event and what they know about the event, (2) being unsure about communicating with patients and families and handling their emotions and interpersonal dynamics, (3) doubts about communicating with colleagues, and (4) uncertainties about legal constraints and financial risk.

**Table 3. Suggestions About Who Is Responsible for Resolving the Barriers Identified and How Those Barriers Might Be Resolved**

Individual Barriers Identified	Whose Responsibility?	What Actions Can Be Taken?
1a. Insufficient insight into patients' and/or relatives' perceptions of what constitutes an incident	Treating clinicians	Communicate with patients and relatives about care expectations and experiences.
	Patient liaison, staff charged with managing open disclosure	Practice "active listening."
1b. Uncertainty about patients' and/or relatives' capacity to understand clinical complexity, medical technicalities, and the systems dimensions of failure	Patient liaison, staff charged with managing open disclosure	Engage in dialogue with patients and relatives to appreciate their depth of clinical, medical, and systems understanding and insight.
	Clinical staff negotiating informed consent	Inform patients about health service complexity and risk.
	Health departments	Educate the public about health service complexity and risk.
2a. Lack of capacity in dealing with complex patient-family emotions and dynamics	Health services and organizational management	Put in place disclosure communication training.
	Clinical practitioners	Sign up for disclosure communication training.
2b. Doubt about the cultural appropriateness and effectiveness of open disclosure (for patients and staff)	Academic researchers	Investigate the cultural impacts, appropriateness, and effectiveness of incident disclosure.
	Clinical educators and trainers; certification and educational institutions	Ensure an appropriate scope of disclosure training for culturally and linguistically diverse staff; arrange appropriate testing, induction, and training services before certifying overseas clinicians
3a. The challenge of dealing with distressed colleagues involved in the incident	Health services and organizational management	Arrange counseling services and appropriate debriefing.
3b. Resolving clinicians' doubts about whether disclosure will enhance professionalism	Health services and organizational management	Provide postexperience training in and information about incident disclosure.
4a. Uncertainty about how to align disclosure and qualified privilege	Policy makers, health departments, and local health services	Clarify the link between apology laws and qualified privilege. Put systems in place for managing the parallel production of victim-specific explanations and systems recommendations.
4b. Uncertainty about insurers' stance on disclosure	National safety policy bodies and agencies	Arrange collaborations between insurers and health services modelled on programs such as the COPIC program.*

\* COPIC Insurance Company, which insures physicians in Colorado, adopted a voluntary intervention program, the "3Rs." Applicable to cases that do not involve death or clear negligence, it involves "recognizing" an unanticipated event, "responding promptly," and "resolving" related issues (Truog R., et al.: *Talking with Patients and Families About Medical Error: A Guide for Education and Practice*. Baltimore: The Johns Hopkins University Press, 2011).

The first domain entails barriers that can partly be addressed through improving communication in general between clinicians and their patients. Going beyond informed consent as a technical indicator of information sharing, clinicians need to be skilled in shared decision-making,<sup>33</sup> strengthen the patient-provider relationship and make it easier to talk about unexpected outcomes when they occur during or after the episode of care.<sup>34</sup> The second domain presents barriers that also are contingent on adequate and sympathetic debriefing following incidents, and effective clinician training in communication skills and cultural awareness. Special emphasis needs to be placed on active listening—the capacity to guide those affected by the incident

through their own emotional responses to it in order to move on from it.<sup>35</sup> These proposals require a range of actions from different actors across the health care system, as summarized in Table 3 (above).

Barriers arising from having to negotiate disclosure with colleagues may be resolved by creating mechanisms through which clinicians can collectively prepare for disclosure and debrief one another following incidents. Preparation and debriefing should focus not just on the technical details of the incident but its emotional aspects.<sup>36</sup> How well clinicians conduct these aspects of disclosure and the extent to which they harness disclosure for professional practice improvement are contingent on education,

training, and coaching.<sup>37</sup> We acknowledge that not all treating clinicians may be coachable because of the incident's adverse impact on them. However, coaching those clinicians able and prepared to enact disclosure responds to a real-time need, while education and training prepares clinicians at graduate and post-experience levels for how to deal with failure and the emotionality of incident communication (Table 3).

The legal barriers identified include uncertainty about whether and how to disclose information that may be subject to qualified privilege as part of a root cause analysis. Resolving this uncertainty requires clarification on two levels. First, clinicians need reassurance that qualified privilege restrictions and disclosure obligations are not in competition. This may be achieved by combining mandatory disclosure with an inability to present information obtained through disclosure as evidence of liability, as is the case in several U.S. states, including Massachusetts, Oregon, and Colorado.<sup>38</sup> Second, clinicians' communication with patients and family members should not be construed as simply a matter of information provision. Instead, disclosure should be a dialogue in which views, insights, understandings, and questions are shared. This dialogue does not just involve supplying facts or choices, but together building a picture of what took place in the patient's care. Such a picture accommodates everyone's understandings of how the incident unfolded and the incident's severity and its implications. Because it may be difficult, such dialogue needs to be carefully planned in consultation with risk managers or disclosure coaches so that appropriate consideration is given to the potential legal implications of dialoguing (or not dialoguing) with harmed patients.

For its part, the uncertainty about how open disclosure might put clinicians' insurance coverage at risk needs to be addressed by involving insurers in discussions about the rationale for disclosure. Such discussions can now be enriched with evidence about the financial and social benefits of open disclosure.<sup>2,39,40</sup> Table 3 sets out the implications of these findings for relevant stakeholders.

## LIMITATIONS

A limitation of this study is that all participants self-selected for the interviews; in addition, the participants self-reported without external means of verification. That is, we were not able to verify the information that clinicians, patients, and family members provided to us. Our sample consisted of clinicians who volunteered to participate, potentially reducing the likelihood of encountering ignorance and disapproval of incident disclosure. Furthermore, participants' exposure to disclosure was uneven, varying from high to low across the sample. The responses obtained nevertheless paint a persuasive picture: Not one clini-

cian or patient/family interviewee rejected the principle of disclosure, and few patient/family interviewees experienced a fully satisfactory disclosure. Both stakeholder groups presented urgent arguments for overcoming the remaining barriers to incident disclosure.

## Conclusion

Considerable attention has been paid to disclosure during the last decade, but we still struggle to meet patients' expectations, suggesting that important but unexplored barriers may be at play. This article highlights several such barriers on the basis of the firsthand experiences of patients, family, and clinicians. Paying more attention to overcoming the full spectrum of barriers that currently inhibit disclosure will be critical if progress on this important topic is to be achieved.

In contrast to the "deny and defend" approach historically used by health organizations when responding to patients' and family members' complaints and legal charges, disclosure promotes openness and sharing of incident information.<sup>41</sup> The realization of a disclosure policy and associated organizational and legal reforms and training, as presented in Table 3, could lead to generally improved relations with patients and among professional colleagues, more learning from unexpected outcomes, more effective incident investigation and complaints processes, lower payouts, and a better chance of reconciliation of all parties after an incident.<sup>22,42</sup>

Disclosure is a policy that harbors the promise of culture change, practice improvement, patient involvement and service alignment.<sup>42</sup> By inducting clinical professionals into conducts that are responsive to how care is experienced and understood by patients and their families, disclosure may render practitioners more mindful of patients and of one another.<sup>43</sup> Such change, in turn, would have a direct positive impact on the broader systems of care that clinicians' individual practices help instantiate. Indeed, disclosure can strengthen quality improvement and safety culture as services learn from patients, and as their transparency bolsters incident reporting, investigation, and improvement. ■

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