**Workshops with patients, healthcare teams and executives about disclosure following a medical error – lessons learned from a national initiative.**

**Abstract**

The idea of encouraging physicians to disclose medical errors to their patients has gained importance since the early 1990s. However, in doing so, physicians infrequently offer complete disclosure. Recognized barriers include shame as well as fear of litigation, disciplinary actions and loss of patient trust. In 2018, the Israeli Ministry of Health initiated a series of workshops about disclosure at medical centers between healthcare providers, management board members, patients, and families previously harmed by a medical error at another institution. This study explores the discourse at 15 workshops until the COVID-19 pandemic halted the project. Using qualitative methodology, data collection included audio recordings, participant observations, detailed field notes documentation, and conventional content analysis. Three main themes were identified: “Physicians and nurses see a great value in transparency after a medical error although they face emotional challenges in implementation”; “The medico-legal discourse presents challenges to making disclosure,” and

“Physicians and patients acknowledged each other’s feelings and found common language about their willingness to change ‘the day after’ a medical error occurs.” Findings show that there is great value in patients and physicians talking openly together about a medical error, outside the courtroom, in an open and protective setting. To the best of our knowledge, this is the first description of an organized national initiative about disclosure in medical centers. Such workshops may help foster an institutional disclosure culture following medical errors.

**Keywords:** dialogue; disclosure; Israel; listening; malpractice; medical error; transparency.

**1. Background**

 Medical errors can be defined as "the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim" (IOM report, To Err Is Human, 1999). These can include adverse drug events, patient burns, and wrong-site surgeries. High error rates with serious consequences are most likely to occur in intensive care units, operating rooms, and emergency departments. Although the way medical errors they are defined measured has been debated in the literature, it is agreed that medical errors occur far too often and remain under-reported, and that systemic changes can improve patient outcomes (Grober and Bohnen, 2005; Makary and Daniel, 2016; Mazer and Nabhan, 2019; Shojania and Dixon-Woods, 2017).

 Disclosure refers to “communication between a healthcare provider and a patient, family member, or proxy that acknowledges the occurrence of an error, discusses what happened, and describes the link between the error and outcomes in terms the patient understands” (Fein et al., 2007: 760). Disclosure following a medical error often includes apology, which has a healing effect psychologically (Lazare, 2006). While patients often say that they want and expect apologies after medical errors, and physicians state that they want to apologize; in reality, physicians infrequently offer complete apologies (Robbennolt, 2009)‏.

Studies recognized some barriers to disclosure among health care providers: blame and shame (Leape, 1994), fear of lawsuit or punishment, losing patient trust, and communication inexperience (Gallagher et al., 2003). Other concerns include determining whether disclosure is needed, when and how to disclose, who should disclose, and whether other team members, including risk management, should be present during disclosure (Jones et al., 2019). Notably, LeCraw et al. (2018) found that events resulting in injury due to medical error were resolved 43% of the time with apologies alone although 60% of these events involved lawyers. John (2018) concluded that: “We need to work towards a different culture, one in which we openly acknowledge our own mistakes and that avoiding them completely is impossible” (p. 2273).

 In a study conducted in Australia (Terry, et al., 2019), 304 patients were asked about their opinions and experiences in the context of medical errors. Physicians were described as lacking in communication skills, especially regarding creating clarity and accuracy in the information conveyed to the patients and their families. Burgess, et al. (2012) examined 33 patients’ perceptions about events that represent errors in long-term illnesses treatment. They suggest that improving communication skills, as well as responding to patients’ side effects and complaints seriously, can have a calming effect in cases when harm is caused. Toffolutti and Stuckler (2019) found that a culture of openness is associated with a reduction in hospital mortality rates, evidence that supports enhancing efforts to increase openness, transparency, and accountability across the hospital system, since doing so improves health care quality.

 Communication-and-resolution programs (CRPs) are intended to enhance communication about events that did not involve negligence and to promote responsibility, transparency, and learning following adverse events (Gallagher et al., 2018). Implementing CRPs does not expand liability risk; rather it may improve some liability outcomes (Boothman et al., 2012; Kachalia et al., 2018, Mello et al., 2014). Hospitals are well suited to design and implement CRPs that give immediate empathic responses to patient harm and implement lessons learned into safety improvement to prevent recurrences of the event (Sage and Underhill, 2020). Nonetheless, there is a controversy as to whether CRP change injury rates (Zeiler, 2017). Moore et al (2017) study show that Patients’ experiences with CRP were satisfied with disclosure and reconciliation efforts made by hospitals.

*Aim of the study*

 The aim of this study was to observe discussions in organized workshops with direct meeting between healthcare providers, managers, patients and families following a medical error. In recent years, it has been increasingly acknowledged that providers should disclose mistakes to patients (Lazare, 2006). In the US, the Agency for Healthcare Research and Quality has suggested organizational tools for such disclosure (the CANDOR (2016) initiative). The workshops were organized by XXX to foster an authentic human interaction between stakeholders, rather than the too-common adversarial exchanges typical of the courtroom. Prior experience with such face-to-face communication demonstrated their potential for generating genuine communication with constructive ideas (King, 2013, Schwetzer, 2018; Tobin, 2013). To the best of our knowledge, this study is the first to describe such meetings at a national level.

**2**. **Methods**

*2.1. Settings*

 The workshops described in this paper, dubbed *Ofek LaChaim*, (Meaning in Hebrew: horizon for life) on behalf of the Israeli Ministry of Health in collaboration with the *Ofek-Back to Life* (<https://en.ofekor.co.il/>) non-profit organization active in legislation and public activity to prevent medical malpractice in the health system. The organization was established to support patients and families that were harmed by a medical error.

The workshops were offered to all hospitals and HMOs in the country and were open to physicians, nurses, and social workers, and participation was voluntary. In each workshop, a patient who had been harmed by a medical error *in another hospital* was invited to give testimony and to participate as a panelist in a panel discussion. A representative of the Ministry of Health was present at the workshops.

The workshops were designed in the form of a one-day meeting composed of three sessions. The same structure was maintained for all 15 workshops: (1) An opening section beginning with greetings from a representative of the host medical center followed by a 45–60 minute lecture delivered by the workshops facilitator (our second co-author, MB), a senior physician and former director of the Center for Clinical Quality and Safety of Hadassah-Hebrew University Medical Center, a large tertiary hospital with rich research experience in the field of medical errors and disclosure (Brezis et al., 2017; 2019). The lecture described the healing value of apology, transparency, and listening to restore truth with short clips sampled from TED talks on errors and vulnerability (Goldman, 2012; Schulz, 2011; Schweitzer, 2013); (2) A personal story shared by a patient or family member from Ofek Back to Life volunteers describing a personal experience of malpractice or medical error during medical treatment. The case presented did not occur in the hospital where the workshop was held and the presentation was made without any identifying details about the case itself; (3) A closing panel with collaboration of the facilitator (MB), the patient and/or family members from session 2 and senior management representatives of the hosting hospital (hospital’s manager or his/her deputy), risk manager, and legal consultant. The panel’s purpose was to discuss with the health providers their opinions and feelings about disclosure in their daily practice after attending the workshop.

*2.2. Data collection*

The workshops were held over the course of two years (2/2018–1/2020) in 14 hospitals (12 general hospitals and 2 geriatric hospitals) out of 29 in Israel and one nursing school in the country (Table 1).

--Insert Table 1 here--

Each workshop lasted an average of 3 hours and was attended mostly by nurses and physicians (Table 2).

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The fieldwork was conducted by the first co-author (AF). Data collection included unstructured participant observation in 15 workshops followed by a detailed field notes documentation and full recording of the workshops. Observation recording and field diary documentation continued during breaks and after the workshop ended until the last participant left. The unstructured observation method, based within the constructivist paradigm, is used to understand cultural behaviors. The researcher usually enters the field with no fixed or prearranged notions as to what they might observe (Mulhall, 2003). In this study, all the authors held an ongoing reflexive discussion throughout the research period about challenges and dilemmas during the workshops (Goodwin et al., 2003).

Participants in the workshops were fully informed about the observation and the recording for research purposes and the observer’s (first co-author, AF) presence. Participants were informed that there was no need to mention identifying details (name, profession, or department) and that in any case, all identifying details would be removed from the transcripts. Participants could ask to not appear in the transcript at all (only one participant in one workshop so requested).

*2.3. Data analysis*

Only the closing panel (session 3) in each of the 15 workshops was transcribed as it included the most lively and open discussions. The workshop’s first two sessions were structured. This final session lasted an average of about 45–60 minutes. All participants’ personal details were changed to ensure anonymity in the transcripts. In cases where the participants identified themselves as a nurse or a doctor, we left this information in the transcript. Each of the 15 workshops received a random number between 1 and 15.

The verbatim transcripts were read and coded for emergent themes according to the six phases of thematic analysis (TA) (Braun and Clarke 2006), an inductive approach identified themes strongly linked to the data (Patton, 1990). Analysis was conducted manually by the first co-author who is experienced in qualitative methodology in collaboration with the other team members who read the analysis drafts and gave their ongoing feedback (Morse & Field, 1995). The final report was presented at a meeting at the Ministry of Health and at another meeting of risk managers from across the country for feedback. Trustworthiness was achieved mostly through peer debriefing (Guba & Lincoln, 1985; Manning, 1997). Direct quotations are presented to facilitate the interpretation of each participant’s contributions through critical examination (Rosenblatt & Fischer, 1993).

*Ethical approval*

The study was carried out with the approval of the Israeli Ministry of Health National Committee for Human Medical Research No. MOH035-2019 **.**

**3. Results**

Providers were the main participants in the workshop discussions. However, the main finding emerging from our observation is that the presence of one patient who had been harmed by a medical error had a critical impact on what providers said and how they said it. Providers often started their remarks by genuinely expressing their sympathy to the patient. The framing of dialogue was about the victim of the error, about the importance of a disclosure policy for healing and about the adverse consequences of a “deny and defend” strategy. The presence of a patient who had actually experienced a tragedy (albeit at another hospital) and who was willing to share their story had a powerful impact on the conversation dynamic. It created an intimate atmosphere that allowed an open conversation and the sharing of feelings among the members of the medical staff, and with the patient, the board representatives and the risk management team.

Three main themes were emerged from the workshops panel discussions' transcripts thematic analysis:

**Theme 1:** **Physicians and nurses** **see a great value in transparency after a medical error although they face emotional challenges in implementation.**

* **Transparency as a professional—moral value.**

Physicians and nurses considered transparency after the occurrence of a medical error a moral and professional value of restoring the patient’s trust: “It is the proper thing that families know what happened to them, or to their loved ones; it’s an important value” (W5). They discussed expressing grief over what had happened to the patient, apologizing, and taking responsibility: “The first step in diffusing any accusations from a victim is to really talk about things with him. To understand that, even if someone hurt him, it wasn’t done on purpose, and that it occurred during a procedure that was intended to be good for him” (W5).

 They mentioned the importance of checking all the details of what happened and what has been done to prevent such events in the future:

Sometimes looking into their eyes and being there with them, even if you don’t say anything… the eyes are going to express that, first, I’m here with you, I’m listening to you… and we’ll investigate 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 (W1).

Healthcare providers considered transparency a critical component of the patient-physician relationship 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, they will have trust in the team no matter what happens” (W1).

 The importance of transparency with colleagues within the hospital and with colleagues from other hospitols was also considered an essential part of medical professionalism to ensure future learning: 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…” (W6). “Information sharing is important. It can be done anonymously; it doesn’t matter to me what happened in which hospital… [what is important is] how I can prevent myself from falling into the same trap” (W6).

* **Emotional challenges evolve in** **performing disclosure.**

Participants shared some of the mixed emotions they experience when an error occurs, such as guilt feelings, a sense of failure, and difficulty coming to terms with the fact that they have made a mistake: “Self-punishment is what the person [e.g., physician] experiences towards himself… self-criticism” (W4); “… A lot of times what happens is that we shy away… I hurt him, I recoiled to face him, and I didn’t go…Because of the shame, because it doesn’t feel good” (W5).

Participants said that engaging in disclosure has an emotional benefit, helping them cope with these feelings, despite the difficulty of facing the harmed patient following the error. “…a sort of catharsis…you feel that you went back to interacting with the family, with the person” (W9); “… as soon as I shared that with the patient, I felt that I had at least closed a circle for myself and for her” (W1).

Participants recalled cases where patients welcomed disclosure: “The father of that girl came to see me and … he says, ‘I’m asking you not to take any action against whoever who made the error…promise me’” (W6). There were examples of cases where disclosure provoked anger and aggression towards the staff: “Most of the time you witness anger… it’s hard for me to even express myself [in front of them], but it’s natural, we’re talking about someone who lost a loved one …” (W6). Participants also spoke about the shame of facing their colleagues and the fear that the error would harm their professional future.

**Theme 2:** **The medico-legal discourse presents challenges to making disclosure.**

* **Physicians’ and nurses’ claim it is almost impossible to be transparent due to the risk of legally entanglement.**

Physicians’ and nurses acknowledged their concerns about the daily practice of disclosure performance in view of the medico-legal discourse. They express concern that the patient and family members might misinterpret their sincere apology and take legal action against them:

“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 changed, these words about transparency are nice but they are empty” (W9).

Participants came with a claim to the hospital managers, risk managers hospital and the risk department said that the medico-legal atmosphere was making it hard to learn from the mistake for the future and to give support to the staff involved in the case. One participant spoke openly about his decision to essentially hide information, thereby depriving his colleagues of the opportunity to learn from the error for future cases:

“I can investigate myself as much as I like, but I don’t leave any traces for outsiders. It hurts me because it prevents colleagues from learning from what happened but it’s a lesson I learned the hard way... transparency is a good thing, but sometimes too much transparency isn’t …” (W6).

The participants expressed uncertainty about how to disclose after a medical error occurs without endangering themselves.

“First of all, thank you very much for this day ... I would be happy to have practical tools and talk more about what was not talked today .... What are the cases that a license is revoked? What is considered a human error? Because today we talked about important issues, but we do not have the tools to do it in real life” (W10).

* **Hospital administrators present ambivalent opinions about the question of staff performing disclosure after a medical error occurs.**

Hospital managers, risk managers, and hospital legal consultants' official position in the panel was that transparency after an error had happened is a fundamental part of the organizational commitment to improve patient care. They conveyed a reassuring message emphasizing their commitment to support physicians and nurses who report medical errors: “… 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” (W4). However, when they responded to statements and questions made by the medical team members, they addressed the problematic aspects of encouraging disclosure with the patient and the families: “As an ideal … I completely agree with the attitude of apology, empathy, and listening and expressing grief. However, I must be honest. In the world that I come from, we have difficulty in implementing it” (W14).

 They expressed concern that an apology and taking responsibility would be construed as an admission of guilt by the doctor or nurse and warned the staff to be careful on the matter. Therefore, and with the backing of the management team, the risk managers emphasized that it is essential to report an error in medical treatment as soon as possible so that they can determine what had happened and then plan the appropriate response. They did not deny that in some cases, the investigation of the case could result in a penalty: “Sometimes there is no choice and actions have to be taken… [such as] transferring someone from a particular ward to one where there is less danger that they will make errors in the future … this idea that there’s a perfect world where we just empower people who made errors and surround them with empathy is just wrong” (W5).

**Theme 3:** **Physicians and patients acknowledged each other’s feelings and found common language about their willingness to change “the day after” a medical error occurs.**

* **An emotional dialogue between the participants evolved from the workshops.**

The workshops stimulated a personal and emotional dialogue between the participants. In different parts of the workshop, whether in the opening or the discussion, senior physicians and nurses from the hospital management shared some of their personal experiences in making medical errors along their career:

“At the beginning 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. Over the years, this is part of what I’m bringing to management; they educated us within the institution itself, that this is the right thing to do” (W7).

In the breaks after the patient panels and in the discussion physicians and nurses approached the patients with questions. They thanked the patients for sharing their personal stories and expressed sympathy and sorrow about what had happened to them: “Thank you so much for sharing your personal life with us. You gave us a lot of food for thought. We hope that one day we will be treated with transparency. Your disclosure was moving” (Medical team member to the patient, W12); “... First, thank you. It was impressive and I will take it with me to the future ... No one is perfect ... life is a process of training ... Being transparent is also very good for the team members ... Always be transparent. Tell the truth. Thank you so much everyone” (Medical team member to the patient, W10).

In the closing panels, both sides acknowledged each other’s challenges, and addressed each other’s viewpoints with empathy: “Thank you for the challenging questions. It showed me that it was important for you to learn” (Patient to the physician, W3). The physicians appreciated the opportunity to learn from the patients' stories: “It isn’t easy. It’s not black and white ... we are all still enthusiastic and willing to do, improve, learn, and cooperate; so thank you for coming, it was important” (Medical team member to the patient, W14).

 Some identified with the story and thought aloud about themselves or their family members as patients:

“Eventually we and our families return to the system as patients. I'm sorry to hear about the tragic case. We want to restore trust in us as a care team …I think there is no school answer to anything ... there is no ‘customer always right’ here because mistakes are part of the job. We need to assimilate a culture of acknowledging our mistakes and learning from them, which is the most important thing” (Medical team member to the patient, W15).

* **Participants call for an improvement in the organizational culture of patient safety.**

Patients reported that the workshop restored their trust in the system. They were surprised at how much the physicians and nurses were willing to listen, want to learn, and get better. It gave them optimism about the possible of a culture change within the medical system:

“I’m optimistic because I’ve heard a few voices here say yes to share, yes to tell [the injured patient] ... because even those that had a certain apprehension ... is someone who says if you give me the right tool, how will I deal with that apprehension ... I believe it’s a start of a change that will do us all good. It’s a win-win situation. We’re all human, good luck” (Patient, W9).

“First, I would like to thank you very much. Each time I do this workshop, it strengthens me, to see that people who work in this profession care… You chose a tough job. Well done to you” (Patient, W7).

“It was a pleasant and big surprise for me that the Ministry of Health pays attention to this issue. Thank you. I think there are people in management department of this medical center and in the medical team who want to work on it and think it is important. I think it’s amazing” (Patient, W1).

Physicians and nurse said that the patients’ stories strengthened their perception of the high value of listening to patients and their feelings to avoid mistakes and encouraged them to tell the truth to the patients if a mistake has already occurred**:**

“The patient is talking about staff education ... that the doctor will not think he is the right hand of God but will listen to the patient who knows himself and knows his body… It’s not just about mistakes. It’s about how we treat our patients. How we listen to them, how empathetic we are towards them, and not how we deal with the shift, the load, and the daily chores” (W1).

“Did you go back to the hospital, to the staff to tell them what you told us? ... When an error happens, it hurts us terribly, but we do not have the training to say we are sorry. To tell ourselves that we were wrong. May be in the procedure itself but also in that we did not listen ... we do not always know how to take it to a good place. We must learn to debrief our mistakes for ourselves and the patient” (Medical team member to the patient, W5).

Physicians and nurses discussed different ways in which disclosure can improve the safety culture at the hospital: “I really believe in organizational culture … I think that forms are important…the so-called checklist… I’m standing in front of a mirror, in front of the list of things to check—got it, got it, got it, got it, excellent?” (W7); “I see the ‘near misses’ as a possibility for growth, which you report’” (W2).

 Participants had some suggestions about how to practically implement transparency with patients in the hospital’s daily routine: “… 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” (W6). They discussed the changes that had already been put into practice to encourage a culture of transparency in their organization, such as refreshing procedures for reducing the chance of errors.

They talked about the importance of recruiting experts from other professions — psychologists, social workers, professional conflict mediators, and more, to help in carrying out transparency with patients and family and between the medical team members and the hospital’s management team. In one workshop, participants suggested integrating representatives from the risk management team into the hospital departments so they can experience and then address the staff’s daily dilemmas about transparency: “We want to have several people who speak the [legal] ‘language.’ who will lead us on this issue, who increase our vigilance and awareness …” (W3). In another workshop, participants suggested that one team member in the department can act as a liaison to update the patient or the relatives during the formal hospital inquiry.

Physicians and nurses raised the importance of education to establish a culture of transparency, i.e., nurturing critical thinking among interns and young nurses and teaching them how to give and accept feedback: “I think both nurses and doctors are sure they are excellent. There is an ego problem here. We are not open to the end to receive feedback from the department head, to learn from it” (W12).

“Modesty and doubt. I think that if all of us, the pharmacists, the doctors, all the hospital staff, if we 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” (W7).

Some participants called for a deeper cultural change in the work of the hospital team to reduce possible errors. This measure could help patients and their families maintain trust in the hospital staff:

“This is something that I think needs to be worked on in terms of the professional hierarchy and sectors too…doctors are only allowed to be transparent with other doctors, nurses with nurses, and there is the support staff, who can sometimes stop everything [even before the situation deteriorates] but they are not part of the discussion …we’re all part of the same [work] place… and we all need to somehow fix this thing…” (W4).

“We are about to set up a groupthink to try to understand this issue ... and build some plan that we will present to our administration for approval, and then we will see how we progress from there ... Anyone interested in taking part in this? We will be happy to get help. We will try to build something that is both useful and right for the hospital” (W9).

**4. Discussion**

This study summarizes the perceptions and feelings of the participants in workshops aimed to encourage an open discussion between patients affected by a medical error, health care provides, management board members, and Ministry of Health representative about disclosure in the healthcare setting.

 The issue of disclosure after medical errors is often associated with its legal aspects rather than with patient safety improvement and better dialogue between health care providers and patients. Often, after a medical error occurs, there is no planned meeting between the hospital staff and the patient and their family about what happened — except, unfortunately, in court.

*Mutual listening, expressing emotions, and transitional space*

Reflecting on our project, we propose that the workshops allowed for a “transitional space” (Friedman et al., 2016) for physicians, nurses and patients “… to free themselves, at least to a certain extent, from the shaping power of dominant fields…” (Friedman et al., 2016: 114), and to raise possible conditions for growth at “Transitional space” is part of “Field theory,” which views social reality as an ongoing creation and recreation of social spaces that allow people to challenge dominant fields and develop change (Lapidot-Lefler et al., 2015). The concept of transitional space captures the phenomenon of constructing new shared relationships, meanings, and rules of behavior through mutual interaction between people (Friedman, 2011; Friedman & Sykes, 2014).

Unlike the discussion of medical malpractice in hospital disciplinary committees and courts, our workshops provided a defined, structured time in a safe environment in which all parties could reflect and express emotions about medical errors and their aftermath. We believe that the greatest contributor to the formation of transitional space in the workshops was the non-judgmental listening for physicians, nurses and patients’ voices. All had an opportunity to reveal their subjective personal, not just professional identities. The mutual recognition of each other’s feelings offered common ground on which to base interaction as partners (Cohn, 2001).

Carl Rogers’ (1980) “listening-with-understanding” approach draws attention to a listening activity that intend to authentically achieve the other person’s reference point with respect and empathy (Rogers and Roethlisberger 1991). Itzchakov et al. (2017) found that “high quality listening reduces speakers’ social anxiety, which in turn enables speakers to process information less defensively which by extension increases objective-attitude ambivalence” (p. 117). Researchers suggest that listening in an emphatic and non-judgmental way whereby the speakers feel the listeners accepted them, rather than agreed with them, reduces defensive reactions. While failure is often dealt with through cognitive responses, a focus on emotions can act as a motivator, allow for learning, and lead to increased effort to improve on past errors (Nelson et al., 2018, von Arx, et al., 2018). In addition, Hannawa et al. (2016) emphasized physicians’ nonverbal involvement during error disclosures as a healing mechanism for patients and the physician-patient relationship.

Koksma and Kremer (2019) found that joining forces with patients fosters change, creates pluralism, and encourages inclusion of patients in initiatives aimed at improving the quality of care. Bell et al. (2018) reported about measures organizations can take to better support harmed patients and families, including involving them in research design, solution development, and after-event learning. The patients participated in our workshops told their stories in front of physicians and nurses whom they did not know at a hospital other than the one in which their case took place. It may be that this lack of personal involvement moderated a potential conflict between parties and allowed what Martin Buber described as an “I-Thou” relationship (Gordon, 2011). The physicians and nurses did not feel threatened and had no need to defend themselves. They could listen to the patients’ stories and be affected emotionally. From what the patients said in the final workshop panels, we learn that the opportunity to tell their story in an inclusive, attentive, and non-judgmental setting had a healing effect on them and they were able to be open to the concerns and difficulties of the medical team; this helped restore their trust in the system.

*Responsibility, professional-moral obligation, and the medico-legal discourse*

 The workshops helped healthcare providers engage in an open discussion about their experiences and their challenges on “the day after” a medical error occurs. Overall, there was an agreement about the importance of disclosure. Physicians, in particular, discussed their professional responsibility and moral obligation for transparency with the injured patient and their families. They mentioned the professional value they see in learning from what happened for the benefit of patients in the future.

Transparency after a medical error event is a moral value and considered to be part of a systematic institutional response to injury (Sage and Underhill, 2020; White and Gallagher, 2013). Transparency is relatively inexpensive. It improves quality and safety across the continuum of care and ultimately leads to lower malpractice agreements (Kachalia et al., 2010; National Patient Safety Foundation’s Lucian Leape Institute, 2015). Followed by honest explanations and apology (Carmack, 2014; Weiss & Miranda, 2008), transparency allows for reconciliation with the patient and support for involved caregivers. It is highly satisfying to patients and to clinicians (Kachalia et al., 2010). Satisfaction of patients was higher when physicians were empathetic and not confrontational and when discussions with them included compensation negotiations (White et al., 2017).

Mazor et al. (2004) and LeCraw et al. (2018) found that transparency with patients and families after medical errors does not worsen liability outcomes; in fact, quite the opposite. Patients tend to turn to legal options not because of what occurred medically, but because of how they are treated once something unexpected happen. However, the physicians and nurses in our workshops shared their concerns about transparency with the patients and their family members after a medical error had occurred in the context of medico-legal issues. They expressed their ambivalence about the consequences arising from taking responsibility or admitting guilt and their concern that patients and families might use their honest apology against them.

Apologies reduce aggression and promote forgiveness and relationship well-being. However, apologizing is not always easy; it requires skills and practice (Schumann, 2018). High-quality apologies include many elements, such as an acceptance of responsibility and offer of repair, and do not include self-protective strategies, such as justifications or self-victimization (Schumann, 2014).

The physicians and nurses in the workshops expressed concern that their openness and honesty would be used against them by the hospital administrators and that it might threaten their professional future. The message from the hospital administrators was ambivalent. On the one hand, they concurred with the idea of transparency. On the other hand, they adopted a non-indulgent attitude to errors and occasionally expressed the need for recording the event in the worker’s personal file to facilitate eventual corrective actions towards recidivists. Combining such a disciplinary approach with empathic support to teams is a challenging task not discussed in the literature.

Collins et al. (2009) found that physicians consider errors personal, not system failures and want to establish a blame-free culture. Cooper et al. (2017) argue that it is difficult to promote learning from medical errors without eliminating an atmosphere of blame in health care. According to LaDonna, et al. (2018), physicians should practice strategies for coping with failure, while emphasizing the value of mentorship, self-care, and support. Bynum et al. (2018) call to develop approaches in medical education that enhance professionals’ resilience to medical errors, helping them acknowledge and confront shame, guilt, and pride. These approaches should also address, for example, how to: provide feedback to colleagues without shaming; guide learners to adapt shame-resilient approaches to error-making; and establish the environmental conditions necessary for learners to willingly share emotions and seek help. For von Arx, et al. (2018), the most important factor for medical team members after a medical error occurs is receiving superiors’ support to reinforce their professional identity, thereby reducing job turnover.

*Limitations*

(1) Our analysis relied on what the participants expressed publicly in front of their colleagues and managers. As would be expected, all had individual interests and motives, and it is likely that there were thoughts, opinions and emotions that did not arise in the discussion. At the same time, from the fieldwork we saw the importance of a diverse assembly of professions and officials, which resulted in a fruitful discussion from both an emotional and professional point of view. In fact, only one participant in all 15 workshops asked us to remove his name from the transcript, which in any case, did not prevent him from speaking his mind publicly. (2) Originally, we planned in-depth interviews and focus groups. Moreover, we had planned to return to the interviewee for member checking to help us ground our conclusions (Mulhall, 2003). Unfortunately, we were unable to complete these important steps because they coincided with the emergence of the COVID-19 pandemic which called on the healthcare teams to deal with the health emergency. However, we think that the documentation of the workshops and the conclusions of our research are valuable.

**5. Conclusions**

The workshops described in this study may help foster a culture of institutional transparency following medical errors, setting the stage for comprehensive interventions such as Communication-And-Resolution Programs (Gallagher et al., 2018) to promote practical disclosure in a respectable, protective, and efficient way.

The workshops provided an important declarative educational message: It is possible to talk openly about a medical error outside the court to prompt organizational culture change. Following Itzchakov and Kluger (2018), an atmosphere of mutual listening facilitated a dialogue between physicians, nurses, patients and their families, and risk management. The workshops evoked intense emotions, exposed concerns, and brought up challenges; they also exposed optimistic feelings of empathy, common understanding, and willingness to change from all parties involved.

Nadler and Schnabel (2008) indicate that reconciliation implies a process of learning where parties increasingly accept and trust each other during social contacts. In our workshops, all parties sought transparency, namely, to share difficult experiences, overcome guilt and shame, ask for forgiveness, apologize, and reconcile. Following, we believe that cooperative efforts aimed at common goals that are significant to both parties — healthcare providers as well as harmed patients and family members — can create a process of reconciliation between patients and medical team members following a medical error. McCullough (2008) calls for a culture change whereby social environments will be characterized by fewer factors deriving from a desire for revenge and richer in factors eliciting forgiveness.

 We had to halt our workshops with the onset of the COVID-19 pandemic. However, we suspect that the burden on the medical team members and the danger of burnout has only intensified since then (Pollock et al., 2020). It is necessary to strengthen measures raised in our study, such as listening and transparency, considering the challenges in communication between the healthcare providers, patients, and family members that have arisen since the period of the epidemic (Back et al., 2020).

 Our workshops illustrated the contradictory views between parties: aspiration for transparency and healing by patients and teams, and a medico-legal demand to report the case of a medical error, investigate, and when necessary, discipline those involved and/or “deny and defend” to protect the institution. Despite the atmosphere of reconciliation in our workshops, the challenge was and still is whether and how this contradiction can be resolved.

Questions arise about what transparency mean practically, such as: Who should be communicating with patients and families after harmful events and when and how it should be done (Bell et al., 2018)? While our workshops did not provide practice tools for transparency, we suggested to medical team participants interested in acquiring skills in disclosure to enroll in a simulation-based training workshop at the Israeli Center for Medical Simulation (Brezis et al., 2017), as described by others (Sukalich et al., 2014).

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**References**

Back A, Tulsky JA, Arnold RM. Communication skills in the age of COVID-19. Annals of Internal Medicine. 2020;172(11):759-760.‏

Bell SK, Etchegaray JM, Gaufberg E, Lowe E, Ottosen MJ, Sands, KE, et al. A multi-stakeholder consensus-driven research agenda for better understanding and supporting the emotional impact of harmful events on patients and families. The Joint Commission Journal on Quality and Patient Safety. 2018;44(7):424-435.‏

Boothman RC, Imhoff SJ, Campbell Jr DA. Nurturing a culture of patient safety and achieving lower malpractice risk through disclosure: lessons learned and future directions. Frontiers of health services management. 2012;28(3):13-28.‏

Brezis M, Cohen-Ashkenazi L, Sharon-Friedman T, Grabler G, Pessah L, Ziv A. Disclosure after Medical Mistakes – Are We Capable? Learning from a Simulation-based Workshop to Improve Skill and Promote a Transparency Culture. Abstract presented at a conference on transparency organized by the Israeli Ministry of Health. Tel Aviv 2017.

Brezis M, Orkin-Bedolach Y, Fink D, Kiderman A. Does physician’s training induce overconfidence that hampers disclosing errors? Journal of Patient Safety. 2019;15(4):296-298.

Braun V, Clarke V. Using Thematic Analysis in Psychology. Qualitative Research in Psychology. 2006;3(2):77–101; doi:10.1191/1478088706qp063oa.

Burgess C, Cowie L, Gulliford M. Patients’ perceptions of error in long-term illness care: Qualitative study. Journal of Health Services Research & Policy. 2012;17(3):181–187; doi.org/10.1258/JHSRP.2012.011122.

Bynum IV WE, Artino Jr AR. Who am I, and who do I strive to be? Applying a theory of self-conscious emotions to medical education. Academic Medicine. 2018;93(6):874-880.‏

CANDOR (Communication and Optimal Resolution) (2016). <https://www.ahrq.gov/patient-afety/settings/hospital/candor/modules.html>)

Carmack HJ. A cycle of redemption in a medical error disclosure and apology program. Qualitative Health Research. 2014;24:860-869; doi:10.1177/1049732314536285.

Cohn F. Existential medicine: Martin Buber and physician‐patient relationships. Journal of Continuing Education in the Health Professions. 2001;21(3):170-181.‏

Collins M E, Block SD, Arnold RM, Christakis NA. On the prospects for a blame-free medical culture. Social Science & Medicine. 2009;69(9):1287-1290.‏

Cooper J, Edwards A, Williams H, Sheikh A, Parry G, Hibbert P, et al. Nature of blame in patient safety incident reports: Mixed methods analysis of a national database. The Annals of Family Medicine. 2017;15(5):455-461.‏

Fein SP, Hilborne LH, Spiritus EM, Seymann GB, Keenan CR, Shojania K, et al. The many faces of error disclosure: A common set of elements and a definition. Journal of General Internal Medicine. 2007;22:755-761; doi:10.1007/s11606-007-0157-9.

Friedman VJ. Revisiting social space: Relational thinking about organizational change. In A. B. (Rami) Shani AB, Woodman RW, Pasmore WA, editors. Research in Organizational Change and Development, Volume 19. Bingley, UK: Emerald; 2011. p. 233-257.

Friedman V, Sykes I. Can social space provide a deep structure for the theory and practice of organizational learning? In Antal AB, Meusburger P, Suarsana L, editors. Learning Organizations: Extending the Field, Knowledge and Space, Volume 6. Dordrecht, Germany: Springer; 2014.

Friedman VJ, Sykes I, Lapidot-Lefler N, Haj N. Social space as a generative image for dialogic organization development. Research in Organizational Change and Development. 2016;124:113-144.

Gallagher TH, Mello MM, Sage WM, Bell SK, McDonald TB, Thomas EJ. Can communication-and-resolution programs achieve their potential? Five key questions. Health Affairs. 2018;37(11):1845-1852.‏

Gallagher TH, Waterman AD, Ebers AG, Fraser VJ, Levinson W. Patients’ and physicians’ attitudes regarding the disclosure of medical errors. JAMA. 2003;289(8):1001-1007.‏

Goldman B. Doctors Make Mistakes. Can We Talk About That? TED talk. 2012. <https://www.youtube.com/watch?v=iUbfRzxNy20>. Accessed DATE

Goodwin D, Pope C, Mort M, Smith A. Ethics and ethnography: An experiential account. Qualitative Health Research. 2003;13:567-577; doi:10.1177/1049732302250723.

Gordon M. Listening as embracing the other: Martin Buber’s philosophy of dialogue. Educational Theory. 2011;61(2):207-219.‏

Grober ED, Bohnen JM. Defining medical error. Canadian Journal of Surgery. 2005;48(1):39-44.

Guba EG, Lincoln YS. Naturalistic Inquiry. Thousands Oaks, CA: Sage; 1985.

Hannawa AF, Shigemoto Y, Little TD. Medical errors: Disclosure styles, interpersonal forgiveness, and outcomes. Social Science & Medicine. 2016;156:29-38.‏

Itzchakov G, Kluger AN. The power of listening in helping people change. Harvard Business Review. May 17, 2018. p 1-7.‏

Itzchakov G, Kluger AN, Castro DR. I am aware of my inconsistencies but can tolerate them: The effect of high quality listening on speakers’ attitude ambivalence. Personality and Social Psychology Bulletin. 2017;43(1):105-120.‏

John CC. The art of constructive worrying. JAMA. 2018;319(22):2273-2274.‏

Jones M, Scarduzio J, Mathews E, Holbrook P, Welsh D, Wilbur, et al. Individual and team-based medical error disclosure: Dialectical tensions among health care providers. Qualitative Health Research. 2019;29(8):1096-1108.‏

Kachalia A, Kaufman SR, Boothman R, Anderson S, Welch K, Saint S, et al. Liability claims and costs before and after implementation of a medical error disclosure program. Annals of Internal Medicine. 2010;153(4):213–21.

Kachalia A, Sands K, Niel MV, Dodson S, Roche S, Novack V, et al. Effects of a communication-and-resolution program on hospitals’ malpractice claims and costs. Health Affairs. 2018;37(11):1836-1844.‏

King S. (2016). An end to error. <https://josieking.org/home/>  &   [https://www.hopkinsmedicine.org/news/publications/hopkins\_medicine\_magazine/features/spring-summer-2016/an-end-to-error](https://www.hopkinsmedicine.org/news/publications/hopkins_medicine_magazine/features/spring-summer-2016/an-end-to-error%22%20%5Ct%20%22_blank)

Koksma JJ, Kremer JA. Beyond the quality illusion: The learning era. Academic Medicine. 2019;94(2):166-169.‏

LaDonna KA, Ginsburg S, Watling C. Shifting and sharing: Academic physicians’ strategies for navigating underperformance and failure. Academic Medicine. 2018;93(11):1713-1718.‏

Lapidot-Lefler N, Friedman V, Arieli D, Haj N, Sykes I, Kais N. Social space and field as constructs for evaluating social inclusion. New Directions for Evaluation. 2015;146:33-43.

Lazare A. Apology in medical practice: an emerging clinical skill. JAMA. 2006;296(11):1401-1404.‏

Leape LL. Error in medicine. JAMA. 1994;272(23):1851-1857.‏

LeCraw FR, Montanera D, Jackson JP, Keys JC, Hetzler DC, Mroz TA. Changes in liability claims, costs, and resolution times following the introduction of a communication-and-resolution program in Tennessee. Journal of Patient Safety and Risk Management. 2018;23(1):13-18.‏

Makary MA, Daniel M. Medical error—the third leading cause of death in the US. BMJ. 2016;353:i2139; doi: 10.1136/bmj.i2139.

Manning K. Authenticity in constructivist inquiry: Methodological considerations without prescription. Qualitative Inquiry. 1997;3(1):93-115.‏

Mazer BL, & Nabhan, C. Strengthening the medical error “Meme Pool”. Journal of General Internal Medicine. 2019;34(10):2264-2267.‏

Mazor KM, Simon SR, Gurwitz JH. Communicating with patients about medical errors: A review of the literature. Archives of Internal Medicine. 2004;164(15):1690-1697.‏

McCullough M. Beyond Revenge: The Evolution of the Forgiveness Instinct. San Francisco, CA: John Wiley & Sons; 2008.‏

Moore J, Bismark M, Mello MM. Patients’ experiences with communication-and-resolution programs after medical injury. JAMA Internal Medicine. 2018;177(11):1595-1603.‏

Morse JM, Field PA. Qualitative Research Methods for Health Professionals (2nd ed.). Thousand Oaks, CA: Sage; 1995.

Mulhall A. In the field: Notes on observation in qualitative research. Journal of Advanced Nursing. 2003;41(3):306-313.‏

Nadler A, Schnabel N. Instrumental and socioemotional paths to intergroup reconciliation and the needs-based model of socioemotional reconciliation. In: Nadler A, Malloy TE, Fisher JD, editors. The Social Psychology of Intergroup Reconciliation. Oxford: Oxford University Press; 2008.

National Patient Safety Foundation’s Lucian Leape Institute. Shining a Light: Safer Health Care Through Transparency. Boston, MA: National Patient Safety Foundation; 2015.

Nelson N, Malkoc SA, Shiv B. Emotions know best: The advantage of emotional versus cognitive responses to failure. Journal of Behavioral Decision Making. 2018;31(1):40-51.‏

Patton MQ. Qualitative Evaluation and Research Methods (2nd ed.). Newbury Park, CA: Sage; 1990.

Robbennolt JK. Apologies and medical error. Clinical orthopaedics and related research. 2009;467:376-382.‏

Rogers C. A Way of Being. New York: Houghton-Mifflin Company; 1980.

Rogers C, Roethlisberger FJ. HBR Classic: Barriers and Gateways to Communication, reprint. Harvard Business Review. 1991;69(6):105-111.

Rosenblatt PC, Fischer LR. Qualitative family research. In: Boss PG, Doherty WJ, LaRossa R, Schumm SK, editors. Sourcebook of Family Theories

and Methods: A Contextual Approach. New York: Plenum Press; 1993. p. 167-180.

Sage WM, Underhill K. Malpractice liability and quality of care: Clear answer, remaining questions. JAMA. 2020;323(4):315-317.‏

Schulz K. On Being Wrong. TED talk. 2011.  Brené Brown: Power of Vulnerability <https://www.youtube.com/watch?v=QleRgTBMX88>. Accessed DATE.

Schumann K. An affirmed self and a better apology: The effect of self-affirmation on transgressors’ responses to victims. Journal of Experimental Social Psychology. 2014;54:89–96.

Schumann K. The psychology of offering an apology: Understanding the barriers to apologizing and how to overcome them. Current Directions in Psychological Science. 2018;27(2):74-78.‏

Schweitzer L. Transparency, Compassion, and Truth in Medical Errors. TEDx University of Nevada. 2013. <https://www.youtube.com/watch?v=qmaY9DEzBzI>. Accessed DATE.

Schweitzer L. (2018). After the Unexpected: Disclosure, Transparency & Collaboration. [https://www.dshs.texas.gov/IDCU/health/Healthcare-Safety/Conferences/2018-Presentations/Schweitzer-AftertheUnexpected-2018-HCS-Conference.pdf](https://www.dshs.texas.gov/IDCU/health/Healthcare-Safety/Conferences/2018-Presentations/Schweitzer-AftertheUnexpected-2018-HCS-Conference.pdf%22%20%5Ct%20%22_blank)

Shojania KG, Dixon-Woods M. Estimating deaths due to medical error: the ongoing controversy and why it matters. BMJ Quality & Safety. 2017;26(5):423-428.‏

Sukalich S, Elliott JO, Ruffner G. Teaching medical error disclosure to residents using patient-centered simulation training. Academic Medicine. 2014;89(1):136-143.

Terry D, Kim JA, Gilbert J, Jang S, Nguyen H. “Thank you for listening”: An exploratory study regarding the lived experience and perception of medical errors among those who receive care. International Journal of Health Services: Planning, Administration, Evaluation. 2020;52(2):292-302; doi.org/10.1177/0020731419893036.

Tobin WN. MITSS: Supporting patients and families for more than a decade. 2013. <https://www.psqh.com/analysis/mitss-supporting-patients-and-families-for-more-than-a-decade/> . Accessed 20.10.22.

Toffolutti V, Stuckler D. A culture of openness is associated with lower mortality rates among 137 English National health service acute trusts. Health Affairs. 2019;38(5):844-850.‏

von Arx M, Cullati S, Schmidt RE, Richner S, Kraehenmann R, Cheval B, et al. “We won’t retire without skeletons in the closet”: Healthcare-related regrets among physicians and nurses in German-speaking Swiss hospitals. Qualitative Health Research. 2018;28(11):1746-1758.‏

Weiss PM, Miranda F. (2008). Transparency, apology and disclosure of adverse outcomes. Obstetrics and Gynecology Clinics. 2008;35:53–62; doi:10.1016/j.ogc.2007.12.007.

White AA, Brock DM, McCotter PI, Shannon SE, Gallagher TH. Implementing an error disclosure coaching model: A multicenter case study. Journal of Healthcare Risk Management. 2017;36(3):34-45.‏

White AA, Gallagher TH. Medical error and disclosure. Handbook of Clinical Neurology. 2013;118:107-117.‏

Zeiler K. Communication-and-resolution programs: The jury is still out. JAMA Internal Medicine. 2017;177(11):1603-1604.‏

Table 1: Workshops characteristics

|  |  |
| --- | --- |
| Characteristics of workshops  | N=15 (%) |
| TypeGeneral hospitalGeriatricNursing School | 12 (80%)2 (13.3%)1 (6.6%) |
| Hospital SizeLarge (>800 beds)Medium (400–800 beds)Small (<400 beds)N/A | 3 (20%)3 (20%)8 (53.3%)1 (6.6%) |
| LocationUrbanRural | 10 (66.6%)5 (33.3%) |
| Size of workshops<50 participants50-100 participants>100 participants | 1 (6.6%)10 (66.6%)4 (26.6%) |

Table 2: Workshops participants’ characteristics

|  |  |
| --- | --- |
| Participants’ characteristics | N=997 (%) |
| GenderMaleFemale | 337 (33.8%)660 (66.1%) |
| Level of Education BAMSN/MAMD/PhD | 388 (38.9%)356 (35.7%)253 (25.3%) |
| Profession PhysiciansNursesOthers | 395 (39.6%)512 (51.3%)90 (9%) |
| Administrative roleYes No | 850 (85.2%)147 (14.7%) |
| Performing disclosure in current positionYes No | 205 (20.5%)792 (79.4%) |