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Communication in open disclosure conversations about adverse events in hospitals

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ABSTRACT

We analyzed eight interactions between clinicians and simulated patients or family members discussing adverse events in patient care. We targeted the interactants' accommodative communication strategies when they discussed the consequent patient harm. In Study 1, 80 psychology students rated eight open disclosure video recordings for the presence of CAT strategies. In the recordings categorized as effective, clinicians demonstrated accommodative emotional expression and interactants engaged in more accommodative interpretability and interpersonal control strategies than in ineffective recordings. In Study 2, the same recordings were analyzed using Discursis (a textual analysis software program). Discursis uses new technology to visualize and identify speaker approximation. Approximation patterns correlated with findings from Study 1. Results provide insights into which CAT strategies assist managing open disclosure.

1. Open-disclosure conversations about adverse events in hospitals

In this paper, we draw on communication accommodation theory (CAT: Gallois et al., 2005) to investigate how health professionals and patients communicate in the specific health context of open disclosure. Open disclosure is the process whereby clinicians engage with patients following an adverse event in hospital that has caused the patient harm. CAT takes account of the intergroup culture that exists in hospitals where status differentials often exist between members of different health professions and also between patients and health professionals (see Hewett et al., 2009a, 2009b; Watson and Gallois, 2002, 2007; Watson et al., 2012). We propose that interactions between patients and doctors are intergroup encounters, it is most often the group membership of each participant (patient or doctor) that is salient rather than the personal characteristics of the two interactants. By their nature, open disclosure interactions between health professionals and patients are difficult encounters. Accordingly, health professionals must understand it is important to be able to navigate these interactions as effectively as possible. Open disclosure research has shown that when patients and family perceive that they are actively involved in the discussion of the adverse event that led to patient harm, and have contact with the clinician or clinicians who were responsible, they feel more satisfied about the process (Allan and Munro, 2008). Such involvement of patients and families is more likely to occur when the situation's intergroup dynamics have been acknowledged by health professionals, and patients and family members are not constrained by health professionals to remain in a passive role.

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The intergroup nature of the interaction between the health professional and patient has previously been investigated using CAT (e.g., Watson and Gallois, 2004, 2007). Open disclosure, a difficult and delicate variant of such an interaction, is eminently suited to exploration by the application of CAT. We provide a brief overview of open disclosure as it has evolved in the last decade, and of CAT and its application within health contexts. Finally using different but complementary methods in applying CAT, we present two studies of the same open disclosure interactions.

2. Open disclosure

The Australian Commission for Safety and Quality in Health Care (ACSQHC) defines open disclosure as "the process of open discussion of adverse events that result in unintended harm to a patient while receiving health care and the associated investigation and recommendations for improvement" (Australian Commission for Safety and Quality in Health Care, 2008, p. 29). Open disclosure is a challenging communication task. In conducting a systematic review of the open disclosure process, O'Connor et al. (2010) found that although both clinicians and patients support a full and open disclosure following an adverse event, in reality a number of barriers prevent or delay that process. These barriers include the possible high litigation costs that may follow an admission of an adverse event; the possible damage to the reputation of the hospital and clinicians involved; and the perception by clinicians that they lack the necessary skills to disclose details of the adverse event to the patient or family.

Iedema and colleagues (Iedema et al. 2011a) interviewed over a hundred patients and family members who had experienced serious adverse events that led to death or permanent disability, and who had gone through the open disclosure process in Australia. The main problems reported by families and patients were the lack of timeliness in reporting the adverse event to them, deficient preparation by clinicians, inadequate information provided, and a lack of future planning to ensure improvements to patient care. Research findings showed that patients and families rarely found the process satisfactory.

Iedema and colleagues (Iedema et al. 2011b) also interviewed 146 clinicians about the open disclosure process. These clinicians reported their own inability to focus appropriately on the events leading to patient harm, a failure to discuss the legal implications of the event and a reluctance to discuss the event with fellow colleagues. They found similar barriers to those identified in O'Connor et al.'s (2010) review. These issues arise in part from the fact that clinicians work within a culture of secrecy where mistakes are not admitted (Walshe and Shortell, 2004). Following an error a clinician may feel a strong sense of guilt and experience a lack of support and respect from colleagues. This in turn may affect their future clinical performance and confidence (Allan and Munro, 2008; Fallowfield and Jenkins, 2004). For the clinician, these issues highlight the intergroup culture of health care and the hierarchical environment of the hospital system.

Since 2000, the ACSQHC has worked to develop a national standard in Australia for the open disclosure process. Open disclosure as a recognized process has been prominent for only the past 15 years, although in the USA this approach goes back more than a decade earlier. Moves to promote open disclosure around adverse events commenced in the USA as a result of increasing legal challenges to hospital care. Established processes for open disclosure exist across the USA, Canada, UK, New Zealand and Australia (for a full review, see Allan and Munro, 2008). It was hoped that litigation by patients could be reduced through honest and open reporting of patient harm.

There are two key foci in the area of open disclosure research. One is the process of communicating to a patient that an error has occurred which has caused them harm. Some errors may be obvious (e.g., wrong site surgery); others may be less so, for instance infection following a procedure or neglecting to provide timely treatment for a deteriorating patient. The second focus is error reduction. Through understanding how an error occurred, systems can be put in place to prevent such an event ever recurring. Ideally, these two processes will work together to improve patient care and reduce harm. The aim of this paper is to examine open disclosure interactions using the theoretical lens of CAT (Gallois et al., 2005). We explore how best to manage the initial communication between clinicians and patients or their families after an adverse event has occurred in order to achieve 'successful open disclosure' (Allan and Munro, 2008, p. 2.)

At each stage of open disclosure there exist different markers of success, some of which are discussed below. However, Iedema et al. (2008) noted that where clinicians have established a good relationship with their patients prior to the adverse event, such a relationship can assist with the open disclosure process and reduce the risk of lawsuits against clinicians and hospitals. Clinicians also stated that financial as well as emotional support was important for patients or their families. The Australian Open Disclosure Standard notes that an open disclosure interaction should contain the following six elements.

- The event should be acknowledged to the patient as soon as possible.
- The patient or family member should receive an expression of regret with an assurance of appropriate support.
- There should be a factual explanation of how the event occurred, and the patient should be allowed to describe their experience of it.
- There should be a discussion of the consequences of the event for the patient.
- The steps that are being taken to prevent a recurrence should be explained.

Sorensen et al. (2010) recognized that not only were there few empirical studies examining open disclosure, but also no models to inform the process. In this research, we address this theoretical gap by invoking CAT (Gallois et al., 2005) to identify and measure the communication strategies used in open disclosure. We then link these strategies to visualization patterns and metric values by using Discursis, a computational text analysis technique described in Study 2.