**Findings**

The main concept that arose in the workshops was that of transparency: “The issue of transparency… I’m thinking about the desire to share a piece of information with someone else, information that you have and they don’t, and that they won’t have unless you share it with them, I think that this connects to a very deep need and desire. Our need to work together, and also our need to be in a position where you can trust another person and cooperate with them. At the end of the day, this is the foundation of every society, including our society.” (3)

Four themes on the topic of “transparency” were found:

**Theme 1: Transparency with patients who suffered adverse effects of care:** *“How to deal with the first victim of an error. That’s the trick. It’s an emotional thing, it’s something there’s no prescription for.”*

The need and duty to be open and candid with patients when an error has been made arose in the workshops: “The first stage in diffusing any accusations from a victim is really to talk about things with him. To understand that, even if someone hurt him, it definitely wasn’t done on purpose, and that for sure it occurred during a procedure that was intended to benefit him. That these things happened during a treatment procedure that was intended to be good for him.” (5). In addition to telling the truth, participants mentioned expressing regret for what had happened, apologizing, and taking responsibility: “…I’m really sorry for what happened, but I myself don’t know what happened…I promise…to look into it and let you know” (1).

Transparency was explained as being an active process on the part of medical staff, who go and talk to the patient and/or their relatives. Participants also raised the possibility of sharing medical notes with patients, should patients wish to see them: “During these conversations, we invite them [the patients/ relatives] to see the notes, that is to say, as far as we are concerned, there is nothing that isn’t transparent.” (9)

In the workshops, participants talked about the significance of listening to patients who have experienced a medical error. “Sometimes looking into their eyes and being there with them, even if you don’t say anything… if you don’t say the difficult words…that will bring them down…the eyes are going to express that, first of all, I’m here with you, I’m listening to you… and we’ll look into it and we’ll get back to you with proper answers and we… I think this is the key to… really calming people down and giving them the feeling that they are in good hands.” (1)

On the importance of acknowledging the harm done and committing to putting things right to prevent similar errors happening in the future: “Most patients who experience something unwanted during their hospitalization don’t start demanding compensation…they want acknowledgement, that’s one thing, and they want lessons to be learned so that things will change, so the same error won’t happen again.” (4)

The importance of being with the patient and their relatives, even after the conversation about the medical error and the difficulties around it, also came up in the workshops. “Proper disclosure is not enough… what is important beyond that is what comes next. Like, did you visit the patient the next day? Did you follow up with them?...A lot of times what happens is we shy way, like, I hurt him, I recoiled from that and I didn’t go…Because of the shame, because it doesn’t feel good.” (5)

There were examples of how patients welcomed transparency and disclosure, for example: “The father of that girl came to see me on the management floor and just look at what he’s thinking, he says I’m asking you not to take any action against whoever who made the error…promise me, he tells me.” (6) On the other hand, there were examples of how transparency had provoked anger and aggression towards staff: “Most of the time you do witness anger… it’s hard for me to even express myself, but it’s natural, we’re talking about someone who lost a loved one, a relative.” (6)

Finally, participants said there were question marks over whether it was possible to maintain a policy of transparency in Israeli culture: “The literature… as presented here…talks mainly about American society, are there any data or understanding of how Israeli citizens or patients behave?” (9)

**Theme 2: Transparency as part of a doctor’s professionalism** *“Don’t put yourself or the team down, but come with openness and transparency”*

In the workshops, it emerged that the policy of transparency is an inseparable part of the medical staff’s professionalism, and that inquiries are needed so that people can learn from incidents, draw conclusions, and take lessons from them to improve things going forward: “Transparency pays off…we research any incident like that, sit down with the team…and then we also learn the lessons…through new procedures that we undertake…” (6). The importance of disseminating information to others so people can learn from errors was also raised within the theme of professionalism: “Information sharing, that can be done anonymously, it doesn’t matter to me what happened in which hospital…how can I prevent myself from falling into the same trap.” (6)

Transparency with patients emerged as being a moral value of professional integrity: “I am really proud to be part of an institution where questions of transparency and inquiry and truth-telling have become part of life” (4); from a humane viewpoint: “We are really coming from a place of human vision, a love of humanity, and empathy” (6); and from a place of justice: “It is just and proper that families know what happened to them, or to their loved ones, it’s a value that is equally as important.” (5)

Some participants described transparency as a professional value that came with the job of being a medical professional, and not just in the context of medical errors: “I think that if, right from the outset, from the moment a patient is admitted to hospital, before any error has occurred, treatment is given with transparency, openness, and trust, and you, a person can feel that he can trust the team with any behavior.” (1) It emerged that good, empathetic communication right from the outset can create a solid basis for a relationship, and can help even if, God forbid, an error should occur going forward: “People who have been treated…in a way that is not insulting or emotionally offensive, they feel uncomfortable filing a lawsuit even if it is factually justified. But people who are emotionally wounded file lawsuits even when they are not justified.” (7)

Workshop participants said making errors caused medical professionals to experience feelings of guilt: “The punishment is what the person experiences toward himself and how he experiences self-criticism” (4). They also mentioned the feelings of shame that come with confessing an error: “This thing gets blown up so big that they don’t remember you, or the decades that you’ve put in…that’s why I think people avoid saying anything.” (5) At the same time, it emerged that there is an emotional value to transparency when it comes to coping with the feelings of guilt that the medical team experience: “There is some sort of feeling there, especially among the people who were more closely involved, but everyone feels it…a sort of catharsis…you feel that you went back to interacting with the family, with the person.” (9) “For me to be able to keep sleeping at night, right now I don’t care about the lawsuit…or what risk management are going to tell me… what interests me right now is really my healing in admitting the error… it’s no secret that I try to hide all the time, and as soon as I shared that with the patient herself, I felt that I had at least closed a circle for myself and for her.” (1)

The final thing—participants mentioned the need to assist those who had made an error, who were in a vulnerable mental state, and who often needed help themselves. “Take the person responsible for the error and be with him. Beyond that, keep him away from the error, let someone else deal with it, first of all, and second, teach him that what he’s going through right now, he needs to move past it.” (7)

**Theme 3: Transparency and medical-legal discourse**

*“Actually, what stops us from developing morally and ethically is the fear of prosecution.”*

In the workshops, the risk management department and the management team noted that transparency is part of organizational professionalism: “First of all, we look at each event systemically. About the work processes, we are not looking to punish anyone, we want to learn from the work processes, how we can improve the working environment and how we can avoid the next incident.” (4)

Representatives from the management team made it clear that it is important that reports about errors came from the staff members themselves: “We will praise anyone who comes to us and reports an incident, and we will really, really be critical if we learn about an incident from a lawyer, or from a claim or serious complaint from a relative.” (4)

Finally, they conveyed a reassuring message emphasizing the commitment of the management team to backing staff who reported medical errors: “I think that first of all, you need to restore your confidence in our managerial commitment… that we will give real backing to transparency…tell the truth even if the truth is hard for the patient.” (9) “At the start of my career, we made an error, we were scared. We were really scared. We said if I report the error, I will get penalized…they’re going to say that this nurse makes errors and I’ll get labelled, and over the years, this is part of what I’m bringing to management, they educated us within the institution itself, which is fine.” (7)

At the same time, representatives from the risk management department reported tensions between the legal team and the medical team: “First of all, there is obvious tension between the legal team and the medical team, the question has been raised on more than one occasion…has the standard of a reasonable doctor become that of a rare doctor?”

These complexities were also raised by the participants: “Unfortunately, in our legal environment, we remain in a situation where a staff member who apologizes is seen as acknowledging responsibility, even if all they want to do is express empathy and sorrow. Until this is fixed, these words about transparency are really nice and everything, but they are pretty empty.” (9)

Some management representatives talked about the complexities in the messages encouraging transparency, since investigating an incident could result in a penalty: “There is a spectrum here. On the one hand, some errors are human errors, we can understand that, and maybe these can be blamed more on the circumstances of the person who made the error, but at the other end of the spectrum… there really are people who deserve a very serious punishment.” (4); “Sometimes there is no choice and measures have to be taken, we are not talking about criminal [proceedings] or dismissals…but about transferring someone from a particular role to one where there is less danger that they will make errors, that’s happened and we’ve done it…I mean, this idea that there’s a perfect world where we just empower people who made errors and surround them with empathy is just wrong.” (5) The possibility was raised of providing mentoring and support to a person who made an error: “In some cases, especially when we see that there is some sort of recurring issue with a specific individual…we actually offer them mentoring and guidance…we don’t call it punishment…[but] sometimes it can be seen as being a punishment.” (4)

This complexity—the fear of punishment alongside the need/desire to admit [errors] was also raised by the staff: “This defense…it’s existential. To admit it or not to admit it. I did it, I didn’t do it. Do you see? There is some sort of cognitive dissonance here… (4). However, in one workshop, the possibility was raised of actual punishment as a condition for learning: “But in any case, maybe it’s not a case of them taking my certificate away, but if I knew that I would pay 100 NIS to charity, say, just for a while, then every error I made would make my learning better.” (2)

Some participants described how these concerns caused them to conceal information: “I can be grilled as much as I like, but I don’t leave any traces for the investigators. It pains me to say that because it prevents others from learning, but it’s a lesson I learned the hard way. I also think that transparency is a good thing, but sometimes too much transparency isn’t a good thing.” (6)

Concerns about lawsuits make cooperation and transparency with patients harder: “[They come] with a lawyer, who guides them in exactly what they need to do to get as much as possible out of the healthcare system afterwards…today, you get recorded by patients, and every word you say can be used against you later on.” (6); “We need to learn, maybe this is how you say it, but also be very careful from a legal point of view.” (5)

According to one of the doctors, the involvement of legal discourse also made it harder to conduct investigations for staff learning needs: “Afterwards, they explained to us that they were stopping all the pathology meetings…because there were lawyers and lawsuits. So, on the one hand we really want to be transparent…to come and talk and tell and hug and do all that. But then you’ve got lawyers hindering us.” (6)

At an organizational level, there was another, different, voice that said that when errors occur, they should actually be publicized, to gain public trust through transparency: “See, we are not perfect people, we are not a perfect organization…the worst thing that could happen is that an incident like this could happen again. We don’t want it to come to that, and we are prepared to root it out.” (4)

**Theme 4: How do we “do transparency?”** *“Modesty and doubt”; “To reach a level where we have the correct technical competence to contain an incident like this…Awareness is fine, but it’s not enough.”*

Participants talked about the importance of acquiring the tools and skills to actually “do” transparency with patients and relatives: “I asked myself what skills a staff member will leave here with, if tomorrow he thinks he made an error….when should I speak up, what do I say, who should say it…” (4) and of being assisted by professionals—psychologists, social workers, mediators with conflict resolution skills, and so on. This is because these conversations could have far-reaching effects on the patient and/or their relatives: “We need to think about what we are doing so that we won’t put the wrong idea into someone’s head when all we want is for us to be OK with him and to admit [what happened]…we could do irreparable damage.” (5)

Practical suggestions were made in the workshops, for example, that representatives from the risk management team could be integrated into the various departments and implement a culture of sharing and listening. “We want to have several people who speak the lingo, who lead on this issue, who increase vigilance…” (3). In another workshop, participants talked about having a staff member act as a liaison person to update a patient or relative while an incident was being looked into and during the inquiry, which would strengthen the sense of trust and responsibility that the victim of the error and their relatives had towards hospital staff. (5)

In some of the workshops, participants talked about things that had already been put into practice to encourage a culture of transparency and learning from errors, such as reporting during departmental meetings: “We started this so that the senior doctors would [talk about] making errors, and then the interns. At the end of the morning meeting, everyone says whether they made an error… and how they thought they could prevent it…change is possible.” (6)

Participants discussed ways to help prevent errors being made. Some participants talked about getting patients and relatives involved to create a sort of “control valve” to prevent errors before they even occurred: “When I prepare a patient for surgery…I explain to them that their name will get called out in the operating theater, and that they’ll be told the side [of the body] on which the operation will be performed, and I encourage them to get involved, so that they’re aware what they are going in for.” (7) Listening to the patient needs to be part of the culture of the doctor-patient relationship, and this will also help prevent errors: “The most important thing is to listen to the patient who knows himself and knows his body. It’s not just about errors, it’s about how we relate to our patients. How we listen to them, how much we empathize with them, not about how we deal with our shifts and the workload and the day-to-day chores.” (1)

Participants mentioned encouraging asking questions, as part of a critical-thinking culture: “How to educate the managers, even to encourage young people to sometimes share” (4) as well as breaking down hierarchies between the various professional roles, including support staff, to create an atmosphere conducive to talking about errors and to learning together from the knowledge that has been gleaned: “This is something that I think needs to be worked on in terms of the sectoral issue too…[supposedly] doctors are only allowed to be transparent with other doctors, nurses with nurses, and there are no support staff, who can sometimes stop everything…we’re in the same place, we’re not in different places, and we all need to somehow fix this thing…” (4). Some participants emphasized mutual cooperation with patients to learn how to move forward after an error had occurred: “When the patients and the medical staff aren’t at each other’s throats but are united in the face of the need to improve medical care and safety, then the whole relationship between these two groups, everything changes” (9).

Finally, there was talk about making changes in medical staff’s self-perception so as to establish a culture of trust: “Modesty and doubt. I think that if all of us, the pharmacists, the doctors, all the hospital staff, stuck to these two words when we’re learning, when we’re caring for patients, when we’re teaching, many of these problems would be solved. It would be easier for us to get over errors and to admit them, to apologize, to prevent them, because we would question everything. So, bear these two words in mind” (7).

The issue of being responsible for safety also came up as part of control procedures for reducing the chance of errors: “I really believe in organizational culture, I really believe in order, and I think that forms are important…the so-called checklist…I checked the end of the operation… I prepared, I got myself organized, I’m standing in front of the mirror, in front of the list of things to check—got it, got it, got it, got it, excellent?” (7) “There are no employee errors, there are team errors. Like, we want to build a team where the team works in such a way that it’s not going to be possible to make errors.” (4)

In the workshops, participants talked about the issue of the “almost-error” as a learning opportunity. “I see the “almost-errors” as a possibility for growth, which you report” (2). However, participants also reported that there was a dilemma over whether every proper disclosure was necessary or appropriate: “I’m just saying that there are situations like this where it causes something that could have easily been resolved without anyone feeling like he had been harmed, and he really hasn’t been harmed, and we go and tell him that there’s been an error here?” (2).