9-28-2009

Nurses' Experiences with the Disclosure of Errors to Patients

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This dissertation, NURSES' EXPERIENCES WITH THE DISCLOSURE OF ERRORS TO PATIENTS, by Debbie Greene, was prepared under the direction of the candidate's dissertation committee. It is accepted by the committee members in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Nursing in the Byrdine F. Lewis School of Nursing in the College of Health and Human Sciences, Georgia State University.

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ABSTRACT

NURSES' EXPERIENCES WITH THE DISCLOSURE OF ERRORS TO PATIENTS

by

DEBBIE GREENE

The 1999 Institute of Medicine report, To Err is Human, raised awareness about the multitude of errors that occur in healthcare. Frequently, errors are not disclosed to patients or their families. While several studies have examined patient and physician perspectives on disclosure, limited research on nurse perspectives exist. In hospitals, nurses are often the last line of defense before errors reach the patient. Because nurses are often present when errors occur, nurses' experiences with disclosure are integral to understanding the issues that surround the disclosure of errors. The purpose of this study was to gain an understanding of nurse experiences with both disclosure and non-disclosure of errors to patients. An interpretive approach was used to guide the study, combined with a feminist perspective to illuminate the issues of power and gender.

Registered nurses (n=17) employed in hospitals and caring for adult medical/surgical patients participated in semi-structured interviews. After the audio-recorded interviews were transcribed, they were reviewed for accuracy by participants. Analysis consisted of an eight-step process including use of a research team and peer debriefing. Three major themes and 6 sub-themes were identified. Major themes were: (a) disclosing errors, (b) perceiving expectations for disclosure, and (c) not disclosing errors. Some nurses provided constant information to the patient, so a disclosure decision was not necessary when errors occurred. Many of these nurses felt that full disclosure was the right thing to do. Other nurses based disclosure decisions on their perceptions of the

culture or policies of the work environment. Disclosing events, but not errors was a method used to vaguely disclose while others overtly concealed errors. Some nurses felt that disclosure was a professional responsibility, while others felt that nurses should align themselves with institutional expectations. Still others indicated that disclosure should be determined on a case-by-case basis depending on the context. This study contributes to nursing science by illuminating the experiences of nurses with disclosure, describing nurses' ways of being truthful when errors occur, and examining the contextual factors that surround nurses' practices of disclosure. Recommendations of the study for nursing practice, education and research were identified.

ACKNOWLEDGEMENTS

I would like to express my deepest appreciation to the chairperson of my dissertation committee, Dr. Ptlene Minick. She has guided me throughout my doctoral program with unwavering support and encouragement. I would also like to thank all of my committee members for their support and thoughtful critiques of this manuscript: Drs. Valerie Fennell, Cecelia Grindel and Krista Meinersmann.

I am grateful to my research team colleagues: Kate Fouquier, Deborah McMillan, Lisa Hedenstrom and Tammy Dennis. Thank you for your insight and dedication to this research. Thank you also to the Epsilon Alpha Chapter of Sigma Theta Tau International for their financial support of this dissertation.

I could not have completed this research without the support, love and encouragement of my family, to include my husband Jim and my sons Ken, Nathan and Riley. Thank you also to my parents, Ken and Inge Daniel, who instilled in me the importance of education. Finally, to the nurses who shared their experiences in order to further our understanding of error disclosure, a heartfelt thanks.

NURSES' EXPERIENCES WITH THE DISCLOSURE OF ERRORS TO PATIENTS

by

DEBBIE A. GREENE

A DISSERTATION

Presented in Partial Fulfillment of Requirements for the
Degree of Doctor of Philosophy in Nursing in the Byrdine F. Lewis School of Nursing
in the College of Health and Human Sciences
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2009

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LIST OF ABBREVIATIONS

AMA	American Medical Association
ANA	American Nurses' Association
IOM	Institute of Medicine
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
RN	Registered Nurse
VAMC	Veterans Administration Medical Center

CHAPTER I

INTRODUCTION

Focus of Inquiry

The 1999 Institute of Medicine (Institute of Medicine 1999) report *To Err Is Human* focused attention on the escalating morbidity and mortality attributable to patient care errors. It is estimated that over 98,000 people die each year from patient care errors (Institute of Medicine, 1999). While often these errors and deaths are invisible to the general public, media coverage of high-profile errors, such as the recent heparin overdose of actor Dennis Quaid's newborn twins (Breuer, 2007) raises public concern about errors and their disclosure. When errors occur, patients should be told. However, current research indicates patient care errors are often not disclosed to patients and families (Allman 1998; Hobgood, Hevia et al., 2005). When they are disclosed, they are often worded in ways that avoid admission of error or liability (Gallagher, Waterman et al. 2003). Several studies have looked at physician and patient perspectives on error disclosure (Hingorani et al., 1999; Hobgood, Peck et al., 2002; Gallagher, Waterman et al. 2003; Mazor et al., 2005; Schwappach & Koeck. 2004). However, there is a paucity of literature on nurse perspectives on error disclosure. Nurses are involved with almost every aspect of patient care and they are likely to be involved with or may witness errors as they occur. Nurses are essential partners in identifying the underlying mechanisms that impact whether disclosure occurs. Additionally, patients often rely on the nurse to interpret communication from other providers or to interpret communication from

other providers or to interpret a lack of communication surrounding events during their hospitalization. When an error occurs, nurses may find themselves in an ethical dilemma with physicians and administrators over whether disclosure occurs. The responsibility of the nurse to ensure the disclosure of errors is mandated according to guidelines contained in the American Nurses' Association (ANA) Code for Nurses (American Nurses' Association, 2001). Advocating for disclosure of patient care errors falls within the nurse's ethical responsibility to protect the rights of the patient. Further research is needed to understand nurses' experiences with both disclosure and non-disclosure of errors to patients.

Purpose and Research Questions

The purpose of this study was to gain an understanding of nurse perceptions of error disclosure to patients. Heideggerian hermeneutic phenomenology, combined with a feminist theory perspective, was selected because of their usefulness in revealing the complex phenomena of disclosure. The focus of the study was on the experiences of hospital nurses regarding disclosure.

The research questions for this study are:

1. What are nurses' experiences with disclosure or non-disclosure of errors to patients?
2. How do nurses describe their ethical responsibility for the disclosure of errors to patients?
3. How do nurses describe the ethical responsibility of other providers in the disclosure of errors to patients?

4. How do nurses describe the contextual factors when errors are disclosed or not-disclosed?

Background of the Study

Patient Care Errors

A variety of terms are used to describe errors within health care. The terms *medical errors*, *patient care errors* and *preventable adverse events* are often used to indicate these errors. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has defined medical error as "an unintended act, either of omission or commission, or an act that does not achieve its intended outcome" (Joint Commission on Accreditation of Health Care Organizations, 2001). It is unclear from this definition if an act that results in a poor outcome would be considered an error. For example, the inability of a surgeon to remove all of a cancerous tumor would be an act that does not meet its intended outcome, although it is not an error. Banja (2005) defines medical error as "an unwarranted failure of action or judgment to accommodate the standard of care". This definition more clearly distinguishes between errors and unintended outcomes and is the definition that will be used for this study. In order to clarify the terms used to refer to errors in health care, the term *patient care errors* seems to more fully encompass the realm of health care errors, while the term *medical errors* may be interpreted as errors made by physicians. For this study, the term *patient care errors* will be used to describe errors in health care.

The severity of patient care errors can vary from errors in which no harm occurs to errors resulting in patient death. Patient care errors are a leading cause of death in the United States (Institute of Medicine, 1999). The Institute of Medicine (IOM) reports

"more people die in a given year as a result of medical errors than from motor vehicle accidents (43,458), breast cancer (42,297), or AIDS (16,516)" (Institute of Medicine). Medication errors, falls, diagnostic and procedural errors, and nosocomial infections are all common patient care errors. Medication errors are some of the most common types of patient care errors (Institute of Medicine; Rothschild et al., 2006).

Nurses are responsible for some patient care errors and witness to many other errors. In a randomized survey, nurses (n=983) reported making an average of 4.9 errors over their careers (Mayo & Duncan, 2004). Nurses are often the last line of defense before errors reach the patient. One study, involving direct observation in a 10-bed critical care unit, found nurses prevented errors from reaching the patient 69% of the time (Rothschild et al., 2006). Of the remaining 31% of errors that did reach the patient, nurses acted to prevent harm in 13% of cases and to minimize harm in the remaining 18% of cases. Because nurses are often present when errors occur, nurses are uniquely situated to experience the aftermath of error, including whether information about errors is communicated to patients.

Responsibility for Disclosure

The term disclosure indicates revealing or uncovering (2000). Disclosure of patient care errors involves revealing the error to the patient and family. Additional elements of disclosure may include an apology, a discussion of follow-up actions to investigate the incident, an offer of emotional or financial support, and assurance of actions to prevent recurrence (Lamb et al., 2003). Institutional policy may assign responsibility for the act of disclosure to the physician, the nurse, the risk manager, or another healthcare professional. Disclosure, as an admission of error, is difficult for

health care providers. Because nurses are taught to not make mistakes, human error is not acceptable, and a culture of secrecy suppresses discussions of error (Leape, 2000). According to the ANA (2001) guidelines, nurses are responsible for assuring that disclosure occurs, even when they are not responsible for directly disclosing the error to the patient and family. The Australian Council for Safety and Quality in Health Care (2003) recommends tiered responsibility for disclosure determined by the severity of the event. For example, lower-level events, such as delayed medication, can be addressed by the nurse, nurse manager, or staff manager, while higher level events, such as patient death, should be disclosed by the primary physician.

In 2001, the JCAHO implemented changes to the patient safety standards requiring disclosure of unexpected outcomes to patients (Joint Commission on Accreditation of Health Care Organizations, 2001). Standard RI.90 states "Patients and, when appropriate, their families are informed about the outcomes of care, treatment, and services, including unanticipated outcomes" (Joint Commission on Accreditation of Health Care Organizations, 2004). The standards do not explicitly require an admission of error, only disclosure of unexpected outcomes. For example, during surgery, if a surgeon dropped the scalpel and nicked the patient's artery, causing excessive bleeding and further treatment, an error has occurred. If the surgeon reported to the patient the complication of bleeding, without discussing the error of dropping the scalpel, this situation would involve disclosing the unexpected outcome of excessive bleeding and not the error of dropping the scalpel.

Selected Methodology and Justification

As the investigation started into the disclosure of errors, numerous studies were found on physician and patient perspectives on disclosure. However, the research with nurses about disclosure was very limited. Current data regarding nurses' disclosure is scarce. For this reason, a qualitative design was selected. Qualitative designs are useful when existing research in an area is limited. Qualitative research is also indicated when the researcher seeks to understand a phenomenon, such as nurses' experiences with disclosure (Patton, 2002).

In qualitative research, one first begins with a philosophical perspective, which provides structure for how we come to know and understand (Speziale & Carpenter, 2007). Philosophical perspectives have methodological implications that guide the use of the perspective for research. The philosophical perspectives of Heideggerian hermeneutic phenomenology and feminist theory were combined for this study.

A phenomenological approach was selected in an attempt to understand the meanings that are implicit in nurses' stories of disclosure. Phenomenology seeks to understand everyday experiences (van Manen, 1990). More specifically, an interpretive approach was planned because interpretation helps to reveal the taken-for-granted meanings and practices of nurses that are implied rather than explicitly stated in their stories. Heideggerian hermeneutic phenomenology is an interpretive approach often referred to as interpretive phenomenology. van Manen writes, "Hermeneutic phenomenological method tries to 'explicate' meanings that in some sense are implicit in our actions" (1990). An interpretive approach can contribute to my ability as a researcher to understand the experiences of participants. Heideggerian hermeneutic phenomenology

is both a philosophical perspective and a methodology. It provides an ontological perspective of how we exist in the world and helps to conceptualize our understanding of lived experiences (Heidegger 1996/1927). For the purpose of this study, the terms Heideggerian hermeneutic phenomenology and interpretive phenomenology will be used interchangeably.

A feminist perspective arises out of feminist theory. A feminist perspective was selected because the majority of RNs are female and the feminist perspective adds a distinct viewpoint which seeks to examine the influence of gender and power on social situations (Campbell & Bunting, 1991). Hospitals are complex organizations with power differentials represented by organizational and class hierarchies. Because gender and power issues are embedded in our culture and institutions, these issues are not always evident (Bell, 1993). Greene (2007) conducted a preliminary study on nurses' experiences with the disclosure of errors to patients in which several nurses described fear and power issues that influenced their decisions regarding disclosure. Most nurses in the study had not considered the incongruity between the professional Code for Nurses' (American Nurses' Association, 2001) and undisclosed errors. Also in this study, nurses' descriptions of disclosure and non-disclosure experiences included descriptions of moral reasoning that may reflect gender differences as described by Gilligan (1982) and Bell (1993). These findings support the use of a feminist theory perspective to more clearly visualize the contextual gender and power issues that surround nurses' perspectives regarding the disclosure of errors.

By combining the rich narrative descriptions of phenomenology with a feminist lens this study is able to more clearly reveal gender and power issues. This approach also

provides the best perspective from which to understand the complex ethical dimensions involved in the disclosure of errors to patients. By combining the philosophical perspectives of Heideggerian hermeneutic phenomenology and feminist theory this study will benefit from the views of both perspectives.

Significance to Nursing

Patients have a right to know when errors occur in their care. By examining nurses' stories of both disclosure and non-disclosure of errors, nurses' perceptions about disclosure, perceived responsibility for disclosure, and issues that impact the ability of nurses to fulfill their responsibilities were illuminated. The findings from this research will help to uncover aspects about disclosure that may assist and support nurses.

Disclosure of errors to patients is one aspect supporting transparency in health care. In *Crossing the Quality Chasm: A New Health System for the 21st Century*, the IOM (2001) purports that transparency in health care will lead to a safer health care system as organizations are openly accountable for quality outcomes and patients participate more fully in decisions that impact their care. Additionally while transparency, manifested through disclosure, in health care may decrease errors, disclosure itself is a measure of patient care quality. Patients should be able to trust that errors in their care will be disclosed.

Summary

In this chapter an introduction to the study of nurses' experiences on the disclosure of errors to patients was provided. The purpose of the study and research questions were explicated. The significance of the study to nursing was examined. The use of a combined theoretical perspective, using Heideggerian hermeneutic

phenomenology and feminist theory was discussed, and justification was provided for using this approach. In the next chapter the research and theoretical literature pertinent to the disclosure of errors to patients will be reviewed.

CHAPTER II

LITERATURE REVIEW

Research on the Disclosure of Errors to Patients

This section will include a synthesis of current research on the disclosure of errors to patients. Research with patients and providers will be examined, followed by research identifying barriers to disclosure. I will also discuss a preliminary study conducted by this researcher on nurse experiences with error disclosure. Finally, gaps in the literature will be identified, along with a discussion of how this study will extend our understanding of nurse perspectives on the disclosure of errors to patients.

Perspectives on Disclosure

Patient Perspectives on Disclosure

Studies addressing patient perceptions of disclosure have examined whether patients desire full disclosure, whether this disclosure should include those errors that did not result in harm, and what actions patients might take based on the disclosure. Patients desire disclosure of errors, even errors that do not result in harm (Fein et al., 2005; Gallagher et al., 2003; Hingorani et al., 1999; Hobogood et al., 2002; Hobgood, Tamayo-Sarver, Elms, & Weiner, 2005; Mazor et al., 2005; Witman, Park, & Hardin, 1996). More specifically, patients want details regarding the error, to include what happened, the consequences, an apology, and what actions would be taken to prevent recurrence (Mazor et al.). Research indicates truthful disclosure of errors may actually decrease negative

consequences for the provider (Hobgood et al. 2005; Mazor et al., 2005; Schwappach & Koeck, 2004; Witman et al., 1996) and preserve the patient/provider relationship (Mazor et al.; Schwappach & Koeck; Witman et al.). In most studies, patients indicated they were less likely to pursue legal action if errors were disclosed (Hobgood et al., Witman et al.). However, in one study, disclosure reduced legal action in only one error vignette (Mazor et al.). Another study found that while the severity of the outcome for the patient was the most important predictor of the consequences of the error, participants were less likely to desire sanctions against providers who were honest, empathetic and accountable for their actions (Schwappach & Koeck).

Only one study limited participants to those patients who had actually experienced medical error. This qualitative study recruited participants identified through a physician malpractice insurance company who were enrolled in a post-injury program in Colorado (Duclos et al., 2005). The study used focus groups to interview 13 patients and 3 spouses who had experienced serious medical error. Researchers identified themes of trauma, worries, frustrations, and communication. Salient to disclosure research was the finding that patients who perceived communication went well after the error maintained a professional relationship with the physician. Patients who perceived communication did not go well after an error did not maintain a professional relationship with the physician. Also, patients were more likely to attribute the error to an "honest mistake" if the communication went well. Patient satisfaction was increased if patients perceived "caring, honest, quick, personal, and repeated provider responses" (Duclos et al.).

Comparisons of Patient and Physician Perspectives on Disclosure

Several research studies have included physicians as participants, including studies that compared both patient and physician perspectives on disclosure. When patient and physician perspectives were compared, patients were more supportive of disclosure than physicians. One study used a cross-sectional design with a hypothetical adverse event in ophthalmologic surgery to compare physician and patient support for disclosure (Hingorani et al., 1999). Ninety-two percent of patients (n=246) believed complications should be disclosed, compared to 60% of ophthalmologists (n=48) (Hingorani et al.).

One study conducted in 2003 in Japan and Denmark compared patient and physician beliefs as to whether physicians would take certain disclosure actions such as informing the patient of the event, admitting their own error, and expressing regret (Itoh et al., 2006). In Japan, for severe errors, the study found that patients (n=920) were more likely than physicians (n=391) to believe that physicians would neglect to inform patients of the event (31% versus 4%, $p<0.000$), admit their own errors (36% versus 4%, $p<0.000$), and express regret (29% versus 6%, $p<0.000$). Similarly, for minor errors, the study found that Japanese patients were more likely than physicians to believe that physicians would neglect to inform patients of the event (37% versus 7%, $p<0.000$), admit their own errors (45% versus 26%, $p<0.000$), and express regret (43% versus 21%, $p<0.000$). The authors noted that a series of events in the press about medical errors may have increased the mistrust of Japanese patients in physicians. Important in this study is the finding that patients had less confidence in physicians to disclose than the physicians had in themselves. The study also compared results between Denmark and Japan.

Overall, patients in Japan were more likely to believe that physicians would withhold information about errors (66%) than patients in Denmark (44%). Differences in health care systems, culture, and media coverage of errors may explain the differences between countries.

In a qualitative study comparing patient and physician perceptions regarding disclosure (Gallagher, Waterman et al., 2003) 52 patients and 46 physicians participated in focus groups to compare perceptions and expectations of disclosure. Patients expected all harmful errors to be disclosed. However, physicians were less likely to disclose error when the harm was minimal. Also, if the physician perceived the patient may not understand or wish to know about the error, disclosure was less likely. The study also identified that perceptions of what constitutes a patient care error can differ between physicians and patients. Patients identified that long waits, provider rudeness, and allergic responses were perceived as medical errors. In contrast, the 46 physicians in this study limited errors to "deviations from the standard of care".

Physician Perspectives on Disclosure

When surveyed, most physicians expressed support for disclosure of errors to patients, particularly serious errors (Gallagher, Waterman et al., 2006; Garbutt et al., 2007). Many physicians agreed that disclosure can decrease the risk of legal action (Gallagher, Waterman et al., 2006; Garbutt et al.). However, research indicates that many patient care errors are often not disclosed to patients and families (Weissman et al., 2003; Hobgood, Hevia et al., 2005; Itoh et al., 2006). Support for disclosure in theory may not translate to actual disclosure in practice. Part of the reason may be that many physicians believe that disclosing a serious error would be difficult (Garbutt et al., 2007), and some

physicians would like to have additional training on disclosure (Garbutt et al.). If physicians are not comfortable with disclosing errors, this discomfort may contribute to the non-disclosure of errors to patients.

Many physicians have disclosed an error to a patient or family (Hobgood Xie et al., 2004; Hobgood, Hevia et al., 2005; Gallagher, Waterman et al., 2006; Garbutt et al., 2007). The majority of physicians who had disclosed a serious error reported satisfaction with the disclosure (Gallagher, Waterman et al., 2006). A comparison study of physicians in the U.S. (n=1233) and physicians in Canada (n=1404), in which malpractice environments differ, did not identify significant differences in disclosure experiences (Gallagher, Waterman et al., 2006.). Physicians in the U.S. were 1.5 times more likely than physicians in Canada to believe they might be sued in the next year (9.4% versus 6.4%; $p<.001$). Although physicians in the U.S. believed they were more at risk of being sued, their experiences with disclosure were not different from those in Canada. This study also examined the content of disclosure conversations. Truthful disclosure should make it clear to the patient and family when an error has occurred. Physicians were asked to select from five statements for disclosure conversations. The study found that physicians only selected responses that used the term “error” 42% of the time, whereas 56% mentioned an adverse event without stating an error occurred (Gallagher, Garbutt et al., 2006). Physicians were less likely to mention an error when the error was not as apparent. This avoidance of the term “error” can leave patients and families with inaccurate perceptions of events, believing complications resulted from medical conditions instead of patient care errors.

Hospital Administrator and Risk Manager Perspectives on Disclosure

Several studies surveyed hospital administrators or risk managers about hospital disclosure practices. Risk managers representing 493 hospitals were surveyed for current disclosure practices (Lamb et al., 2003). The study found that 65% of hospitals reported disclosing errors resulting in serious injury or death, while only 54% reported routine disclosure of medical errors that resulted in harm to the patient. The study also found that serious preventable harms, such as administering the wrong medication, were less likely to be disclosed (90%) than serious non-preventable harms (94%), such as previously unknown drug allergies. Thirty-three percent of the hospitals surveyed had a board-approved policy for disclosure of harm-causing errors, while 70% reported an increase in disclosure over the previous two-year period. Risk managers reported barriers to disclosure that included fear of litigation, opposition of staff, concern over scaring patients, malpractice insurance issues, and cost concerns. Despite the trends identified in increasing disclosure, the researchers note, "Our study also suggests that there is still a long way to go before serious harm is consistently and thoroughly disclosed to patients. For example, our respondents reported considerably fewer disclosures than would be expected from epidemiologic estimates of general rates of iatrogenic injury" (Lamb et al.). While disclosure rates appear to be increasing, it is difficult to measure due to overall under-reporting of errors.

Another study surveyed 203 administrators using clinical vignettes in which varying degrees of patient harm occurred (Weissman et al., 2003). Depending on the vignette, between 84 and 100% of administrators reported that serious harm was always disclosed to patients, while 76 to 96% reported moderate injuries were always disclosed.

This figure decreased to 38 to 57% for errors in which minor injury or no harm occurred. Eighty-five percent of hospitals surveyed had a written disclosure policy. Of the facilities with written disclosure policies, 98% reported disclosing serious injury believed to be caused by error, 87% reported disclosing minor injury, and 31% reported disclosing injuries that caused no harm.

The Veterans Administration Medical Center (VAMC) in Lexington, Kentucky adopted a humanistic policy of disclosure in 1987 (Kraman & Hamm, 1999). A comparison of the Lexington VAMC liability costs from 1990 to 1996 to 36 other VAMC facilities found that disclosure did not appear to increase the cost of settlements. The authors concluded that additional research is needed to examine the financial impact of disclosure policies on a broader scale.

Research addressing the disclosure practices of hospitals is limited. Because the Joint Commission mandates disclosure of unexpected outcomes to patients, disclosure of errors is increasing (Joint Commission on Accreditation of Health Care Organizations, 2001). However, it is unclear whether patients are informed when adverse events are actually the result of error. Truthful disclosure would require an admission of error.

Nurse Perspectives on Disclosure

In this section the state of the science on nurse perspectives on disclosure of errors to patients will be discussed. Six research studies pertinent to disclosure that included nurses were identified. Two studies on disclosure to patients grouped nurses with other caregivers as participants. The first study used a quantitative approach to examine the disclosure practices of nurses, emergency medical technicians, and doctors in an emergency department. In this study, the authors compared disclosure practices of 116

providers in an emergency department to include 41 emergency medical technicians, 33 RNs, and 42 physicians and found patient disclosure rates of 19%, 23% and 74% respectively (Hobgood, Xie et al., 2004). In reviewing this study, it would have been helpful to have more information about the hospital policies on the disclosure of errors to patients. It is not known whether the facility had a disclosure policy, and whether this policy specified who should conduct conversations with patients regarding disclosure. Another qualitative study used a grounded theory approach with focus groups of nurses, physicians, patients and administrators to develop a conceptual model on factors that influence disclosure (Fein, Hilborne et al. 2005). The latter study will be discussed in the next section, *Factors that Influence Disclosure*.

Katsuhara (2005) used a qualitative approach to research the ethical dilemmas of 25 Japanese nurse executives who described forty-eight ethical dilemmas. Salient to disclosure research was the identification of dilemmas on disclosing errors to patients in 8 of the 48 ethical dilemmas. The author stated,

> The patient's right to be informed caused much confusion; how much information about medical mistakes should be given for example. A participant stated that she usually would side with her patient, but said that when put on the spot she occasionally sided with the hospital president who wants to hide the fact of misprescribed medication.

In this example, a nurse administrator describes how she was pressured to agree to non-disclosure by the hospital administrator. This situation suggests that power issues may be important contextual factors when examining the disclosure of errors to patients. The

authors note that differences in Japanese cultural norms and health care systems may influence the findings (Katsuhara, 2005).

In another qualitative study, Spears (2002) used a descriptive phenomenological approach to explore nurses' stories about patient care errors. Twelve nurses were interviewed for the study. In extracting the themes and categories, the author identified a category of "communication experiences with patients". Spears writes, "The purposes of the communication with patients were to solicit participation in monitoring for effects of error, relay regret related to the error, explain harmful or negative outcomes, or communicate errors as required by the manager". Two participants told stories of disclosing errors and being relieved by the patient's positive response. Another participant shared contrasting stories of two errors, one serious error in which a large conference was held with the parents, and another in which the error was not disclosed to the parents. In the latter case in which the child received an overdose, the parents were told the infant was given a drug to help him sleep "very well". In this example the serious error was disclosed to the parents, while the error that was not as serious (sedated child) was not disclosed.

In China, researchers conducted a qualitative study interviewing seven nurses about the nursing management of medication errors (Luk et al., 2008). Researchers identified themes of "non-disclosure of errors", "no serious harm done to patients" and "nurses acknowledge mistakes made in caring for patients". Of the seven interviews, non-disclosure to patients was mentioned five times. Reasons for non-disclosure included: (a) not wanting to alarm patients/family; and (b) minor or no harm to patients. In one case a nurse described telling a lie to a mother to cover up for a suppository administered to her

child in error. The child required enemas to remove the suppository medication, yet the mother was not told the truth about the error. Chinese cultural norms may have influenced the findings of this study, since in China, a paternalistic relationship between caregivers and patients may be more accepted than in the United States (Luk et al., 2008).

Greene (2007) conducted a preliminary study on the disclosure of errors to patients. In this interpretive phenomenological study, six nurses were interviewed about their experiences with the disclosure of errors to patients. Analysis of the interviews resulted in the identification of three themes: (a) "patients should be told"; (b) "nurses' roles in disclosure are often unclear"; and (c) "barriers discourage disclosure". All participants were able to recall patient care errors. Participants told stories of both disclosure and non-disclosure of errors to patients. While some participants admitted they had not disclosed an error, most indicated disclosure was the right thing to do. However, over and over, nurses told stories of errors that were not disclosed to patients. Some participants expressed fear. Others indicated they were powerless to disclose if hospital administration and physicians chose not to disclose. One nurse stated, "It just doesn't seem to me that nurses have a place to disclose information…It's my responsibility, but I'm not allowed to [disclose]." Several participants also expressed concerns with the punitive nature of administrative responses to errors. These concerns influenced both disclosure to the organization and disclosure to patients. Other participants expressed concern about the impact of disclosing the error on the relationship with the patient and family. One nurse described a disclosure experience as, "there is a sudden crushing of trust"… followed by "they were very suspicious of that nurse and every other nurse that

came in the room" (Greene). In this case, the disclosure of error caused the family to lose trust in the nursing care provided on the unit.

The pilot study (Greene, 2007) included nurses employed by a total of four different health care facilities. The diversity in institutional cultures were evident in nurses' stories. For example, several nurses were employed by a private hospital system that provided recognition for employees who caught errors, encouraged patients to ask providers if they had washed their hands, and involved all levels of caregivers in root cause analysis for major errors. Nurses in this institution told more stories of disclosing errors to patients. While nurses acknowledged that not all errors were disclosed, it was evident that the culture of the institution was more supportive of nurse disclosure of errors. Because of the limited sample, further data are needed to more fully understand the context of nurses' experiences with the disclosure of errors.

Factors that Influence Disclosure

Several studies identified factors that influenced the disclosure of errors to patients (Fein, 2005; Gallagher, Waterman et al., 2003; Gallagher, Garbutt et al., 2006; Garbutt, Brownstein et al., 2007). One study used a grounded theory approach to develop a conceptual model of factors that influence the disclosure of errors to patients (Fein et al.). After the study is introduced, the conceptual model will be used as a framework to synthesize the findings of related studies that have identified factors that influence disclosure.

The study by Fein et al. (2005) involved an exploratory, qualitative design with 25 focus groups of physicians, nurses, administrators, and consumers. The purpose of the study was to construct a model of factors that influence the disclosure of medical errors.

A protocol was followed with each group to facilitate discussion regarding the expectations of disclosure and ethical perceptions regarding disclosure. The study identified four categories influencing the disclosure of patient care errors to include error factors, patient factors, provider factors, and institutional factors (Fein et al., 2005).

Error Factors

The disclosure model by Fein et al. (2005) identified characteristics of the error as important factors in decisions to disclose patient care errors. These characteristics included the outcome of the error, who has knowledge of the error (patient, family, other caregivers), the likelihood others will learn of the error, and the consequences of the error for the patient. Other studies have implicated similar characteristics of errors influencing disclosure. For example, several authors found errors may be more likely to be disclosed if the patient care error resulted in harm to the patient (Fein; Gallagher, Waterman et al., 2003). Disclosure was less likely to occur if the harm was minor (Gallagher, Waterman et al., 2003). Some physicians indicated disclosure was more likely to occur when patients had knowledge of the error, or were likely to discover the error, or if the error required follow-up testing (Gallagher, Waterman et al., 2003).

Patient Factors

Patient characteristics were another factor influencing disclosure identified by Fein et al. (2005). Patient characteristics such as perceived desire to know, rapport with the provider, and level of knowledge of health care influenced the likelihood of disclosure. Some patients did not want to know about every error, although all patients wanted to know about harm-causing errors (Fein et al,. 2005). Several studies identified that physicians' perceptions of the following patient factors influenced disclosure: a) the

patients' desire to know (Gallagher, Waterman et al., 2003; Gallagher, Waterman et al., 2006); b) the likelihood the patient would understand what they were told (Gallagher, Waterman et al.) and, c) the patient's knowledge of the error (Gallagher, Waterman et al.).

Provider Factors

The third factor influencing disclosure identified by Fein et al. (2005) was provider factors. Provider factors may have the most influence on whether disclosure occurs. Providers articulated fears regarding disclosure. For example, one physician remarked,

> I think there are a few kinds of fear. One is fear of what your colleagues are going to think. Two is fear of being sued and what is that going to do to your future, and three is your own internal fear of admitting to yourself that you made a mistake .

Other studies reported provider factors that may influence disclosure. For example: a) concern about lawsuits (Gallagher, Waterman et al. 2003; Gallagher, Waterman et al. 2006), b) fear of loss of patient trust (Gallagher, Waterman et al.), c) fear of damage to reputation (Gallagher, Waterman et al.), d) fear of loss of respect from colleagues (Gallagher, Waterman et al.); and, e) decreased self-confidence (Gallagher, Waterman et al.) were factors influencing disclosure. Additionally, provider discomfort with disclosure may influence the disclosure process (Fein et al., 2005).

Institutional Culture

Organizational factors in the model influencing disclosure include the culture of the organization, the policies (and whether providers knew of the policies), and workload issues (Fein et al., 2005). Participants commented on not only the culture of the

organization overall, but also on the sub-cultures of specific groups of nurses, physicians, and management. Often, providers were not aware of policies regarding disclosure. Additionally, time was a factor in disclosure decisions. If providers were overwhelmed with heavy workloads, disclosure was less likely to occur (Fein et al., 2005).

The model by Fein et al. (2005) provides a useful framework for illuminating the factors that influence the disclosure of patient care errors. By examining characteristics of the error, patient, provider and institution that may encourage or hinder disclosure, improvements can be made to the health care system to support the disclosure of patient care errors. Because Fein and colleagues combined responses of all providers, administrators and patients, nurse's perspectives on disclosure are not clear from this study. It may be that nurses experience different concerns than other providers.

Summary of the State of the Science and Gaps in the Literature

In the previous section, the empirical literature on the disclosure of errors to patients was reviewed. A preliminary study conducted by Greene (2007) on nurses' experiences with the disclosure of errors to patients was discussed. In this section, the current state of the science will be summarized, recognizing gaps in the literature and providing recommendations for further research.

Multiple studies have examined patient perspectives on disclosure. Patients expect disclosure of all errors, especially harmful errors. Studies comparing patient and physician perspectives have found that patients desire disclosure more than physicians are likely to disclose. Additionally, the language used when errors are discussed may serve to conceal rather than disclose through the use of terms such as "adverse event" and "treatment complication", instead of the term "error". Truthful disclosure may decrease

lawsuits and preserve patient/physician relationships. Further study is needed with patients who have experienced patient care error to determine the long-term outcomes of disclosure versus non-disclosure practices on patient initiated litigation and continuation of the patient/physician relationship.

Research indicates physicians support disclosure, particularly disclosure of serious errors. Disclosure rates for Canadian physicians, practicing in different malpractice environments, did not vary, from those of U.S. physicians. Because each of the research studies with physicians used hypothetical vignettes of error, it is unclear whether physician support for disclosure would be similar in actual error situations. Additional research is needed to identify physicians' actual disclosure practices, to include use of the term "error" in conversations, along with consequences of disclosure versus non-disclosure. A longitudinal study of physicians who adopt truthful disclosure practices would contribute to identifying how disclosure may influence the consequences of error to the provider.

Research with healthcare organizations indicates that disclosure may be increasing, in part due to Joint Commission patient safety standards mandating disclosure of unanticipated outcomes. Further research with risk managers and administrators over the implementation of the Joint Commission standards would be beneficial in determining the extent to which truthful disclosure is occurring. While many providers identified fear of legal action as a barrier to disclosure, studies support that patients are less likely to sue when providers are open and honest. One case study reported the financial consequences of disclosure for an institution may not be higher than non-disclosure; however, research on a larger scale is needed to support this initial finding.

While nurses are frequently witness to patient care errors, and are responsible for some errors, few research studies have investigated nurse perceptions of disclosure. Six studies included in this review represent the extent of research on nurses' experiences with disclosure of errors to patients. In these studies we see glimpses of the nurses' role in disclosure, the ethical dilemmas inherent in this role, and the finding that while some errors are disclosed, some are not. The American Nurses' Association (2001) calls on nurses to be patient advocates and ensure that errors are disclosed, however factors are preventing nurses from disclosing. Clearly, with disclosure of errors to patients there is a disconnect between the ANA Code for Nurses and the realities of nursing practice. It is important to identify factors related to nurse disclosure and non-disclsoure. If nurse administrators are pressured to withhold information from patients (Katsuhara 2005), it may be that staff nurses experience even more pressure to withhold information from patients. The study by Greene (2007) indicated that in some cases nurses felt they should disclose, but they did not. This study was limited due to the number of participants (n=6) and the lack of repeat interviews to obtain missing data and validate interpretations with participants. By refining the study using interpretive phenomenology and a feminist theory perspective, the current study was able to examine nurses' perspectives from an enhanced view, sensitive to issues of power and gender.

Additional research is needed to understand nurses' experiences with disclosure. This study helped to fill this gap by examining nurses' experiences with disclosure, nurses' perceptions of their ethical responsibility in disclosure situations, and the contextual factors hindering the ability of nurses to fulfill the advocacy responsibilities assigned in their professional code. Additionally, by using a feminist perspective, this

study was able to examine the issues of power nurses' described in disclosure situations. Only through understanding nurses' experiences with disclosure can we identify measures to support nurses in their role as advocates in ensuring errors are disclosed to patients.

Theoretical Context

Ethical Theory

The ethical theory related to the disclosure of errors to patients will be examined in this section. Ethical reasoning influences nurses' beliefs and actions regarding disclosure. Davis, Aroskar, Liaschenko, and Drought (1997) identify three approaches to ethics in nursing, to include normative ethics, virtue ethics and an ethics of care. Additionally, Bell proposes a feminist ethic of freedom. Each of these ethical theories and their implications for the disclosure of errors to patients will be discussed.

Normative Ethics

Normative ethics is the approach most widely used in healthcare. Normative ethics is a rationalistic approach that deals with the rights and duties of individuals. This approach is based on the moral theories of deontology and teleontology. Deontology focuses on moral behavior and actions, while teleontology focuses on the utility or consequences of the actions (Catalano, 2006). Deontology argues that decisions should be universal, and not change with the situation. For example, if disclosure is the right thing to do, it is always the right thing to do. If it is wrong to lie in one situation, it is always wrong to lie. Teleontology considers the consequences of actions. Applying a teleontological approach, the nurse would balance the utility of consequences of disclosure with the harm to the client if disclosure does not occur.

Beauchamp and Childress explicate biomedical principles grounded in the principles of deontology and teleontology (2001). These principles include autonomy, beneficence, justice and nonmaleficence. Autonomy is the duty to allow others' to make their own decisions, beneficence is the duty to do good, justice is the duty to treat fairly, and nonmaleficence is the duty to avoid harm. These principles help to clarify appropriate actions within a given ethical situation. The ethical principle most salient to disclosure is autonomy (Henry, 2005). Within the provider/patient relationship, patients must have the information necessary to make responsible decisions about their care. Failure to disclose error violates the principle of patient autonomy by withholding information from the patient necessary to decision-making.

Virtue Ethics

Virtue ethics examines the righteousness of our character. "Virtue ethics asks what sort of person ought I be…" (Davis et al., 1997). Using a virtue ethic, the nurse considers the qualities of the "good nurse". In nursing education, we often use virtue ethics when we teach students to be "professional" and "caring" nurses. A nurse using virtue ethics in a disclosure situation would examine the alternatives for action to determine which action best reflects the virtues of the professional nurse. In the case of disclosure, the "good nurse" would be honest, professional, and therefore ensure errors are disclosed to patients.

Care Ethics

The ethic of care approach focuses on relationships and the responsibilities inherent within these relationships (Thomasma, 1994). The ethic of care approach arose from research by Carol Gilligan into the differences in moral development between

women and men (Keller, 1996). Prior to Gilligan (1982) Kohlberg developed a framework for moral development based entirely on research with men. When women failed to "measure up" in moral development, they were considered deficient. Gilligan found that the voices of women in moral situations are often different from men as women tended to focus more on relationships than principles. This focus on the relationship led to the development of the ethic of care approach. While this approach is considered feminist, some feminists criticize the ethics of care approach as adhering to the traditional roles of women as nurturers and caretakers (Bell, 1993).

Differences in moral reasoning may be evident in nurses' stories of disclosure and non-disclosure. Nurses using an ethic of care approach to moral decision making may be less supportive of disclosure than those who use a principled approach. It is possible that some nurses may justify non-disclosure because they may want to preserve relationships with patients, families, physicians, peers and administrators. This justification may be more prominent in the case of errors in which harm is absent or limited.

Ethic of Freedom

Linda Bell (1993) proposed an alternate feminist ethics, an ethics of freedom. According to Bell, feminist ethics arises out of a concern to eliminate injustice and oppression. "An ethics of freedom, but not an ethics of caring, develops ideals of love and caring in such a way that they do not support a violent and oppressive status quo" (Bell, 1993). Similar to an ethics of care, the caring relationship is supported as long as it does not uphold an oppressive system.

In developing this version of feminist ethics, Bell (1993) drew from the writings of Jean-Paul Sartre, while at the same time recognizing the gender bias present in Sartre's

writings. The ethics of freedom approach values the authentic individual, who recognizes her or his own freedom and in so doing also recognizes and values the freedom of others. Acting on an ethic of freedom requires one to examine the violent and oppressive context of society and commit to avoiding actions that contribute to oppression. Withholding error information from a patient limits their freedom to information and their choices in decision-making. Limiting information constitutes oppression because the nurse acts in a power-over relationship rather than holding power between herself and the patient by sharing error information with the patient.

Applying an ethic of freedom to disclosure situations, the nurse would recognize the violence and oppression present in the withholding of information about the error from the patient. The nurse, valuing the freedom of the patient, would disclose the error. This example of disclosure, however, is based on individual ethical action, while the institution may continue to function as an oppressive, powerful organization that withholds information from the patient, and that may punish the nurse for disclosing an error. Therefore, an ethic of freedom approach is most effective when it addresses oppression at the institutional level, seeking to remove those powerful and oppressive structures that conceal errors from those they affect most (Bell, 1993). For example, instead of seeking to improve disclosure through individual providers, an organization can implement measures to support disclosure by removing the barriers to disclosure within the organization. According to Bell, this organizational approach is more effective in eliminating oppression and supporting an ethics of freedom.

In summary, multiple ethical perspectives provide useful frameworks for considering the ethical dimensions involved in disclosing errors to patients. Normative

ethics is based on principles that can be used to guide ethical decision making. The use of a *virtue ethics* perspective frames ethical decisions on the basis of how a good person would act. The *ethic of care* is a relational form of feminist ethics that focuses on the caring relationship and the care responsibilities inherent within that relationship. Some feminists have criticized the ethic of care as promulgating the traditional stereotypes of women as caring and nurturing. An alternative feminist ethical framework is the e*thic of freedom* perspective that views ethical decision making on the basis of respect for individual freedom and avoidance of oppression.

Ethical Codes

The American Nurses' Association has developed a code of ethics to guide nursing practice. The disclosure of patient care errors is supported in the interpretive statements of the ANA's Code for Nurses (American Nurses' Association, 2001):

> …when errors do occur, nurses are expected to follow institutional guidelines in reporting errors committed or observed to the appropriate supervisory personnel and for assuring responsible disclosure of errors to patients. Under no circumstances should the nurse participate in, or condone through silence, either an attempt to hide an error or a punitive response that serves only to fix blame rather than correct the conditions that led to the error.

The professional organization for nurses, the ANA, indicates that nurses have an ethical responsibility to ensure that errors are disclosed, regardless of who is involved in committing the error.

Similarly, other healthcare professionals are bound by ethical codes to be truthful and respect patient autonomy (Henry, 2005). The American Medical Association issued a

current opinion approved June 2003 clarifying the ethical responsibility of physicians in cases of patient harm as follows:

> When patient harm has been caused by an error, physicians should offer a general explanation regarding the nature of the error and the measures being taken to prevent similar occurrences in the future. Such communication is fundamental to the trust that underlies the patient-physician relationship, and may help reduce the risk of liability (American Medical Association, 2003).

While not explicit, this statement from the AMA suggests that physicians have an ethical responsibility to disclose errors that result in patient harm.

Theoretical Framework

In this section the theoretical framework for this study will be discussed, to include both Heideggerian hermeneutic phenomenology and feminist theory. The components of the perspectives most salient to this disclosure study will be examined. Finally, the two perspectives will be compared for congruency, to ensure the theoretical perspectives are compatible.

Heideggerian Hermeneutic Phenomenology

In phenomenology, the core question to be answered is, "What is the meaning, structure, and essence of the lived experience of this phenomenon for this person or group of people?" (Patton, 2002). The purpose of phenomenology is to understand lived experience. van Manen (1990) describes phenomenological study as "the study of essences", and "the description of the experiential meanings as we live them" and "a search for what it means to be human" (van Manen, 1990).

Historical Development

Heideggerian hermeneutic phenomenology is based on the philosophy of Martin Heidegger. In his essay, *Being and Time* (Heidegger 1996/1927), Heidegger described knowing as a pre-reflective condition of being-in-the-world or experiencing the world. For Heidegger, knowing comes from living day-to-day without conscious effort of thinking about the situation or context. By existing day-to-day people understand and participate in creating the situation or context of their world. As a result, people are part of their world as much as the world is part of the person. Thus, knowing is pre-reflective, meaning that it is already present without conscious thought. So knowing is a part of being, and Heidegger developed the term "being-in-the-world" to describe this idea. For this study, the terms Heideggerian hermeneutic phenomenology, hermeneutic phenomenology, and interpretive phenomenology will be used interchangeably to refer to phenomenology based on the philosophy of Heidegger.

Major Tenets of Heideggerian Phenomenology

Central to hermeneutic phenomenology is Heidegger's assertion that we must understand what it means to be a person, to exist, before we can understand how we come to know the world (Heidegger 1996/1927). The main concepts of the Heideggerian view of the person include "(1) the person as having a world; (2) the person as a being for whom things have significance and value; (3) the person as self-interpreting; (4) the person as embodied; and (5) the person in time" (Leonard 1994). These concepts provide a framework for the interpretive phenomenological view of the person and should be integrated into the researcher's approach when using Heideggerian phenomenology.

The person as having a world. In interpretive phenomenology, the world consists of not only the physical environment, but also the "set of relationships, practices, and language that we have by virtue of being born into a culture" (Leonard, 1994). Heidegger describes our world as coming before-hand, pre-reflectively, without our conscious attention (1996/1927). Benner (1994) describes this as "taken-for-granted", in that we fail to notice these everyday routine activities. The world already exists for the individual, even before one stops to consider it. The individual is both shaped by the world and shapes the world by its' presence.

Heidegger uses the phrase *being-in-the-world* in two ways (1996/1927). The first way of being-in-the-world is physical existence, in much the same manner as a table or rock is in the world. The second way of *being-in-the-world* means not only existing, but being aware of our existence and the existence of the world around as well. Heidegger uses the example of the hammer, which Dasein knows without having to stop and reflect as a tool to drive in nails, instead of as a piece of wood with a metal head (1996/1927). People see objects not simply as hammers or tables, but with an understanding of how the object exists and the purpose it has served for the person. The hammer or table has been experienced, and served a purpose for a person (Heidegger 1996/1927). Thus, individuals understand the world and the objects in it through their experiences rather than by analyzing or consciously thinking about it.

A person exists in this world in a given set up circumstances, consisting of its' culture, language, family, and personal characteristics, which Heidegger describes using the term *thrownness* (Heidegger 1996/1927). Within this *thrownness*, Dasein pre-reflectively defines its' possibilities for action in the world. Similarly, because nurses'

worlds consist of a shared culture of societal norms, professional and gender expectations, and formal and informal power structures, these influences circumscribe nurses' self-interpretations of their possibilities for action when errors occur. To understand nurses' experiences with disclosure, it is necessary to gather the full context to include contextual factors such as the perceived culture of the organization and how institutions assign responsibility for disclosure. Institutions may assign responsibility implicitly through power structures and explicitly through dissemination of information regarding policies and procedures. In addition nurses interpret this assignment of responsibility for disclosure within the institution.

Heidegger describes three ways that people interact with the world (1996/1927), a) ready-to-hand, b) unready-to-hand, and c) present-at-hand. Ready-to-hand interaction involves those activities we engage in without conscious attention. When a person repeatedly performs a skill they become more and more experienced with exactly how the skill is performed. This repeated performance becomes almost second nature to the person, and the person no longer has to think about each step that must be taken. They simply perform the skill in a seamless manger. The skill is so seamless that the skill becomes part of who the person is rather than what the person does. This is called a ready-to-hand activity.

When a person is performing a ready-to-hand activity, and something unexpected occurs, then the person must turn their conscious attention back to the activity. This turning of attention is then called unready-to-hand activity. Here the person is trying to problem solve, so the activity is no longer seamless. Conscious attention about the steps

involved in the activity goes along with the problem solving, thus the activity is unready-to-hand.

Present-at-hand interaction involves reflective, analytic consideration of an activity. In present-at-hand interaction the person may examine the meaning of an activity. When nurses think about an error they have made and analyze their actions, their analysis of the event may change the meaning of the event to them.

Many aspects of disclosure represent ready-to-hand, taken-for-granted activities that are carried out without conscious reflection on their meaning. During their everyday existence, it is possible that nurses may not have considered their role in disclosure or the disparity between the ANA Code for Nurses and actual practice. An interpretive phenomenological approach allows the researcher to examine these taken-for-granted meanings.

The person as a being for whom things have significance and value. Heidegger uses the concept of care to indicate the things to which one gives attention (Heidegger 1996/1927). For example, in our average everydayness, while being-in-the-world, we give attention to our work, our families, or a favorite book, because these things matter to us. Heidegger writes, “In everyday terms we understand ourselves and our existence by way of the activities we pursue and the things we take care of” (1975). Our actions reveal our interests and concerns. When nurses share their stories of error disclosure, their stories reveal their most salient concerns from their experiences. The nurses remember the details that are of most concern to them. Benner writes, “A story of an event is remembered in terms of the participant’s concerns and understandings of the situation” (Benner, 1994).

The person as self-interpreting. By self-interpreting, Heidegger suggests we interpret all things that come to our attention in light of our understandings and culture (1996/1927). The things that come to our attention have meaning to us because of how we use them, that is, how we interpret their use. A nurse would see a sphygmomanometer as a device associated with a procedure for obtaining a physiological measure. This device has meaning to nurses because of our shared understandings and culture. When a child first sees a sphygmomanometer, the child may interpret the device as something that may cause harm or pain, as the child lacks understanding of the device.

Nurses self-interpret situations in terms of their experiences. For this study, the researcher is interested in the participants' perceptions of their experiences, the contextual factors associated with their decisions, their fears, their understandings of their options for action, and their ethical and professional conflicts. While one nurse may interpret non-disclosure as a moral dilemma, another nurse may interpret non-disclosure as a means to support a peer who has erred. The researcher recognizes that one person cannot fully understand another person's perspective, although understanding can be further clarified through entering the hermeneutic circle. "The hermeneutic circle refers to the flow of understanding that takes place through being-in-the-world. It refers to the back and forth movement between partial understandings and the more complex whole" (Mackey, 2004). The hermeneutic circle allows the researcher to see glimpses of the participants' reality, although one can never completely understand another person's reality.

The person as embodied. The Cartesian view of the person separates mind, body and spirit (Heidegger 1996/1927). The phenomenological view of embodied incorporates

the person as interconnected with the body (Heidegger 1996/1927). “Our bodies provide the possibility for concrete action of self in the world. It is the body that first grasps the world and moves with intention in that meaningful world” (Leonard, 1994). It is through this embodiment that we can perceive shared meanings for terms such as pain, fatigue, and anger, recognizing that each person comes with a different background and therefore, somewhat different meanings for these terms.

The person in time. Heidegger describes temporality as more than our usual linear understanding of time, positing that everything we experience is interpreted from our past experiences and our future expectations (Heidegger 1996/1927). The effect of temporality provides us with a *fore-structure*, or pre-understanding (Heidegger). As researchers our pre-understandings influence everything from our choice of research topic to our findings. Interpretive phenomenology recognizes and embraces the influence of the researcher’s pre-understanding, acknowledging that there is no reference point that is totally objective.

Applying the concept of temporality to error disclosure, a nurse who makes an error decides their subsequent actions based on her/his past (i.e. education, previous experiences, knowledge of others errors, knowledge of unit culture) and her/his expectations or fears for the future (i.e. unemployment, legal action by the patient, anticipation of guilty feelings for non-disclosure). This temporality is ever-present. There is no being-in-the-world without the influence of our past and our expectations for the future.

These five concepts describe the major tenets of the phenomenological view of the person. When examining nurse experiences with disclosure, this Heideggerian

hermeneutic phenomenological framework provides an approach that situates the researcher within the hermeneutic circle. The researcher and participant align shared meanings with narrative experiences to engender meaningful, interpretive understandings. The process of interpretation is a circular process with the researcher always endeavoring to look deeper into the text, beyond the fore-structures. The researcher maintains a commitment to remain true to the text, and avoid seeing interpretations that are expected, but not supported by the text. Finally, the outcome of hermeneutical analysis should reveal an understanding of the experience among readers of that which was always present, but now is more clearly revealed.

Feminist Theory

In addition to the interpretive phenomenological perspective, a feminist theory perspective was used to enable a closer look at issues of gender and power. Campbell and Bunting (1991) emphasize that feminist research is emancipatory and seeks to free women from oppression. The core question in feminist inquiry would be "How is feminist perspective manifest in this phenomenon?" (Patton, 2002). A feminist methodology orients the study to seek out issues with gender that may not otherwise be evident. Patton writes, "A feminist perspective presumes the importance of gender in human relationships and societal processes and orients the study in that direction" (Patton, 2002). Nurses may not be aware of the taken-for-granted practices they experience in their everyday lives that are influenced by gender and power differentials. A feminist perspective provides a view to more fully uncover the gender and power issues that impact disclosure.

A History of Feminist Theory and Feminist Approaches to Research

Feminist theory had its origins in early efforts to secure education, voting rights, workforce access, and women's' rights in marriage. Later, feminist criticisms of the traditional view of the family, the Vietnam War, and discrimination against minorities drove the feminist movement (Tong, 2007). However, not all women agreed with the feminist movement, which led to criticisms from multicultural and global feminists who felt there was not one voice for women and that the views of western women did not represent all women. Today, many feminists embrace the contradictions and ambiguity inherent in the feminist movement while seeking to unite women against oppression (Tong, 2007).

Feminist methodologies apply feminist theory to research (Harding ,1987). Harding identified three feminist approaches to research, to include feminist empiricism, postmodern feminism, and feminist standpoint theory (Harding, 1987). Feminist empiricism adheres to the positivist quantitative research methods and the belief that androcentric biases in traditional research are due to poor adherence to methods (Harding 1991). Feminist empiricists believe that truth can be learned by adhering to traditional methods.

Postmodern feminists assert there is no one truth and that even the existence of gender is socially constructed. The postmodern view embraces diversity, ambiguity and contradictions. Because of this view of the relativity of truth and even gender identity, some have questioned the ability of postmodern feminists to bring about change for the better in women's situations (Olesen, 2005).

Feminist standpoint methodologies assert that women have a different view for social research because of gender differences and women's perspective of the "other", that is, their view from within oppression (Harding, 1991). Harding explains how the position of men as dominant in our culture limits men's views of knowledge, while women's views are enhanced. Harding believes that the views of women are "equally valuable but for different reasons" (1991).

Feminist Theories: Epistemology

Campbell and Bunting identify five epistemological issues common to feminist methodologies (1991). First, feminist methodologies assert that the experiences of women are valid sources of knowledge. Second, the value of subjective data is recognized. Third, participants are respected as experts on their lives. Fourth, feminist methodologies view knowledge as both relational and contextual. Finally, feminist methodologies recognize boundaries between the personal and political as contrived. Incorporating these epistemological issues into feminist research includes: (1) inquiring into women's' experiences while accepting women as experts on their lives; (2) avoiding dichotomies; (3) examining the historical context of events throughout the research process; (4) asking questions women want answered (and asking the right questions); (5) describing one's own ethnicity, class, and race as the researcher and how these characteristics could influence the research; (6) avoiding the use of hierarchical structures within the research; and (7) sharing findings with participants for their benefit (Campbell & Bunting 1991).

Congruence between Heideggerian Hermeneutic Phenomenology and Feminist Perspective

When combining theoretical perspectives it is important to ensure the perspectives are congruent. Interpretive phenomenology and feminist perspectives are congruent. In examining the view of the person, Heideggerian hermeneutic phenomenology views the person as self-interpreting (Heidegger 1996/1927), similarly, feminist methodologies view the participant as the expert on their lives (Campbell and Bunting 1991), indicating that participants interpretations of their experiences are valued. Also, Heideggerian hermeneutic phenomenology emphasizes the importance of the context, as "being-in-the-world". Heideggerian hermeneutic phenomenology describes how the person's understanding of their being-in-the-world can limit their choices. Because feminist theories value the full context of participants' stories, both these perspectives share in their acknowledgement of the importance of context to understanding lived-experiences. Finally, Heideggerian hermeneutic phenomenology describes the taken-for-granted-meanings of our everyday activities that we may not be aware of (Heidegger 1996/1927). Similarly, the emphasis of the feminist perspective on uncovering issues with power and gender constitute an examination of "taken for granted" meanings that are often invisible to us because "they have always been there." Explicating the issues of power and gender is enhanced using this combination of theoretical perspectives.

One area in which Heideggerian hermeneutic phenomenology and feminist theories diverge is the use of themes in Heideggerian hermeneutic phenomenology. Feminist methodologies generally avoid overarching themes and generalities (Campbell and Bunting 1991). To address this difference in perspectives for this study, the

researchers were careful to represent the voices of diverse participants, even while examining thematic similarities across interviews.

Assumptions of the Researcher

Having worked in hospital administration and education for eight years, academic education for 10 years, and clinical practice for 6 years, this researcher has observed the essential role of the nurse in advocating for quality patient care. Integral to quality patient care is the expectation that, when things go wrong, patients and families are dealt with honestly and truthfully. Nurses are in a unique position and interact with patients before, during, and after errors occur. As a result, their experiences may offer key information regarding disclosure.

The following are my assumptions regarding this study:

1. Nurses are the experts on their own lives and practice.
2. Nurses seek to practice ethically.
3. Nurses are commonly involved in caring for patients before, during and after errors occur.
4. Patients and families have a right to full disclosure of errors.
5. Nurses' experiences about communicating with patients after error can contribute to understanding the complexities surrounding the disclosure of errors to patients.
6. Information from nurses about disclosure is essential in designing strategies to increase transparency regarding errors in healthcare.

Some authors have recommended that feminist researchers introspectively consider the impact of their research on society and participants (Maxwell-Young et al.,

1998). When considering the impact of my research on nursing, it was important to reflect on the effect research on nurses' stories of non-disclosure could have on nurses. Depending on the findings, it is possible that the image of nurses as trustworthy and professional could be damaged. It is my responsibility as the researcher to involve participants as partners in the research process and maintain sensitivity to the image of nursing throughout the research process. The findings from the proposed research can help to emancipate nurses in their ability to fulfill their role as patient advocates in disclosure situations. Because I believe that nurses are often put in situations where they face ethical and professional dilemmas, I believe it is important to illuminate these situations, with the ultimate aim being societal recognition of the power of nursing to protect the rights of patients entrusted to our care. By using a feminist perspective I can view nurses' stories of disclosure from a perspective sensitive to gender and power issues. This view can uncover hidden sources of oppression that participants may not have considered.

The following are my assumptions regarding feminist theory:

1. Nurses' subjective experiences with disclosure or non-disclosure are valid sources of knowledge.
2. Nurses, as members of a predominantly female profession, experience gender oppression in the current healthcare culture.
3. Many systems that oppress nurses are invisible because they are accepted as normal in our culture.
4. My experiences as a white, middle-class, educated, heterosexual woman influence my interpretation of nurses' experiences.

Summary

In this chapter the research and theoretical literature pertinent to the disclosure of errors to patients has been reviewed. Gaps in the literature have been identified, and the role of this research as the next step in the science has been explicated. Several ethical theories and their application to disclosure were described. Finally, the theoretical framework for this study and my background and assumptions as a researcher were discussed. The next chapter will include a discussion of the research plan.

CHAPTER III

RESEARCH METHODOLOGY

In this chapter the methodology, participant recruitment and sampling, and participant protection are described. The process for data generation and data analysis is discussed. Finally, measures taken to ensure the methodological rigor of the study are elucidated.

Methodology

The purpose of this study was to gain an understanding of nurse perceptions of error disclosure to patients. A qualitative approach was chosen because qualitative approaches are useful when the goal is to understand phenomenon (Speziale & Carpenter, 2007). The value of understanding to nursing is best expressed by Benner, "It is posited that understanding is more powerful than explanation for prediction in the human sciences because it stands more fully in the human world of self-understandings, meanings, skills, and tradition" (Benner, 1994).

Heideggerian hermeneutic phenomenology was selected as the methodology for this study because this method is particularly useful in revealing taken-for-granted meanings that occur in complex ethical situations such as those involving the disclosure of errors. van Manen writes, "phenomenology attempts to explicate the meanings as we live them in our everyday existence, our lifeworlds" (1990). Because the data in interpretive phenomenology consists of the participants' stories, these stories provided

access to rich narrative accounts of disclosure and non-disclosure experiences. “The role of storytelling is central to interpretive phenomenology because when people structure their own narrative accounts, they can tap into their more immediate experiences, and the problem of generalities or ideologies is diminished” (Benner, 1994). When nurses relayed their experiences with disclosure or non-disclosure, the rich textual descriptions provided insight to the experiences from the nurses’ perspectives.

Feminist methodology was also incorporated into the study. The use of a feminist methodology promotes an expanded worldview in which the importance of gender and power in social interactions is recognized (Patton, 2002). In an earlier study, Greene (2007) found disparities between nurses’ beliefs and actions regarding disclosure. Nurses expressed fear and uncertainty about their roles in disclosure. Fein et al. (2005) also identified fear and power issues as influencing the disclosure of error. Power issues in social relations may be a key component in understanding nurses’ experiences with disclosure. These findings supported the need for further study elucidating issues of gender, power, and oppression that may provide an important context regarding the disclosure of errors to patients. Feminist research arises in feminist theory and seeks to create knowledge to empower the oppressed (Ramazanoglu, 2002). The use of feminist methodology can help reveal issues of gender and power present in nurses’ stories of disclosure and non-disclosure of errors to patients.

Participants and Sampling

Participants were recruited by networking with professional contacts across a large geographic area to ensure representation of a diverse group of nurses from various regions and hospital types. To identify additional participants, the snowball technique of

sampling was used by having participants provide referrals (Patton, 2002). Inclusion criteria specified that participants be registered nurses ages 21-65 providing direct patient care for at least 24 hours per week, currently employed in a hospital setting. These criteria were selected to ensure a sample of nurses with current experience, directly involved in patient care. Participants needed to be fluent in English and have experience with the topic. All participants met the inclusion criteria. In addition, both men and women were recruited. This researcher sought to include participants from a variety of ethnic and racial backgrounds to ensure representation of the diverse voices of the participants (Tong, 2007).

When recruiting participants, nurses were asked if they were interested in participating in research about patient care errors and their experiences with patients being informed about these errors. Participants were told that they would be asked to talk about their experiences with patient care errors. Participants were advised that the interviews would take approximately one to one-and-a-half hours and they will receive a $25 gift card upon completion of the interview, in appreciation of their investment of time. This incentive amount was designed to encourage nurses to participate, yet not substantial enough to coerce participation. Grant funds to support this participant incentive were received from the Epsilon Alpha Chapter of Sigma Theta Tau International.

Interested nurses were screened for eligibility. For nurses who met the inclusion criteria, a convenient time and location was agreed upon for the interviews. Participants were asked to think about their experiences with patient care errors prior to the interview.

Participant Protection

Approval from the Georgia State University IRB was obtained prior to initiating this study. Informed consent was obtained at the time of study enrollment, prior to initiation of the interview. Participants were given a description of the study and information regarding confidentiality of responses. Participants were informed the research involved nurse experiences with patient care errors. Interested participants received and signed consent forms. Consent forms are stored separately from data collected during the study. The participant population was of working age, between the ages of 21 and 65. No subpopulations were excluded from the study. Licensure as an RN requires a minimum of a two-year college degree or attendance at a three-year diploma program. The inclusion of minorities was assured by sharing the intent to include minorities when networking with peers to recruit participants.

Participants were told the study was about patient care errors and the nurses' experiences with error disclosure to patients. Confidentiality procedures were explained, to include the separation of participant names from interview transcripts. After a nurse indicated an interest in participating in the study, a convenient time and location was agreed upon for the interview. The nurse was asked to think about error experiences prior to the interview. Participants received a $25 gift card upon completion of the interview, in appreciation of their investment of time in the study.

The risks of this study were minimal. Minimal risks are within those encountered in daily life. Strict procedures were followed to ensure participant confidentiality. Confidentiality was particularly important because of the sensitive nature of the research. While the possibility of a breach in confidentiality was extremely small, it was important

to recognize the risk and assure participants of measures to protect their anonymity. At the time of data collection, a private area was available for interviews. Participants selected a pseudonym and were assigned a participant identification number. Participant identification numbers and pseudonyms are the only identifiers on audiotapes and transcripts. The participant roster and informed consent forms are kept in a locked file cabinet. Only the principal researcher has access to these forms.

Another potential risk was the emotional distress to the participant of discussing errors that may have caused harm to patients. In a study on barriers to disclosure, Fein et al. (2005) discussed the fear of admitting a mistake to oneself as a barrier to disclosure. When participants discuss patient care errors and disclosure, this researcher was concerned that feelings of fear and guilt might surface, resulting in emotional upset. However, no participants became emotionally upset during the interviews.

Data Generation

After recruiting participants, this researcher met them at the agreed-upon time and place. Nurses were interviewed in a private location, chosen for the convenience of the participant and for the safety and comfort of both participant and researcher. The purpose of the study and the risks and benefits of participation were reviewed. Confidentiality was emphasized. After consent was signed, demographic data was collected to include gender, age, race, nursing education, years of nursing experience and practice setting. Participants were asked to select a pseudonym to represent them in the final document. This was followed by the open ended, non-structured interview. The interview was recorded, using a digital audio-recorder and audiotape recorder to protect from data loss in the event of technical problems. Data was collected until saturation was reached.

The use of interviews supported giving voice to participants, consistent with feminist methodology. Interviews were dialogic, in which validation and sharing with participants occurred (Campbell & Bunting, 1991). Consistent with interpretive phenomenological methods, participants engaged in storytelling about their experiences with the disclosure of errors to patients. Stories provide accounts of lived experiences that enable us to look beyond the obvious to understand the background themes that form and shape everyday experiences (Dreyfus, 1991). Nurses' tacit understandings of these experiences are hidden in the background and not considered as nurses are immersed in everyday activities. By examining nurses' engagement in ready-to-hand, unready-to-hand and present-at-hand activities through stories, meaning can be revealed.

The interviews began with an informal, unstructured dialogue between the participant and the researcher about patient care errors. The purpose of this dialogue was to create a safe, non-judgmental atmosphere in which participants felt safe discussing their stories of error. Following this dialogue, interviews continued with a prompt such as, "Do you remember a time when a patient care error occurred?" By asking nurses to recall a time when an error occurred, this researcher hoped to elicit data representing unexamined, ready-to-hand and unready-to-hand practices. These practices are useful in revealing background structures. Further prompts were used to elicit details about the experience, to reveal the full context.

Nurses recalled feelings and concerns about their actions and the actions of others. By eliciting participant descriptions of their feelings, the meaning of the experiences to the participants could be better understood. To elicit feelings, participants were asked questions such as, "Can you help me understand your feelings?" Participant

concerns were revealed with questions such as "Could you tell me about your concerns?" Participants were asked about their concerns to help them focus on those aspects of an event they considered the most salient. In everyday practice, nurses may not stop to consider the meanings of their actions when errors occur. By asking about concerns, participants were able to bring to the forefront those salient aspects that may not have been considered. To reveal present-at-hand meanings, participants were asked to reflect on situations where nurses might be more at ease with disclosure. For example, one question asked, "Can you think of situations where nurses might be more at ease with disclosure?"

As the interviews progressed participants were asked to tell about their experiences communicating with the patient about the error. An important contextual element was whether or not disclosure of the error to the patient or family occurred. Because this was a sensitive topic that could have been perceived by participants as judgmental, this issue was approached by asking participants how the patient and family responded to the error. Approaching the topic from this perspective helped the participant to feel more comfortable in revealing whether or not the error was disclosed. Because issues of power and gender may be implicit in nurses' stories, participants were asked about their perceptions of support for disclosure from doctors and others in the organization. This allowed the power structures that made up the contextual elements of the nurses' worlds to be more closely examined. An interview guide was used to provide potential interview questions to support consistency across interviews (Appendix A).

Interviews lasted from 20 to 65 minutes, depending on the stories of error disclosure and non-disclosure participants discussed. After each interview was

completed, field notes were recorded on the interview. These field notes consisted of descriptions of the setting, nonverbal observations, beginning understandings, concerns, and other details not captured by the audio-recorder. Transcripts and field notes served as the data for analysis. Participants were asked for permission to contact them later for clarification of data and validation of interpretations. All participants except one were amenable to further contact from the researcher.

Following the interviews, a transcriptionist was used to assist with transcribing interviews. Interviews were transcribed verbatim, including the "ahs" and "ums" that frequently occur in conversation. The accuracy of transcriptions was verified by listening to the audio-recording of each interview while reading the transcription. Corrections were made as needed. Participants were given the opportunity to review typed transcripts for verification and feedback. While most participants did not request changes or additions to the transcripts, one participant requested rewording of one section of the interview. Participants were also asked about their reactions to the transcripts, and if there was anything further they would have liked to add. Notes from follow-up contacts became part of the data.

As transcription was completed for each interview, analysis was begun so that continuing interviews and analysis would progress concurrently. As a result, changes to the data collection process were incorporated based on the findings of the analysis. For example, during the fifth interview, the participant remarked that the term "disclosure" seemed to her to represent a very formal meeting between hospital personnel and patients and their families. When she considered her discussions with patients about error, she did not think of this as "disclosure". As a result of this participant's statement, during

subsequent interviews this researcher used more informal language to refer to disclosure, such as “discussing the error with the patient.”

Data Analysis

In order to foster insight and add credibility to data interpretation, a research team was used. A research team was assembled consisting of this researcher and three other doctoral students who had completed coursework in both qualitative research and phenomenology. Additionally, a faculty member with extensive expertise in qualitative research consulted with the research team. To sensitize the research team to their own feelings about error disclosure, members either privately recorded or were interviewed about their experiences with error disclosure.

Analysis of data involved a circular process moving from parts to wholes within the hermeneutic circle, seeking to delve deeper into the text, beyond the fore structures (Heidegger 1996/1927). The hermeneutic circle conceptualizes the movement between interpreting the whole and examining salient parts which in turn modify the interpretation of the whole (Dreyfus, 1991). Thus, “…the circle is supposed to lead to a richer and richer understanding of the text” (Dreyfus, 1991). During data analysis, multiple stages and multiple interpretations by the research team helped to expose unsupported meanings and inaccurate interpretations not substantiated by the data.

The stages of data interpretation described by Diekelmann and Allen (1989) and modified by Minick (1992) were used as a guide for analysis. The following process was used to analyze the data:

1. A summary of the interview was written by reading the entire transcript, along with the field notes. This summary described the overall message in

the text and the researcher's beginning understanding of the overall meaning of the experience to the participant. At least two members of the research team summarized 13 of the 17 interviews.

2. The research team discussed the summaries. Meetings of the research team were conducted utilizing the meeting software *Elluminate Live,* which permits synchronous audio online discussions in private meeting sites. Confidentiality was assured by requiring password access to the meeting site. Research team members usually achieved a high degree of consensus on the salient aspects of each transcript. Any discrepancies in the interpretation between team members were clarified by returning to the text. Differences in interpretation were shared and discussed until consensus among the team members was achieved.
3. Interviews and analysis occurred concurrently. Interpretations from earlier interviews were helpful in identifying areas to clarify during later interviews.
4. Next, line-by-line coding of data was done using terms that best described the meaning of a given excerpt of text. To manage the data, transcripts were loaded into the software program *Ethnograph,* a qualitative data management software program. Codes were assigned to the data, using participants' words whenever possible. A code book was used to provide consistency in coding definitions. One example of a code was "fearsue" which was defined as "statement regarding fear of litigation". Each subsequent interview was constantly compared to previous interviews to

ensure newly established codes were identified consistently in interviews. A total of 79 codes were identified in the final code book.

5. Once coding was complete, excerpts of the transcripts were printed by code. By analyzing these coded excerpts, codes were collapsed into themes and subthemes.
6. Using these themes and subthemes, paradigm cases were identified that best represented each theme. Narrative descriptions were composed.
7. The interpretation was then read by the principle researcher and another member of the research team. Changes were made to the narrative based on feedback from the research team.
8. Two participants reviewed the interpretation. These participants were in agreement with the findings.

Credibility

Several authors have proposed frameworks for evaluating qualitative research. These frameworks include traditional scientific research criteria, social construction and constructivist criteria, artistic and evocative criteria, critical change criteria, and evaluation standards and principles (Patton, 2002). In many cases mixed criteria are used to evaluate the research. Patton proposes a mixed evaluative approach, purporting that the quality of a study is established through measures to ensure credibility (2002). Credibility is defined as, “the quality, capability, or power to elicit belief” (credibility, n.d.). Credibility is supported through rigorous methods, researcher credibility, and philosophical beliefs (Patton). These measures to support credibility were applied in this study and are described in the next section.

Scientific Rigor

In qualitative research, rigor is often described in terms of trustworthiness (Patton, 2002). Trustworthiness is supported through research practices that ensure sound interpretive methods. "Trustworthiness becomes a matter of persuasion whereby the scientist is viewed as having made those practices visible and, therefore, auditable; it is less a matter of claiming to be right about a phenomenon than of having practiced good science" (Sandelowski, 1993).

These methods were employed in this study to support trustworthiness:

1. Field notes were recorded during and immediately after each interview. The use of field notes helped to preserve the full meaning of participants' stories by supplementing narrative texts with non-verbal descriptions of the environment, participant's body language, and the researcher's impressions and emerging ideas.
2. Transcribed interviews were returned to participants for review and corrections.
3. A research team composed of four doctoral students participated in analysis of the data. While all four members were not able to be present at all team meetings, the combined expertise of the group in qualitative analysis, particularly Heideggerian hermeneutic phenomenology, contributed to the interpretation of the data. The use of a research team also helped to reveal participant meanings not considered by the principal investigator.

4. Upon completion of the final interpretation by the research team, two participants were asked to review the final transcript to ensure accurate interpretation and adherence to the voices of the participants.
5. The use of combined theoretical perspectives, to include Heideggerian hermeneutic phenomenology and feminist theory, contributed to viewing the data from multiple perspectives.
6. The research team discussed alternate explanations and conclusions during the frequent meetings.
7. A research journal was maintained to provide an audit trail to allow other researchers to follow the research process from the conception of the study until the final report.

Adherence to these methods supported the trustworthiness of the study.

Additionally, because the use of a feminist perspective includes implications for the methodology of the study, the trustworthiness of the study is also measured by adherence to feminist methodology. Campbell and Bunting (1991) explicated seven implications for incorporating feminist methodology into a research study. The first implication of feminist methodology is that women are accepted as experts on their lives. In this study, all participants were recognized as experts on their lives. Participants were given the opportunity to review and edit transcripts. Key participants were asked to review the final interpretation. While the participants who reviewed the interpretation were in agreement with the interpretation, had there been a disagreement the views of the participants would have prevailed. A second implication of feminist methodology is the avoidance of dichotomies. For this study, the researcher sought to avoid dichotomous

categories of "good" and "bad," but sought rather a more in-depth understanding of the contextual factors that make up nurses' experiences with disclosure. A third implication of feminist methodology is to examine the historical context of the study. In Chapter I, the historical context, including the recent Institute of Medicine book, To Err is Human, along with a particularly high profile patient care error, was discussed. A fourth implication of feminist methodology is to ask questions that women want answered. The issue of disclosing errors to patients has been researched with physicians and patients, while research with nurses was limited. Research with nurses' experiences with disclosure is an area in which women, as nurses and as patients, can benefit. A fifth implication of feminist methodology is describing one's own ethnicity, class, race and how these characteristics can influence the research study. In Chapter II, I revealed my personal characteristics and how these characteristics could influence the study. A sixth implication of feminist methodology is to avoid hierarchical structures. By including participants as partners in the study, instead of as subjects, the researcher sought to eliminate hierarchical relationships. Finally, the seventh implication of feminist methodology is to share the findings with participants for their benefit. All participants will be offered a copy of the findings from the study. Adherence to the feminist methodological implications contributed to the trustworthiness of the study.

Researcher Credibility

Researcher credibility considers the qualities of the researcher that may influence the study (Patton, 2002). Researcher credibility is supported through measures to ensure that researchers reveal personal and professional biases and connections (such as funding, group membership, past experiences) that may influence the research. Reactivity may

also influence researcher credibility. Reactivity is the response of participants to characteristics and actions of the researcher (Patton). Reactivity is altered by the behaviors and actions of the researcher when interacting with participants and the length of engagement with participants. Researcher credibility is also influenced by the intellectual rigor of the researcher, who seeks at all times to understand the phenomena (Patton).

In this study, researcher credibility was supported through a) explicating my assumptions as a part of the research study; b) revealing sources of funding for the study, c) engaging participants in dialogue about errors at the start of interviews to foster a trusting relationship between participants and the researcher; d) having members of the research team reflectively examine their personal experiences with errors and disclosure; e) returning to participants for follow-up; f) utilizing a thorough process of analysis that returns to the data repeatedly in search of understanding, and g) including faculty advisors with extensive experience in qualitative research as research consultants.

Philosophical Belief in the Value of Qualitative Research

In order to accept that the results of qualitative inquiry are credible, one's philosophical beliefs must value qualitative research as a way of knowing (Patton, 2002). This belief in qualitative inquiry does not consist of a qualitative versus quantitative stance, but more a valuing of the strengths of both traditions. The Heideggerian hermeneutic phenomenological and feminist perspectives combined in this proposal align with my personal beliefs in qualitative research as integral to research within the human sciences.

In this section a framework to evaluate the quality of the study was examined. A mixed evaluative approach was introduced that focuses on the credibility of the research, to include rigor (trustworthiness), researcher credibility, and researcher beliefs in the value of qualitative inquiry. Measures to ensure the quality of this study were examined using these criteria.

Summary

In this chapter the methodology, participant recruitment and sampling, and participant protection were described. The process used for data generation and data analysis. Measures to ensure the credibility of the study were described. In the next chapter the findings and interpretation of the study will be discussed.

CHAPTER IV

FINDINGS AND INTERPRETATION

The purpose of this study was to gain an understanding of nurse perceptions of error disclosure to patients. Seventeen registered nurses, employed in in-patient settings caring for adult medical/surgical patients, were interviewed. Transcripts were analyzed using the stages of data interpretation described by Diekelmann and Allen (1989) and modified by Minick (1992). A combined theoretical perspective, to include Heideggerian hermeneutic phenomenology and a feminist perspective, was used to guide the review and interpretation. In this chapter the findings and an interpretation will be discussed. To protect the anonymity of the participants, pseudonyms have been used in place of actual names.

Participant Characteristics

Fifteen female and two male nurses were recruited for this study. Information was collected about participant gender, ethnicity, age, education and years of nursing experience. Participant characteristics are summarized in Table 1. Participants included fifteen Caucasian and two African American nurses.

Table 1

Participant Characteristics

Gender	
Female	15
Male	2
Race	
Caucasian	15
African American	2
Nursing Education	
B.S. Nursing	9
A. S. Nursing	8
Years of Nursing Experience	
3 to 7 years	4
11 to19 years	8
26 to 28 years	2
31 to 39 years	3

Participant ages ranged from 25-62 years. A total of three participants ranged in age from 25 to 29 years. Three participants ranged from 35 to 38 years of age. Five participants ranged in age from 42 to 48. Four participants ranged in age from 51 to 54. Finally, two participants were 60 to 62 years of age.

Nine participants held bachelor's degrees (BSN) as their highest level of nursing education while eight participants were educated at the Associate Degree (ASN) level. The oldest of the nine BSN nurses had started out as a Diploma nurse. Four of the BSN nurses had started out as ASN graduates. One ASN nurse held a non-nursing bachelors degree in management.

All participants were currently RNs at the time of their interviews. Participants' years of nursing experience ranged from 3 to 39 years. The nurse with the most experience (39 years) had practiced two years as an LPN prior to continuing her education to obtain her RN license. Two other participants had started their nursing careers as Licensed Practical Nurses (LPN). Four of the nurses that were interviewed had 3 to 7 years of nursing experience. Eight nurses had 11-19 years of nursing experience. Two nurses had 26-28 years of nursing experience. Finally, three nurses had 31 to 39 years of nursing experience.

Findings

At the beginning of each interview, participants were asked to tell a story about a patient care error. Further prompts were used to elicit the full context of the experience. Participants told stories of both disclosure and non-disclosure of errors to patients. Most participants shared multiple stories of both their own errors and the errors of nurse and physician peers. A total of 41 specific stories of error were shared. Eighteen of these errors were made by the participants, while 23 were errors made by others.

Notably, all participants but one were able to vividly recall the details of error experiences, some of which occurred as long as 15-35 years ago. Participants described details such as patient and family issues, the patient's response to the error and how the error occurred. The ability to recall the details of error experiences after many years suggests that the details were meaningful enough to remember for years. Benner (1994) indicated that nurses remember details of events when they stand out as salient to the nurse. One participant remarked that because errors were very common, she was more likely to remember errors that were harmful compared to those that were not harmful.

Nurses may remember harmful errors because these errors seem to have a strong emotional impact on the nurse. It may be that the participant who was unable to remember any specific errors actually had not made (or did not know of making) any harmful errors. Another interpretation could be that the errors made by the nurse could not be recalled because they did not stand out as salient, or meaningful, to the nurse.

Participants' experiences were analyzed using the steps described by Diekelmann and Allen (1989) and modified by Minick (1992). Analysis of the transcripts resulted in the identification of three themes and 6 subthemes. The themes were: (a) disclosing error; b) perceiving expectations for disclosure; and (c) not disclosing error. Themes and subthemes are listed in Table 2. In the remaining sections of this chapter each of these themes will be discussed. Literature from both theoretical and empirical sources will be included as contextual to the study interpretation.

Table 2

Themes and Subthemes

Disclosing Error
Disclosing Error through Constant Communication
Disclosing Error as a Decision
Perceiving Expectations for Disclosure
Cultures of Openness and Honesty
Cultures of Secrecy
Not Disclosing Error
Disclosing Events but not Errors
Overtly Concealing Errors

Theme: Disclosing Error

The theme Disclosing Error describes participants' stories of revealing errors to patients and families and was reported in at least two ways. While in some cases disclosing error seemed to flow from nurses' embodied ways of being, in other cases the decision to disclose was described as situational. As a result, two subthemes were identified: (a) disclosing error through constant communication; and (b) disclosing error as a decision.

Disclosing Error through Constant Communication represents participants' descriptions of a way of being with patients that involved keeping patients constantly informed about what was happening. Instead of decisions to disclose made with each event, these participants described a way of being engaged with the patient in a continuous encounter. Within these encounters, keeping the patient informed, even about errors, was embedded in nurses' taken-for-granted human interaction. Heidegger (1962/1927) would describe these embedded actions as ready-to-hand.

The subtheme Disclosing Error as a Decision represents participants' stories involving making a decision to disclose errors to a patient. Different from an embodied practice, these participants were not committed to disclosing all errors, but instead, made a decision about disclosing errors with each event. These participants described the contextual elements when deciding to disclose errors. In the next section these subthemes will be further illuminated.

Disclosing Error through Constant Communication

Several participants described disclosing error not as an individual event, but as an ongoing narrative between the nurse and patient in which patients were kept informed

about every aspect of their care. In one story, Michele, a nurse with more than 26 years of experience, shared an example of disclosing error as a part of her routine practice of keeping patients informed. Before she discovered the error, Michele was troubleshooting to determine why the intravenous medication she was administering to the patient was infusing before the scheduled administration time. Michele had an ongoing minute-to-minute exchange with the patient as she discovered and disclosed the error. Michele found the problem as she was there with the patient. She shared, "The pump kept beeping that it was empty, but there was still a little volume in it [the IV bag]. I was busy with my other patients, so I kept running in the room and adding volume [to the pump setting]." Michele began to suspect that something was not right with the infusion, as it was infusing too rapidly. Her suspicions were confirmed when she arrived at the pharmacy for more fluids and medications. The pharmacist told her that the infusion should not be running out as quickly as it was. Michele described how her "heart just sank" when she realized something was wrong with the infusion. She returned to the patient's bedside and began troubleshooting, all the while sharing her concerns with the patient and involving the patient in the search for answers. Michele told the patient something was not right. The patient's heart began beating rapidly as a result of the excess medication being administered. Michele shared: "She was tachycardic, and I was going, 'Well that's odd. You have been doing so well.' I was trying to figure it out, you know, looking at different things to see what was wrong." Michele's repeated interaction with the patient while finding out what was wrong let the patient know an error had occurred. Finally, Michele discovered an error in the way she had programmed the pump. Michele explained to the patient that there was a problem with the infusion. She checked the pump, talked with the

patient, and discovered that she had mis-programmed the pump, causing the medication to infuse too rapidly. Michele was truthful with the patient not only after the error, but during her investigation of the error. For this participant, communicating with the patient while she investigated the error flowed naturally from the relationship they had established.

Michele's commitment to being truthful with patients can be viewed from multiple ethical perspectives. Using the perspective of *virtue ethics*, in which the nurse seeks to do those things that a "good nurse" would do, Michele's motivation for keeping the patient constantly informed about the error may have risen out of her desire to be a good nurse. Making a decision to be a "good nurse" is consistent with virtue ethics. Another interpretation is that Michele's way of constantly communicating with the patient arose from the caring relationship she had established with the patient, and represented an *ethic of care* perspective. Similarly, this caring relationship could also be interpreted as respect for the freedom of the patient to be informed about an error that occurred in care, which would represent an *ethic of freedom* ethical perspective. This approach is a feminist ethical framework that that recognizes one's own freedom and values the freedom of others. Within this framework, the nurse values the freedom of the patient to make informed decisions regarding their care. It seemed that Michele's way of disclosing error extended beyond her own interest of being "good," and extended to a deep concern for what was right within her relationship with the patient. Michele's way of being truthful with the patient supported an ethic of freedom perspective by respecting the freedom of the vulnerable patient.

Michele's commitment to disclosing error also portrayed her ability to recognize the ethical dimension of her everyday practice. It may be that Michele, as an expert nurse, had developed skillful ethical comportment from her extensive clinical experiences. Skillful ethical comportment depicts a way of relating to others with respect that embodies ethical expertise (Dreyfus H. L., Dreyfus S. E. et al., 1996). While skillful ethical comportment is developed throughout life, nursing practice fosters the development of skillful ethical comportment at another, deeper level as nurses' clinical experiences teach them to recognize the ethical dimensions of clinical situations. "The nurse must learn skillful ethical comportment that protects the vulnerable in complex clinical situations, in health promotion, and in crisis" (Dreyfus et al., pp. 263-264). When errors occur, nurses' skillful ethical comportment manifests as recognition of the appropriate way to respectfully relate to the patient by disclosing errors.

Disclosing Error through Constant Communication was also evident in another story, told by Dixie, a baccalaureate-prepared nurse with 15 years of experience. Dixie worked in a small rural hospital. Dixie told of discovering that she had hung intravenous fluids containing dextrose on a diabetic patient by mistake. As Dixie discovered the error, she said to the patient, "Oops—something is not right." She looked up at the bag of intravenous fluids and said,

> You know what? I'm sorry. I just hung the wrong bag on you. It was supposed to be this… I think you will be okay. This is the wrong bag of fluid…we caught it in time. I'm going to switch it out and check your blood sugar to make sure.

As Dixie discovered her error she communicated openly with the patient about the error and the actions she would take to correct the error. By explaining the error, apologizing,

and describing the corrective actions she would take, Dixie lessened the patient's concerns about the error. Dixie did not stop to consider whether to disclose the error; instead disclosure of the error flowed naturally out of Dixie's open and honest way of being with the patient. Dixie used the phrase "how I live" to represent her personal philosophy on being truthful as a way of living her life and responding to errors. Dixie sought to be truthful in everything, no matter what the situation; she was committed to disclosing error. Dixie said, "You can't just make the error and let it go, because they [patients] need to know, I mean it's their life…if it was me I would want to know. People make mistakes." When participants openly discussed their concerns with patients as a natural process of care, never really stopping to make a decision about whether or not to disclose, the situation was labeled disclosing error through constant communication. It seems that at some point in advance of these stories participants decided the kind of nurse they were going to be. From that point forward participants were truthful as an embodied way of being with patients, without renewing the decision to disclose error with each event.

The subtheme Disclosing Error through Constant Communication was also evident in the stories of other participants as they discussed disclosing errors to patients and families. Mike was a 25-year-old associate degree nurse, who had worked in a small rural hospital for the three years since he became an RN. Mike told about a time when he accidentally administered a vitamin injection to the wrong patient. He described being very upset when he realized his error. Mike explained that there was never a question in his mind as to whether he would tell the patient. He shared:

> I went in there to the patient and I said "I just gave you the wrong medication" and I told her what I gave her. "The doctor said it would probably help you rather than hurt you, and we'll be monitoring you for reactions."

Mike said that he recognized that disclosure may involve some risk of litigation, but he emphasized that patients should be told about errors. He shared his personal philosophy on disclosing errors to patients. He suggested that nurses,

> Be honest regardless of what the consequences are…You know, even if something were to happen, and I was in front of a judge, and I told him "yeah I was honest," I believe he would look at that a lot better than me keeping that from him and the family or patient. Always be honest. That's what I was taught, and I still believe that.

Telling the truth for Mike was an integral part of how he practiced nursing. Despite concerns about the consequences, Mike was committed to disclosing error. Because error disclosure was never a conscious decision for Mike, the situation he recalled was labeled Disclosing Error through Constant Communication.

Several participants described being truthful with patients as an essential part of their being nurses. It seemed these participants were in the habit of constantly informing patients about the context and what they were doing. For these nurses, disclosure of errors flowed out of their interactions with patients and became a part of their usual nursing care rather than something extraordinary.

It seems that for some participants, being open and honest with patients was so embodied in their practice that they did not consider disclosure as an event, but as a part of communicating with patients. For example, when Lee, a nurse with 35 years of

experience, was asked about disclosure, she said she did not usually disclose errors. As her story progressed, she described when she told a patient, "You didn't get this earlier when you were supposed to, so I need to give it to you now." Communicating openly with patients was such an embodied part of Lee's practice that she disclosed minor errors without even considering her actions. She explained:

> We just don't think of it as disclosure, because its' not some big deal. Disclosure sounds so formal, like you're going to give them a piece of paper, with all that terminology, and say "sign here."

In nursing, late medications and missed medications are considered errors. It may be that many nurses, like Lee, communicate truthfully with patients about minor errors without considering their acts disclosure.

Disclosing Error as a Decision

In other cases, participants described situations in which thoughtful decisions resulted in the disclosure of errors to patients. For these participants, the decision on whether to disclose errors was not embodied in their practice but was, instead, a decision made based on the contextual elements of the situation. For example, Gloria, a nurse in a small rural hospital for three years, did not see it as important to always disclose error. She shared a story of deciding to disclose an error to a patient with severe constipation. Gloria had been caring for the patient for three days and other measures were not relieving his constipation. On the third day, the physician gave a verbal order for neostigmine. Gloria was not familiar with the drug, and the physician was standing at the desk waiting for her to administer the medication. She felt rushed to give the medication, and did not have the written order in hand. Once she had administered the neostigmine

intravenously, the patient experienced profuse diaphoresis, tachycardia and anxiety. Gloria realized she should have given the medication intramuscularly instead of intravenously. Gloria explained, "He [the patient] thought he was going to die." When Gloria realized her error, she immediately informed the physician, who told her the effect would only last about 15 minutes. Gloria decided to tell the patient about the error. When Gloria explained the error to the patient, he was very understanding. In discussing this error, Gloria commented:

> This was the third day I had him. So we had already established a rapport. Probably, if it had been the first day I had him, he might not have been so…pleasant or understanding…But he really, I thought he did great with it, and I think it was because…he knew that I had been trying to take really good care of him the other two days. It was just the third day I had tried to hurry.

Gloria made a decision to tell the patient about the error, even though the error caused the patient considerable discomfort and anxiety. Gloria felt the relationship she had developed with the patient over the past two days positively affected his response to the error and supported her decision to disclose the error.

Nurses may fear disclosing errors because the nurse may become the focus of patient anger or litigation. The nurse may be faced with a decision to disclose error and risk angering the patient, or to conceal error and maintain the positive relationship with the patient. Previous studies have found that non-disclosure among physicians is related to fear of the repercussions of disclosure, such as litigation, loss of livelihood, and damage to their reputations (Berlinger, 2005). Nurses are also vulnerable to litigation, loss of livelihood and damage to their reputations, yet several participants shared stories

of deciding to disclose errors to patients. While the participants did not always decide to disclose errors, in some stories they did disclose. It seems that Gloria decided to disclose because she was comfortable with the relationship she had developed with the patient over the three days she cared for him. This relationship made it easier for her to disclose the error. It may be that the relationship mitigated Gloria's fears about the patient's responses to the error.

Lee also described a story in which she decided to disclose an error. Lee was a nurse with over 35 years of experience. Lee shared a story about administering an overdose of Lunesta to an elderly client to help her sleep. While the order called for 2 milligrams, Lee accidentally administered 6 milligrams of the medicine. Lee described being very upset about this error. Lee explained that "she was a patient that I was particularly drawn to." When Lee discovered her error several hours later, she made the decision to tell the patient about the error. She woke the patient and told her about the mistaken dose. The elderly woman replied, "That's all right honey, I slept good!" Later, when the patient was fully awake, Lee spoke with her again about the error, to ensure the patient understood. Once again, the patient reassured her it was okay. When asked about her decision to disclose this error, compared to other errors she had not disclosed, Lee talked about the rapport she had developed with the patient. The caring relationship Lee had established with this patient made Lee more comfortable with disclosing the error. Other participants also shared how a good relationship with patients made communicating errors much easier. One participant said, "If you can get a rapport going with the family and patient, then it's a lot easier to tell them about things that happen."

Another participant described how her relationship with the patient can help make the decision to disclose error.

> If they're friendly with me, and we have a good working relationship, and you talk back and to, it's easier. But if it's someone that's very quiet, maybe angry to start with, or ill, mad about being there, it would be more difficult.

Lee felt that her positive relationship with the patient supported her decision to disclose the error. Several participants expressed similar beliefs about the importance of having a good relationship with the patient in order to be able to disclose error.

In contrast, perceived negative relationships with patients and families seemed to make it more difficult for nurses to engage in disclosure conversations. Participants expressed concerns about family members who were trying to find fault or were constantly complaining. One participant expressed frustration in dealing with patients who were angry about "something" even before an error occurred in their care. The participant explained, "It is very hard to please these patients, and hard to talk to them about error." Both Lee and this participant indicated that the relationship between the nurse and patient influenced their decision to disclose. It seemed when nurses had already established open communication with the patient through a caring, trusting relationship, the decision to disclose errors was easier.

Some participants said they were less likely to disclose error to patients they perceived as difficult. Gloria shared:

> I would probably be more apt not to tell somebody that was a belligerent patient, that I had made a mistake, or that I had an oversight, or not given a medication on time…than a patient who is thankful that you're taking care of them, or who

> appreciates whatever you did for them, but those who just are constantly whining, and complaining, and just fussing about everything you do, I'd probably come down the side of telling that patient nothing, you know, versus the patient who is thankful for what you do for them.

When patients and families were perceived as critical of their care, the decision to disclose errors was harder. It seemed that nurses felt more fearful telling patients about error if they felt the patients would respond negatively. From a feminist perspective, a salient feature of participant's stories is the power differential between the patient and the nurse, in which the nurse has control of the decision over whether to disclose errors to the patient or not. Because nurses have access to error information that patients do not have, they are faced with a choice on whether to reveal the error to the patient. If nurses feel threatened by disclosing error to a patient that is critical of their care, they may be less likely to disclose an error.

In this section, the theme Disclosing Error resonated in participants' stories of being truthful with patients. The subtheme Disclosing Error through Constant Communication described the experiences of some participants who shared stories of communicating errors to patients in which disclosure seemed embodied within the nursing care they provided. It seemed that for these participants, communicating openly with patients about errors represented their enactment of routine nursing care and skillful ethical comportment. Virtue ethics, an ethic of care, and an ethic of freedom approaches were examined as interpretations of the underlying structures that supported nurses' ways of being truthful.

For other participants, the subtheme Disclosing Error as a Decision was reflected as participants carefully considered whether to disclose error. In these stories, relationships were often formed before errors occurred, and these relationships formed the context in which decisions regarding disclosure were made. The presence of a trusting relationship with patients seemed to support nurses' decisions to disclose errors to patients. Conversely, if patients were perceived as critical of their care, disclosure was described as more difficult.

Theme: Perceiving Expectations for Disclosure

The theme Perceiving Expectations for Disclosure emerged from participants' stories describing the culture, policies, and practices surrounding disclosure in their work environments. Organizational culture represents the "values and practices shared across all groups in an organization" (Truskie, 1999). Through perceptions of the organizational and unit cultures for disclosure, nurses form their embedded understandings of organizational expectations. In participants' stories, organizational expectations regarding disclosure were communicated both implicitly and explicitly from administrators, managers, nurse peers and physician peers. Expectations were communicated at times through formal policies but more often through implicit means within the organizational culture. Descriptions of support for disclosure varied from organization to organization, and even from participant to participant within those organizations. Some participants described how some organizations had policies that explicitly supported disclosure, while other participants described organizations whose lack of policies and lack of disclosure practices implicitly discouraged nurses from disclosing errors. Perceptions of organizational support for disclosure seemed to be unique to the individual, in that

participants employed in the same organization expressed very different perceptions of administrative support for disclosure. It may be that people interpret situations differently, and also that subgroups within the organization may actually have different expectations for disclosure.

For example, Robin expressed a lack of organizational support for disclosure: "Telling patients about errors? Oh, no. Oh, no. They [hospital administration] will not disclose that, they would like you to write it down, and it's done discreetly." However, Dixie had worked for the same organization as Robin for many years and perceived the organization as very patient-centered and supportive of disclosing error. People interpret situations based on their past experiences, so perceptions regarding disclosure can be very different among individuals in an organization.

From participants' descriptions of organizational expectations surrounding disclosure, two subthemes were identified. Subthemes include: (1) cultures of openness and honesty; and (2) cultures of secrecy. The subtheme Cultures of Openness and Honesty represents participants' descriptions of organizations and units that supported openly communicating with patients and their families about all aspects of care, including errors. The subtheme Cultures of Secrecy represents participants' descriptions of organizational and unit cultures in which participants perceived they were expected to withhold information about errors from patients and their families. In the next section each of these subthemes will be described in more detail.

Cultures of Openness and Honesty

The first subtheme was labeled Cultures of Openness and Honesty because it represents participants' descriptions of organizational and unit cultures that they felt

supported openness and honesty in disclosing errors to patients. Nurses' ability to practice ethically is closely tied to the presence of an ethical work environment (Storch, et al., 2002). Several participants shared their perceptions of support for disclosure from administrators, physicians, nurse managers and peer nurses.

Some participants described policies in their organizations that explicitly supported disclosure. While some organizations had written policies for disclosure, other organizations either did not have policies addressing disclosure, or the participants were not familiar with the policies. Three of the seventeen participants knew of policies in their organizations that specifically addressed disclosing errors to patients. Participants described these policies as supportive of disclosure. One of these participants worked in a small rural hospital, while the other two participants worked for a federal healthcare system.

Elise was a 35 year old nurse with over 11 years of experience. Elise had worked in a small rural hospital for several years. According to Elise, this rural hospital had a policy supporting disclosure. Elise described the disclosure requirements:

> At first we notify the physician, and with the policy, on the report form it asks "was the patient informed?" and "was the physician notified?" and you have to check "yes." You have to put the time and the response to it [disclosure].

The policy required nurses to disclose and check "yes" on the form. By making the requirements for disclosure explicit through a formal policy and inclusion on the error reporting form, this small rural hospital demonstrated a culture of openness and honesty.

Similarly, Melissa also discussed policies in her organization that reflected a culture of support for disclosure. Melissa had worked for a federal healthcare system for

most of her 13 year career as an RN. Melissa said the regulations of the federal healthcare system required reporting and disclosure of all errors. Melissa shared one story of error in which a patient mistakenly received 65 units of regular insulin instead of a slower-acting insulin that was ordered. In the federal healthcare system, while nurses initiated the incident report, physicians were required to disclose the error to the patient and complete a portion of the incident report. In this federal healthcare system in which Melissa worked, physicians were employees, as were nurses, and both were required to follow institutional regulations or face disciplinary action. These regulations mandated reporting of error and disclosure of error to patients. Once nurses initiated error reports, physician documentation of disclosure to the patient was monitored. Melissa said: "The doctor had to go in and talk to the patient, because we had to start IV fluids. We had to start D50. The [patient's] blood sugar was dropping." If physicians did not document disclosure, the quality review department would follow-up on the physician's noncompliance with the disclosure policy. By providing mechanisms to support disclosure that included regulations and follow-up by the quality review department, nurses were able to ensure that errors were disclosed to patients. In most settings, nurses do not have the ability to ensure disclosure occurs when physicians choose not to disclose. This is because in most health care organizations, physicians are not employed by the hospital, but instead use the services of the hospital to care for their patients. Hospitals rely on physicians to admit patients to the hospital and use the hospital services. The physician is seen as a customer of the hospital, while the nurse is an employee of the hospital. Therefore, not only does the physician possess expert power as the physician, but the physician-as-customer relationship further enhances the physician's power within the organization. Thus, if a

nurse were to disclose an error, or report a physician who failed to disclose error, the nurse may risk angering the physician and the hospital administration. In the federal health care system, the culture of openness and honesty was clearly communicated through policy, providing a mechanism for nurses to ensure that errors were disclosed to patients.

Few of the facilities where participants worked had written policies specifically supporting the disclosure of errors. While only three participants knew of clear administrative policies supporting disclosure, the remaining fourteen participants reported that either (a) their organizations did not have a disclosure policy, or, (b) they did not know if their organizations had a disclosure policy.

Even in the absence of a policy requiring the disclosure of errors to patients, several participants described organizational cultures that were supportive of disclosing errors. For example, Mike felt that managers, physicians, and administrators in the small, rural hospital where he worked were supportive of nurses' disclosing errors to patients. He used the phrase "we take it as a team" to describe the support of his peers when errors occurred. While not all participants felt organizational support for disclosure, many described their nurse managers as supportive of error disclosure. Gloria shared:

> I think they [managers] would be fine with it…I think they would support us…if you made a medication error, and we [nurses] went to the patient and told them. I think they would not have a problem with that.

Gloria perceived that the manager where she worked would be supportive of her disclosing an error to a patient. Another participant agreed, emphasizing that her manager

would be supportive if she disclosed her own errors, but not those of others, such as nurse and physician peers.

Dixie was an experienced nurse who was committed to disclosing errors (see Disclosing error theme). Dixie told of how, as a charge nurse on a unit in a small, rural hospital, she sought to communicate a culture of openness and honesty that supported the disclosure of errors to patients. When nurses would tell her about an error they made, she would encourage the nurse to disclose the error to the patient. She told one nurse: "It's going to be better if it came from you, and you let them know, 'this is what I've done to fix this problem.'" Dixie emphasized the importance of supporting nurses who were new to disclosing error. For example, she would offer to go to the patient's room with the nurse when the nurse went to disclose the error. Dixie's practice of teaching and supporting disclosure encouraged disclosure among other nurses and portrayed a unit culture that supported disclosure.

In this section, participants described their perceptions of cultures of openness and honesty that supported the disclosure of errors to patients. While some organizations had explicit policies detailing actions to support disclosure, other organizations showed more implicit support for disclosure through the organizational culture. Several participants felt their managers would be supportive if they disclosed their own errors. One participant described her efforts to communicate a culture of openness and honesty to nurses new to the organization.

Cultures of Secrecy

The second subtheme was Cultures of Secrecy, which represents nurses' perceptions of organizational cultures that seek to keep errors hidden. The subtheme

Cultures of Secrecy was used when nurses described their perceptions of organizational expectations to conceal information about errors from patients. When describing their perceptions of a culture of secrecy, participants described serious errors that they felt should have been disclosed but were not. Participants described organizational and unit cultures that they felt limited their ability to ensure errors were disclosed to patients.

For example, Zoey, who had been a nurse for over 15 years, shared an error that she felt had never been disclosed because the organizational culture did not support disclosure. Zoey told a story of caring for a patient with an anoxic brain injury from an error that occurred on another unit. The patient was transferred to the unit where Zoey worked. She said, "I had some strong feelings about it [disclosure]. I thought that the doctor should have told them what happened." From her interactions with the family, she believed the error had never been disclosed. In describing the organizational culture surrounding the disclosure of errors, Zoey said, "The culture dictates I shouldn't say anything, just take care of the patient from that point on, for the best outcome that could come out of that." She continued, "Well, that is one part that really confuses me, because I don't know what legally we are allowed to say to patients." Zoey felt frustrated because her perception of the culture was that disclosure to patients was not supported. She felt that the physician should disclose the error and was uncomfortable when he failed to do so. She explained how nurses in the organization are taught to follow policies for reporting errors through the proper channels. When errors occur, the error reporting policy requires that the nurse assess the patient, notify the doctor and complete the occurrence report. Disclosure to the patient or family was not mentioned in the error policy. Zoey felt it was important to follow the policy "so that the lawyers would be

prepared for what might happen." In the absence of a policy specifically supporting the disclosure of errors, Zoey questioned what she could legally do to ensure disclosure occurred. Zoey related,

> We as nurses sit around and talk about situations that are bothering us, and I think we all feel pretty much the same way—that we don't have the right to go in and tell the patient what we think happened, because, you know, the legal perspective of it or a threat to what might happen to us if they [administration] find out we told them.

When asked what she thought would happen if nurses were to disclose the error, Zoey said, "I think my job would be in jeopardy." She discussed an employee ethics hotline that was available to report ethical concerns, but Zoey did not believe this hotline would address the issue of non-disclosure. It may be that Zoey did not trust the hospital reporting system or believe that the system would address her concerns. Nurses may distrust hospital ethics reporting systems or see them as unlikely to resolve their ethical concerns (Attree, 2007; Storch et al., 2002.).

Zoey felt powerless to ensure that this serious error would be disclosed to the family. Zoey said that she would like for risk management to investigate and disclose the error to the family and in some way compensate the family for the error. She related,

> I think it would benefit the nurse to know that it was followed through on, and that our hospital was an upright organization that was willing to put the patients first, and, so we would trust the organization more.

Zoey felt that nurses' confidence in the integrity of the organization would be supported by the disclosure of harmful errors to patient and families. However, Zoey believed that

the organization's administration would not disclose the error to the family because she perceived that the culture of the organization did not support disclosure. Zoey felt her choices for action were limited, and that she could lose her job if she were to disclose the error.

When nurses perceive that the organizational and unit culture is not supportive of disclosing errors to patients, they may feel powerless to ensure errors are disclosed as called for in the Code for Nurses (American Nurses' Association, 2001). Because nurses' worlds consist of a shared culture of societal norms, professional and gender expectations, and formal and informal power structures, these influences circumscribe nurses' self-interpretations of their possibilities for action when errors occur. Heidegger (1996/1927) refers to this shared culture as *throwness*. Within this throwness, nurses perceive their possibilities for action. Zoey felt limited in her possibilities for action because of her perception of a culture of secrecy in the organization that did not support disclosure of errors to patients.

In addition, another aspect of this story involves Zoey's description of nurses sitting around at the nurses' desk and discussing the need for disclosure; however, none of the nurses took action to bring about disclosure of the error. It could be that when nurses share their disclosure concerns with other nurses, they validate their own perception that, as nurses, they are unable to do anything to rectify the situation. In Zoey's scenario of the nurses sitting around talking about their concerns with serious non-disclosed errors, it seems the nurses see themselves as helpless and powerless to act. Bell (1993) discusses the problems when women bond together out of their helplessness because, according to Bell Hooks (1984), this bond perpetuates women's view of

themselves as victims. When nurses view themselves as victims, the choices they have to act in cases of moral concern, such as non-disclosure of errors, are obscured. Another problem when women view themselves as helpless is that helplessness encourages silence, or a fear of speaking out (Bell, 1993). Nurses who feel helpless are less apt to speak out on behalf of the patient to ensure that disclosure of errors occurs, thus the culture of secrecy is perpetuated.

Power structures that exist in the hierarchical organization may limit nurses' willingness to raise concerns over non-disclosure. One study identified a fear of repercussions and a belief that nothing would be done as reasons nurses did not voice concerns (Attree, 2007). When nurses do raise concerns, power structures and gendered beliefs within the organization may limit nurses effectiveness in bringing about change (Ceci, 2004). Ceci examined issues of gender in the case of twelve pediatric deaths in 1994 after cardiac surgery at the Winnipeg Health Sciences Center in Manitoba, Canada. When nurses reported their concerns about one surgeon's competence to hospital administration, the nurses were not taken seriously. Administrators believed the nurses to be emotional over children's' deaths, and used terms such as "upset" to dismiss nurses' concerns about one surgeon, even when nurses' claims were supported by evidence. Similarly, embedded beliefs about gender may limit nurses' effectiveness in raising concerns about undisclosed errors. In this study, some participants were hesitant to raise concerns about disclosing errors to patients when administrators and physicians chose not to disclose. Amid gender and social constraints, it may be that nurses felt powerless to speak out against administrators and physicians.

A culture of secrecy was also apparent in a story Noah shared. Noah had been working on the same unit for the five-years since she completed her baccalaureate degree in nursing. She explained how she perceived a lack of support for disclosure. Noah felt the perception of secrecy prevented disclosure to the family of a patient who was seriously harmed by an error. Noah was caring for a patient who had an appendectomy, and received a pathology report that indicated that fatty tissue, not the appendix, had been removed during surgery. Noah showed courage by bringing the report to the physician's attention, even when she knew that the pathology department would have already contacted the physician directly. Noah expected the physician to tell the patient's family about the error and return to surgery with the patient to remove the appendix. However, the physician did not address the report, disclose the error, or return to surgery with the patient. The patient died a few days later. While the patient suffered from many other physical problems, Noah felt the failure to remove the appendix contributed to the patient's death. She felt strongly that the harmful error should be disclosed to the family. When asked about disclosure of the error, Noah replied: "Well… there's really not a policy, that requires that you tell them that something like that [an error] has happened." When the physician chose not to disclose the error, and in the absence of a hospital policy requiring disclosure, Noah felt that disclosure was not supported by the organizational culture. Noah felt powerless to advocate on behalf of the patient when the physician would not disclose the error. When asked about the nurses' responsibility in this situation, Noah replied, "to notify the doctor of the pathology report." She felt that the nurses' responsibility ended with his/her report to the physician. Noah did not consider it a nursing responsibility to ensure that disclosure occurred. She reasoned that

administration would hear of the error when the pathologist reported his findings through the quality monitoring program. She said, “As far as I know that’s as far as it ever went.” Noah felt that even though the hospital might later investigate the error, the error would not be disclosed to the family in this culture of secrecy.

In Zoey and Noah’s stories, nurses felt limited in their choices for action. Nurses described feeling caught in the middle between patients and families who need to know about errors, and organizations that do not support disclosure. Participants felt that organizations expect nurses to follow institutional policies, but often the error policies did not address error disclosure. Disclosure may occur after the patient leaves the unit. Nurses would likely not know about these disclosures. However, the lack of feedback to nurses when serious errors occur promulgates the nurses’ perceptions of a culture of secrecy and seems to create the idea that the nurse could lose his/her job if they chose to disclose. In addition, this secrecy damages nurses’ confidence in the integrity of the organization. Based on the information available to Zoey and Noah, a culture of secrecy prevailed in these organizations.

In the subtheme Cultures of Secrecy, participants shared stories in which they felt that organizational and unit cultures did not support disclosure of errors to patients. When nurses were unclear about the organizational policy for disclosing errors they often perceived that they should withhold information from the patient and family. Nurses shared stories of serious errors that were not disclosed. These nurses felt powerless to ensure that errors were disclosed.

In this section, the theme *Perceiving Expectations for Disclosure* represents nurses’ perceptions of the expectations for disclosing errors to patients within their

respective organizations. While some participants reported both implicit and explicit organizational support for disclosure, other participants shared stories of specifically withholding information from patients and families. While participants shared a limited number of serious errors, in these cases, nurses believed these errors were never disclosed to patients and families. When serious errors were not disclosed by physicians, hospital administrators or risk managers, nurses often felt powerless to ensure that the errors would be disclosed.

Theme: Not Disclosing Error

The theme Not Disclosing Error represents participants' stories of concealing errors. Participants' stories often involved situations where participants felt either administration or physicians were responsible for disclosing errors, yet the errors were not disclosed. In other situations participants shared contextual elements that may have influenced the concealment of errors. For the theme Not Disclosing Error, the subthemes include: (1) disclosing events but not errors; and (2) overtly concealing errors.

Disclosing Events but Not Errors

One way errors were concealed was by telling patients about events, but not identifying these events as errors. Participants described conversations between providers and patients or families in which terms were used which served to conceal instead of disclose the error. For example, Susan, a nurse with 16 years of experience, chose to conceal an error. Susan found that the nurses on the previous two shifts had overlooked an order for an intravenous line. She chose to conceal the error by starting the patient's intravenous line without revealing that the order was missed. Susan was working night shift when she discovered the error. Susan woke the patient in the middle of the night to

start the intravenous line. Instead of disclosing the missed order to the patient, she said: "it's time to start your IV." While the patient may have wondered why the intravenous line was started in the middle of the night, he was not told the intravenous line was delayed because of error. The patient was told about the event, starting the intravenous line, but not the error, in which the order for the intravenous line was missed for two shifts. Similarly, several other participants described conversations with patients about errors in which terms such as "complication" and "adverse effect" were used to disclose events but not errors. Gloria shared a story of an error that was disclosed to the patient as an event. Gloria had been a nurse for three years on a medical-surgical area of a small rural hospital. She described an error made by a coworker on an elderly patient, in which a potassium infusion was administered too rapidly, causing damage to the blood vessel and infiltration to the surrounding tissue. The potassium infusion caused extensive tissue damage. Gloria stated, "It was a bolus of potassium, and it went in too fast…it should have been at a slower rate." Gloria felt that the infusion infiltrated because it mistakenly infused too rapidly. However, the physician explained the problem to the patient as an event instead of an error, saying "the intravenous site infiltrated," without revealing the infusion error. In this example of error concealment, because the patient did not understand that the infiltration of the intravenous site was related to the infusion of the potassium too fast, the error was concealed.

When information is given to patients about events but error is not revealed, disclosure of the error has not occurred. Without knowledge of the error, the patient does not have the information needed to make informed health care decisions, further endangering them. Disclosing events but not errors becomes a routine way of

communicating with patients about errors for some caregivers. Berlinger and Wu (2005) describe how medical students learn to use the language of concealment through using terms such as "unexpected outcomes" and "complication." As caregivers begin framing reality using these terms, they may perceive that errors are no longer errors, and concealment of errors is no longer lying. It is possible that this failed attempt at disclosure convinces caregivers that they have been honest with patients, allowing those caregivers to maintain their self-images as good nurses and good physicians.

Overtly Concealing Errors

Other participants described overtly concealing errors. With overt concealment, no attempt was made to disclose events or errors to the patient. Several nurses described stories of hiding errors that were not harmful, while other nurses reported hiding more serious errors. Overt concealment was also seen when nurses felt someone else was responsible for disclosure of the error.

Noah shared a story of overt concealment. Noah had worked in an organization for five years and felt the organization was not supportive of disclosure. When a coworker accidentally over-sedated a patient with a Versed infusion, Noah and her coworker did not report the error or disclose the error to the family. Noah described the error as not harmful, because the patient was on a ventilator and a vasopressor infusion to maintain her blood pressure. The nurses continued to monitor the patient, adjusting the vasopressor infusion rate to ensure the patient maintained an adequate blood pressure after the error.

One interpretation of why nurses concealed this error may be that the culture of secrecy defined the organizational expectations for the nurses' behavior, encouraging

nurses to withhold information and hide the error from the family. If nurses sense that organizational expectations support concealment, they may fear repercussions from the organization if they fail to comply with these perceived expectations. The power of the organization to expect obedience on the part of employees is a characteristic of hierarchical organizations. Milgram (1974) demonstrated the power of authority in soliciting obedience in his research. Milgram's studies found that participants followed the "orders" of those in authority 65% of the time, even when the experiment involved inflicting harm on the subjects by delivering increasingly strong electric shocks. By unquestionably yielding to the authority of the organization, obedient employees seem to surrender their responsibility for ethical action to the organization. In this study, some errors were overtly concealed because nurses believed that disclosure was not permitted by the organization and they would risk being fired or retaliated against. Obedience to the perceived culture of the organization often meant that errors were concealed.

Several participants shared examples of overt concealment of non-harmful errors. Of 12 stories of non-harmful errors, 6 were disclosed and 6 were not disclosed. One of these non-disclosed errors was shared by Macenzie, who was a 29-year-old nurse who had worked in the same small rural hospital since she graduated from an associate degree nursing program seven years ago. Macenzie shared a story of overtly concealing an error because she felt that disclosing errors that were not harmful was not necessary. She told of drawing up normal saline flush solution in two syringes, and morphine sulfate in a third syringe. She intended to flush the intravenous line with normal saline, administer the morphine sulfate, followed by the second normal saline so that the morphine sulfate would not mix with the drug that was constantly infusing. She shared:

> I was going to flush [the IV line] and then give my medicine, and then flush again, like usual. I didn't have my syringes labeled, and I got them mixed up. I didn't know it at the time, but I went to flush and it was the medicine. And the line turned white, and I really was upset because I realized I had made an error.

After injecting one of the syringes, Macenzie realized she had made an error and injected the wrong syringe first. While Macenzie meant to inject the flush solution first, she realized she had rapidly injected the morphine. She then flushed the line with the remaining syringes of saline. Macenzie chose not to disclose the error to the patient, reasoning that the patient was not harmed by the error and therefore did not need to know. She described being very upset about the error, and how two of her coworkers had provided support for Macenzie when she was upset. When asked about her concerns in revealing errors to patients, she stated:

> I'm sure that [disclosure] would just increase their anxiety level of being in the hospital. Here you have a nurse that has told you she has made a mistake and now, you know, the rest of their [patient's] hospitalization they're going to be in there, having an anxiety attack, because they're afraid another nurse might do something to them, to harm them.

Macenzie overtly concealed this error because she felt that the patient would worry unnecessarily if the error was disclosed. While Macenzie did not share any stories in which patients were harmed, she said she would be more likely to disclose harmful errors. She felt that administration in her facility would be supportive if she disclosed harmful errors. "If there was an error that occurred and the patient was harmed, I feel like, we [nurses and administration] would probably tell the patient, be upfront with

them." While Macenzie felt that administration would be supportive of disclosing harmful errors, she also felt that if she disclosed errors that were not harmful, administration would question why she disclosed the error. Macenzie overtly concealed the error because she felt it was not necessary to disclose errors that did not harm the patient.

Similarly, Lilly discussed a non-harmful error she chose to conceal. A patient's heparin drip ran at a higher rate than prescribed for two hours. Lilly explained that she did not disclose the error to the patient because the patient was elderly and the family was not present. She stated, "I did not…find them and tell them." She explained:

> It is difficult to admit your error, because it's embarrassing, and you want to apologize time and time again and you need to have some good answers when they ask the questions, and honest answers…Like they could request you not be their nurse anymore. That's their right… and then you feel like they may talk about you.

Lilly's concerns were that the error would embarrass her as a nurse. She felt disclosure would make it more difficult to care for the patient. Initially, when describing the situation, Lilly justified concealing the error because there was not any harm to the patient. After discussing the situation in the interview, Lilly commented that, in retrospect, she felt that telling the family about the error would have been the right thing to do. It seems that at the time of the error, Lilly did not consider the ethical dimensions of not disclosing the error. When Lilly later reflected on the error and her actions, she regretted not disclosing the error. This entire situation suggests that Lilly learned about her practice by reflecting back on the situation. It may be that if Lilly were to make

subsequent errors, she may be more likely to disclose the errors to the patient and family. Experiences of reflecting and learning from one's past decisions may have important implications for the development of interventions to support disclosure. These implications will be discussed in the next chapter.

Some participants described concealing errors they felt should have been disclosed by peers, managers or physicians. For example, Mike felt errors should be disclosed by the person who made the error. Mike told of an error he discovered when caring for a patient diagnosed with a possible myocardial infarction. The patient was receiving a smaller dose of heparin than the protocol indicated. Mike remembered:

> When I came in, this person had a questionable MI as the diagnosis. The heparin drip was set to 2 milliliters an hour, and there was something just kind of fishy about that. And the nurse was giving me report, and she said "Well, the PTT was this and that so I figured I'd just start it at two milliliters an hour."

Mike explained that according to the hospital protocol, the heparin infusion should have been started at 10 milliliters an hour. Mike corrected the error, completed the occurrence report, and reviewed the protocol with the nurse who made the error. When asked if he disclosed the error to the patient, he stated:

> I don't think so. I'll be honest with you in that I don't think so. That was a med error that I found that I corrected. Of course it wasn't up to me. I didn't want to be held liable. I just wanted to document that the corrections were made.

Even though Mike expressed a strong personal commitment to disclosing his own errors to patients (see Disclosing Error theme), he did not disclose this error made by another nurse. He went on to explain: "I'd rather that nurse who really committed the error fess up

to it." Because the error had been made by another nurse, Mike did not feel it was his place to disclose the error to the patient. In contrast, Mike shared another error in which a medication infused at an inaccurate rate for two hours before he discovered that the rate had been set wrong, again the error was made by the nurse on a previous shift. The medication was infusing too rapidly. Mike took responsibility for the error because the incorrect dosage continued into his shift. Thus he felt he shared the responsibility for making the error and disclosing to the patient. Mike told the patient "he was getting a lot more [medication] than he was supposed to." Several participants echoed Mike's belief that errors should be disclosed by the person who made the error. When the persons who made the error did not disclose, other nurses did not feel that they should disclose. Thus the error was concealed from the patient.

Sheryl also shared a story of an error that was concealed. Sheryl had worked in a post-surgical cardiac unit for most of her 16 years as an RN. She shared an example in which she felt the physician was responsible for disclosure. Sheryl used the phrase "not my place" to describe her role in disclosing error when caring for a patient post-operatively who had obviously experienced an error while in surgery. Although Sheryl felt the family should be told about the surgical error, the physician told the family that a complication (not error) had occurred in surgery. Since Sheryl was not present during the surgery, she felt it was not her place to disclose the error, but she was sure that an error had occurred. Although Sheryl believed an error occurred, the error was overtly concealed because the physician, who was present during the surgery, did not disclose the error.

Nurses' hesitation to disclose errors made by physicians may reflect perceptions of role expectations and professional boundaries. In a study on surgical error reporting and disclosure, authors identified scope of practice boundaries that influenced reporting practices (Espin et al., 2006). While nurses indicated they would report errors within the nursing domain, such as sponge counts, nurses felt errors by physicians and anesthetists should be documented and reported by those professionals. Perhaps the disclosure of errors is similarly influenced by scope of practice boundaries. Nurses may be more likely to disclose errors made by nurses versus those made by physicians. Also, when errors were serious, participants felt that errors should be disclosed by physicians, managers or risk managers. Elise discussed serious errors:

> I think the doctors are very supportive of their patients being informed of what is going on. If it is something that was very major, they would just prefer to go along with administration and find out exactly what happened, before you go in and divulge any of the information.

While Elise perceived support for disclosure, she made a distinction about reporting a serious error. She felt that for errors that caused serious harm or death, both physicians and administration would prefer that disclosure be done by a physician, manager, or risk manager. Similarly, other nurse participants stated they felt serious errors should be disclosed by a physician, manager, or risk manager. It seemed that many participants were comfortable with disclosing their own errors that resulted in no harm or minimal harm. However, when errors were more serious, participants described a need for disclosure by those with the responsibility to disclose serious errors, such as physicians, managers or risk managers. Participants relinquished responsibility for disclosure to

others, expressing a concern for thoroughness and the need for a more formal disclosure process as reasons for preferring that disclosure be done by managers or physicians. It may be that nurses did not feel they had the authority to disclose errors. However, often these serious errors were concealed when physicians, managers or risk mangers did not disclose the errors to patients. When nurses took no action, errors were concealed.

At times errors were overtly concealed when physicians indicated reporting and/or disclosure of the errors was not necessary. In these cases, when nurses asked about reporting/disclosing, physicians indicated reporting and disclosure were not necessary. For example, Elise shared a story in which another nurse administered 50 units of regular insulin to an elderly patient, instead of the 50 units of NPH insulin that were prescribed. When the nurse reported the error to the physician, the physician prescribed glucose and frequent glucose monitoring. When the physician found out that neither nurse had written up the error, the physician said, “Don’t worry about it.” The nurse reported that she felt the physician had indicated that reporting and disclosure were not necessary, thus the error was concealed. As a result, an occurrence report was not filed and disclosure to the patient and family did not occur.

Melissa also shared a story of an error that was overtly concealed. In this error, an order for magnesium sulfate was missed. When the error was discovered the next day, the physician wrote an order to cancel the previous order for the magnesium sulfate. The error was not reported or disclosed to the patient. The participant justified the cover-up of this error as an attempt to avoid the extensive and time-consuming paperwork of reporting and follow-up required by the organization. Participants employed in diverse hospitals shared similar experiences, in which the word from the physician made it okay

to overlook hospital reporting requirements, and disclosure to patients. One interpretation is that physicians were suggesting that the errors were not serious enough to warrant reporting or disclosing. Another interpretation is that nurses feel that informing the physician somehow satisfied the reporting requirements. A third interpretation is that the physicians are perceived as having the authoritative power to absolve nurses of the need to report and disclose error. This practice of concealing error from the organization circumvents the hospitals' error reporting process which is designed to identify and correct the causes of error.

In this section, the theme Not Disclosing Error represents participants' stories in which errors concealed from patients or their families. The reasons for non-disclosure of errors are multiple and complex. In some cases, patients and families were told about events without explaining that an error had occurred. Several participants described concealing non-harmful errors because they did not believe it was necessary. Other participants indicated errors causing minor harm should be disclosed by the physician or the person who made the error, while the responsibility for the disclosure of serious errors belonged to someone with more authority. The relationships within the organization were explored as contextual to decisions to conceal errors.

Summary

Seventeen nurses employed in hospitals in a southeastern state in the United States were interviewed about their experiences with the disclosure or non-disclosure of errors to patients. Three themes were identified: (a) disclosing error; (b) perceiving expectations for disclosure; and (c) not disclosing error.

The first theme, Disclosing Error, included the sub-themes: (a) Disclosing Error through Constant Communication; and (b) Disclosing Error as a Decision. Disclosing Error through Constant Communication represented nurses' embodiment of ethical expertise, as participants described keeping patients continually informed about all aspects of their care, including errors. Disclosing Error as a Decision emerged as participants described disclosing some but not all errors. For these participants, decisions about disclosure were contextual, with the relationship between the patient and nurse comprising a salient contextual factor in these decisions.

The second theme, Perceiving Expectations for Disclosure, describes nurses' organizational environments in which administrators, managers, physicians and peers communicate implicit and explicit expectations for disclosure. Two subthemes were identified: (a) cultures of openness and honesty; and (b) cultures of secrecy. Perceptions of organizational culture surrounding disclosure were unique to the individual, with nurses in the same organization describing very different perceptions of support for disclosure.

The third theme, Not Disclosing Error, represents stories of concealed errors. The subtheme, Disclosing Events but Not Errors, involved the use of terms such as "complication" to describe events and avoid conveying when errors had occurred. Another subtheme, Overtly Concealing Errors, occurred when patients were not told about events or errors. Several participants told of concealing non-harmful errors. Participants also described overt concealment when nurse participants felt that someone with more authority should disclose the error. Serious errors were felt to be the responsibility of physicians, managers or risk managers to disclose.

Participants' stories exemplified the complex nature of nurses' roles in the disclosure of errors to patients. While nurses are present with patients twenty-four hours a day in acute care facilities, often organizational policies fail to address nurses' responsibilities for communicating with patients after errors occur. In the next chapter the research questions and implications of these findings for nursing practice, administration, education, and research will be discussed.

CHAPTER V

DISCUSSION AND RECOMMENDATIONS

The purpose of this study was to gain an understanding of nurse perceptions of error disclosure to patients. Seventeen nurses were interviewed about their experiences with disclosure, or non-disclosure, of errors to patients. Participants were asked to tell a story about a patient care error. Further prompts were used to elucidate the details of each story to include whether the errors were disclosed to the patient. After transcription, the texts were analyzed using a Heideggerian hermeneutic phenomenological and feminist perspective. Three themes were identified, to include: (a) disclosing error; (b) perceiving expectations for disclosure; and (c) not disclosing error. This chapter will include three main sections. The first section includes a discussion of the research questions and the answers to those questions derived from the data. The second section will contain recommendations for three areas of nursing, practice, education and future research. A discussion of the strengths and limitations of the study will comprise the final section.

Research Questions and Answers

While the research questions guided the initial exploration into the topic, the data obtained from the rich, descriptive stories of the participants provided insight into nurses' experiences with error disclosure that extended far beyond the research questions. The research questions for this study were: (a) What are nurses' experiences with disclosure or non-disclosure of errors to patients? (b) How do nurses describe their ethical

responsibility for the disclosure of errors to patients? (c) How do nurses describe the ethical responsibility of other providers in the disclosure of errors to patients? and (d) How do nurses describe the contextual factors when errors are disclosed or not-disclosed? In the following section the questions are identified and answers found in the data will be described.

Question One: What are nurses' experiences with disclosure or non-disclosure of errors to patients?

The seventeen participants shared 41 specific stories of errors. Eighteen of these errors were made by the participants, while 23 of these errors were made by others. Participants shared stories of both disclosure and non-disclosure of errors. While some of these errors were serious, most errors either caused no harm or transient harm to patients. An example of an error resulting in, "no harm" was an intravenous order that was delayed. An example of an error that caused transient harm to the patient was when neostigmine was given intravenous instead intramuscularly, resulting in ten minutes of extreme discomfort and anxiety for the patient. Serious errors included permanent harm such as brain damage. Nurses' experiences were represented by the themes of Disclosing Error, Perceiving Expectations for Disclosure, and Not Disclosing Error. In this section each of these themes will be discussed.

The first theme, Disclosing Error, represents nurses' experiences with revealing error and contains two subthemes, that of Disclosing Error through Constant Communication, and Disclosing Error as a Decision. The first subtheme, Disclosing Error through Constant Communication, represented nurses' embedded practice of keeping patients continually informed about all aspects of their care, including errors. Instead of

making a decision with each event, these nurses practiced in a way that kept patients constantly informed about the care the nurse was providing. As a result, these nurses never had to decide to be open and honest about errors. The patients knew that "something was not right" when the nurse discovered it. They knew that the nurse was diligently trying to protect them and find out what was going on as the nurse discovered that an error had occurred. The second subtheme, Disclosing Error as a Decision, emerged as participants described disclosing some but not all errors. Participants described contextual factors that either made disclosure easier or more difficult. In the presence of a trusting relationship, participants indicated the decision to disclose was easier. When patients were seen as critical of their care, disclosure was less likely. From a feminist perspective, the power differential in the nurse/patient relationship formed a salient feature of nurses' decisions to disclose. Nurses were seen as having the power to conceal or reveal error. It seemed that when nurses were more fearful of how patients would respond to error, the decision to disclose was more difficult, and at times these errors were concealed.

The second theme, Perceiving Expectations for Disclosure, portrays nurses' experiences of perceiving the organizational culture surrounding disclosure. This theme is represented by two subthemes: (1) cultures of openness and honesty, and (2) cultures of secrecy. The subtheme Cultures of Openness and Honesty arose from participants' stories of perceived organizational support for disclosing errors to patients. The subtheme Cultures of Secrecy was described by nurses who felt that disclosure of errors to patients was not supported in their organizations. Several participants shared stories of serious errors that were concealed from patients and their families because of nurses' perceptions

of a culture of secrecy in the organization. The final theme was Not Disclosing Error, which represented nurses' experiences with errors that were concealed. Two subthemes were identified, to include (1) disclosing events but not errors; and (2) overtly concealing errors. The subtheme Disclosing Events but not Errors depicts situations in which the patient was told about the event, for example, telling a patient their blood sugar is low, without telling the patient the blood sugar is low because an error was made when too much insulin was administered. This type of disclosure conceals the error from the patient. The subtheme Overtly Concealing Errors emerged from participants stories of deciding not to disclose error. Some errors were not disclosed by the nurse because participants felt someone else was responsible for disclosure. Some errors were not disclosed because participants felt errors that did not harm the patient did not need to be disclosed.

Question Two: How do nurses describe their ethical responsibility for the disclosure of errors to patients?

Participants expressed diverse views on their ethical responsibility for disclosing errors to patients. While some participants felt they were responsible for disclosing their own errors to patients, other participants described that the decision to disclose was based on contextual factors, such as their relationship with the patient or the harm caused by the error, rather than the nurses' ethical responsibility. While 16 out of 17 participants felt harmful errors should be disclosed; only 5 out of 17 participants felt that all errors should be disclosed.

The ethical frameworks of virtue ethics, an ethics of care, and an ethics of freedom were reflected in nurses' stories of disclosing error. When viewed from a virtue

ethics framework, nurses disclosed error to fulfill their personal goal of being a "good nurse." When viewed from an ethics of freedom framework nurses looked beyond their desire to be a "good nurse" and recognized and valued their freedom and the freedom of the patient. Freedom in this sense arose by disclosing the error to the patient so the patient would have the necessary information to make decisions for their care. The ethics of freedom perspective arose from feminist ethics and seeks to avoid oppression within the relationship (Thomasma, 1994). Decisions to disclose were interpreted as an ethics of freedom approach when nurses seemed to focus on doing what was right to avoid oppressing the patient. Michele described a situation with an error in which she communicated constantly with the patient as she discovered an error. Michele's way of being with the patient revealed a respect for the patient and a desire to avoid oppressing the patient by withholding information that could impact the patient's health care decisions. Michele's way of being a nurse embodied ethical expertise as she sought to keep her patients continuously informed about their care. Instead of a decision to disclose, disclosure flowed from Michele's way of being a nurse, thus, disclosure was embedded in her practice. Michele was committed to open communication with her patients which was interpreted as an ethic of freedom.

Some nurses discussed their responsibility for disclosure by referring to organizational policy instead of using an ethical framework. Several nurses were not aware of an organizational policy addressing error disclosure to patients. In these cases, many participants perceived that disclosure was not supported by their organization. When institutions had policies explicitly supporting disclosure, nurses described their responsibilities for ensuring disclosure. In one organization, nurses documented

disclosure to the patient on the error reporting form. In another organization, nurses initiated error reporting and physicians were required to follow-up by disclosing the error and documenting this disclosure.

Question Three: How do nurses describe the ethical responsibility of other providers in the disclosure of errors to patients?

Participants described situations in which they felt the ethical responsibility for disclosure belonged to others, such as when the error was made by another person, or the error was serious and should be disclosed by someone with more authority or more expertise in formal disclosure. Several participants felt that the responsibility for disclosing errors belonged to the person who made the error. In another study, authors (Espin et al., 2006) described scope of practice boundaries that influenced nurses' reporting of errors made by physicians. If error reporting practices are influenced by scope of practice boundaries, the disclosure of errors made by physicians may also be influenced by perceived scope of practice boundaries. In this study, some participants felt all harmful errors should be disclosed by physicians, managers, or risk managers. Participants who shared serious errors felt that disclosure of these errors was the responsibility of physicians, managers, or risk managers. This belief is consistent with the type of tiered disclosure recommended by the Australian Council for Safety and Quality in Health Care (2003), in which responsibility for disclosure is assigned based on the severity of the error. Lower level events are disclosed by staff nurses or other professionals, while more serious events are disclosed by physicians, managers or administrators. So, with tiered disclosure, the professional responsible for disclosure is determined by the type of error.

Question Four: How do nurses describe the contextual factors when errors are disclosed or not-disclosed?

Consistent with the findings of Fein et al. (2005) who developed a conceptual model of factors influencing disclosure, participants shared characteristics of the error, patient, provider, and institution that were contextual to their decisions to disclose error. The severity of harm for the error was described by several participants as a contextual factor in their decisions to disclose error. If errors were not harmful, often participants did not feel the errors needed to be disclosed. Gallagher et al. (2003) reported similar findings, with errors more likely to be disclosed if they were harmful.

Some participants described the relationship with the patient as a contextual factor in their decisions to disclose error. When nurses perceived a positive, trusting relationship, they were more comfortable talking to patients about error. Fein et al. (2005) also described the rapport between the provider and the patient as a factor that influenced disclosure of the error.

Another contextual factor participants described was the perceived expectations of the organization regarding disclosing error. Expectations for disclosure were communicated by administrators, managers, physicians and nurses both explicitly and implicitly. Some participants described organizational policy that explicitly provided support for disclosure, while others described more implicit support for disclosure, such as a supervisor encouraging staff nurses to disclose their own errors. Participants were not always aware of institutional policy. Other participants described a perceived lack of support for disclosure within their organizations. Some participants described serious errors that were concealed. Several nurses felt their organizations did not have

mechanisms to effectively address non-disclosure. Similarly, other authors have described the effect of organizational culture on the disclosure of errors (Fein et al., 2005).

Recommendations for Nursing Practice

Several nurses in this study identified a lack of clarity in organizational policies about disclosing errors to patients. These nurses described error reporting policies that did not address disclosure of the error to the patient. These findings indicate that nurses should partner with hospital administrators to ensure that policies on medication errors clearly assign responsibility for error disclosure to patients and families. These guidelines can incorporate the Joint Commission (2004) patient safety standards requiring that unanticipated outcomes be discussed with patients. Disclosure responsibility should be delineated specific to the severity of the error. The policy should provide guidelines for disclosure, such as those proposed by the Sorry Works Coalition (2007), which calls for a three-step process of disclosure, to include: (1) empathy and apology without admitting fault in the immediate aftermath of error, assurance of continued communication as facts are identified; (2) rapid investigation into the facts of the incident; and (3) resolution with empathy, admission of fault when appropriate, and compensation when appropriate. By establishing clear guidelines for the disclosure of errors to patients, organizations display a commitment to a culture of openness and honesty.

In addition to disclosure policies, organizational efforts to support transparency and a culture of safety that are clearly and extensively communicated to all health care providers can support the disclosure of errors to patients. Examples of successful strategies for developing a culture of safety are included in the IOM document, *Crossing*

the Quality Chasm (2001). The IOM (2001) provides recommendations for ten rules to redesign and improve health care. Recommendation four states: "Patients should have unfettered access to their own medical information and to clinical knowledge. Clinicians and patients should communicate effectively and share information" . This recommendation calls for an open exchange of information between the patient and the provider of care. The IOM translates these recommendations into corresponding patient expectations. One of these patient expectations states, "Your care will be confidential, but the care system will not keep secrets from you. You can know whatever you wish to know about the care that affects you and your loved ones". By implementing these IOM initiatives to create a culture of openness and honesty, measures to keep patients informed about health care error through disclosure are supported.

Participants described how disclosure to patients was often facilitated by an existing rapport with the patient or family. By involving patients and families in care, such as by asking patients to verify medications prior to administration, patients can better understand the complexity of the nurses' role and help to recognize errors before they are made. Through engaging patients in a mutual dialogue about safety, nurses can partner with patients to validate medications and treatments as a final safety check prior to administration. The IOM (2001) recommends involving patients as a final "fail safe" step before medications are administered. This practice requires teaching patients what they are taking and why, the side effects of the medications, and how to recognize their medications.

Finally, because nurses are present and care for patients twenty-four hours a day in hospitalized settings, they are often aware of errors that are concealed from both

patients and internal reporting systems. If mechanisms are developed for anonymous reporting of ethical concerns such as concealed errors and undisclosed harm, ethical concerns regarding disclosure can be addressed. Concerns reported through this mechanism can be targeted to receive timely follow-up so that, in cases of non-disclosure, disclosure can occur prior to the patient's hospital discharge, when applicable. When nurses and other providers see evidence of administrative commitment to transparency through disclosure of errors to patients, confidence in the integrity of the organization's leadership will increase.

Recommendations for Nursing Education

When considering the implications of this study for education, issues for both academic and clinical educators can be identified. Nurses in this study shared stories of errors that were concealed both from patients and hospital reporting systems. These stories suggest that the culture of secrecy in health care continues to thrive. One implication of these findings for academia is to emphasize to student nurses that even "good nurses" make mistakes. If educators focus on teaching measures to prevent and minimize error, while acknowledging the extent to which errors are a reality of practice then students may understand that errors are always a possibility. Curricula can include positive responses to error that foster healing and personal and professional growth for the nurse. Positive responses to error include reporting, disclosing, and learning to prevent the error in the future, while negative responses include concealment and rationalizing about the error (Crigger & Meek, 2007). In both academic and clinical education settings, nurses should be taught how to disclose errors appropriately, to include education regarding organizational policies, delineated responsibility for

disclosure, measures to ensure accuracy of the disclosure, and strategies to show support for the patient and family.

Several participants in this study described a way of continually keeping patients informed about their care. When errors occurred, disclosure was embedded in this routine communication instead of a decision made after the error occurred. Conversely, some participants described making a decision about disclosure based on contextual factors such as their relationship with the patient or the support for disclosure by the organization. Implications for ethics education in basic nursing programs should include multiple ethical frameworks and clinical scenarios that prepare nurses to recognize the moral issues embedded in everyday practice. Nurses who view patient encounters with an "ethical lens" will be better prepared to make ethical decisions when errors occur. Several participants did not consider disclosing error when errors occurred. By not deciding to disclose, errors were concealed. Benner, Tanner, and Chesla (1996) emphasize the importance of teaching nursing as a form of "engaged moral reasoning" (p. 326) in which the student learns to recognize and respond to the ethical issues embedded in everyday nursing practice. One way to support nurses' development of engaged moral reasoning is through the use of the narratives of patients and families who have experienced error. By experiencing the error, error concealment, and error disclosure through the patients' eyes, nurses can be sensitized to the ethical dimensions of responding to patient care errors.

Clinical educators hold an integral role in indoctrinating new nurses into the culture of the institution. During orientation, clinical educators can emphasize the responsibility of nurses to advocate for patients and how the institution supports nursing advocacy and ethical practice. Acknowledging errors as a reality of practice, educators

can emphasize positive responses to error to include reporting and disclosure of errors to patients. Clinical simulations and videos of patient experiences with error can supplement didactic content.

Viewing disclosure from a feminist perspective reveals a profound imbalance of power in which the medical establishment makes all the decisions regarding the release of information to the patient about an error, often deciding not to disclose error. This imbalance of power exists not only between the physician and the patient, but also between the nurse and the patient, and the physician and the nurse. This medical model of health care has been described as characteristic of a dominant/subordinate model (Roberts, 1998). Within this model, both patients and health care professionals are expected to operate within a clearly defined hierarchy. Nurses in this hierarchy have a great deal of responsibility, but limited independence. Patients are expected to be "compliant" with their care and accept the decisions of health care providers, even when these decisions include withholding information about errors. Roberts recommends a move to a model of health care that empowers not only nurses, but patients as well. In this model, the role of the health care provider becomes one of an advisor and health resource, removing the power based dominant/subordinate relationship of the medical model. Education is an important first step in redefining the relationship of patients and providers in the health care system (Roberts). Teaching health care providers how to use empowering language with patients can facilitate a more balanced relationship between the provider and the patient (Hewison, 1995). Similarly, Andrist (1997) recommends a feminist model for women's health care that is applicable to all patients. This model incorporates four major themes of (1) symmetry in provider-patient relationships, (2)

access to information, (3) shared decision making, and (4) social change. By educating providers to empower patients utilizing a model similar to the model Andrist recommends, providers decrease the power differential in patient/provider relationships. Through measures to empower patients, disclosure of errors is supported.

Recommendations for Future Research

This study examined nurse experiences with error disclosure from a sample of hospital-based nurses caring for medical-surgical patients. This study has generated new information about nurses' experiences with disclosure and the ethical concerns and interpersonal relationships that surround these experiences. Variations in hospital support, policies and practice were identified. The results of this study can be helpful to provide a foundation for the development of an instrument to assess nurses' error disclosure perceptions and experiences on a larger scale. Comparisons of these disclosure experiences between public and private organizations would contribute to the science in understanding how disclosure of errors can be supported. Also, since several participants expressed concerns about litigation if they were to disclose errors, further research is needed to determine the impact of full disclosure programs on patient initiated legal action. While initial research seems to indicate that litigation costs may decrease with full disclosure policies (Kraman & Hamm, 1999), further research is necessary before many organizations will commit to the type of transparent disclosure systems patients and families deserve.

Many participants shared stories of disclosing errors. Some of these errors were harmful, some were not. When participants discussed deciding to disclose, their decisions seemed to reflect consideration of several factors: (1) who made the error, (2) the nurses'

rapport with the patient, (3) the likelihood of patient harm from the error, and (4) organizational support for disclosure. Participant stories indicate disclosure of errors by nurses may be a common practice since 12 out of 17 nurses shared stories of disclosing their own errors. These findings support the need for further research to identify the extent of nurse disclosure of error and the benefit of error disclosure by the health care provider who made the error. A longitudinal study utilizing concurrent logging of errors and disclosure decisions would be useful to study this phenomenon.

Finally, from the perspective of nurses in this study, it is clear that the Joint Commission patient safety standards (2004) requiring the disclosure of unanticipated outcomes to patients have been implemented with limited success. Further research comparing the success of diverse strategies to implement these patient safety standards would help to identify best practices. This research should involve a multidisciplinary approach to illuminate the disclosure practices of all members of the health care team.

Study Strengths and Limitations

The strengths of this study include the use of a both Heideggerian hermeneutic phenomenology and a feminist perspective to reveal the background structures that may otherwise have been invisible. Also, the use of one-on-one interviews provided rich, descriptive data about nurses' lived experiences with the disclosure of errors. Another strength of the study is that participants were employed by a total of ten public and private hospitals. By utilizing participants from many different hospitals, participants' stories provided a view of nursing practice in multiple, diverse practice settings. In participants' stories, the organizational environment was often a contextual element nurses mentioned in their discussions of disclosure. While some settings had policies

supporting disclosure, the cultures participants described in other organizations did not support disclosure. The rigor of the study was supported through the use of field notes to help preserve the full-meaning of participants' stories, the use of a research team, and the use of a research journal to provide a audit trail to follow the research process. Additionally, two participants reviewed the final interpretation and verbalized agreement with the findings.

A limitation of this study was that participants were not required to have experiences with errors they themselves had made. Participants could share errors that were made by other nurses or health care providers. When nurses told of errors made by others, sometimes participants shared an incomplete construction of events surrounding the error. Also, because the study involved patient care errors, participants may have been hesitant to share errors. While 41 stories of error were shared, it may be that some participants shared only select errors to avoid revealing more serious errors.

Summary

This study examined nurses lived experiences with disclosure or nondisclosure of errors to patients. The purpose of the study was to gain an understanding of nurse perceptions of error disclosure to patients. Seventeen registered nurses, employed in inpatient settings caring for adult medical/surgical patients, were interviewed. Interviews were recorded, transcribed, and reviewed for accuracy. Transcripts were analyzed using the stages of data interpretation described by Diekelmann and Allen (1989) and modified by Minick (1992). Heideggerian hermeneutic phenomenology and a feminist perspective provided the theoretical perspective to guide the study.

Three themes were identified in the transcripts. The themes were: (a) disclosing error; (b) perceiving expectations for disclosure; and (c) not disclosing error. The theme Disclosing Error describes participants' stories of disclosing errors to patients and families. Two subthemes were identified: (a) Disclosing Error through Constant Communication; and (b) Disclosing Error as a Decision. The subtheme Disclosing Error through Constant Communication represented participants' descriptions of a way of being with patients that involved keeping patients constantly informed about what was happening. Instead of decisions to disclose made with each event, these participants described a way of being engaged with the patient in a continuous encounter. The subtheme Disclosing Error as a Decision emerged as participants described situations in which thoughtful decisions resulted in the disclosure of errors to patients. While the participants did not always decide to disclose errors, in some stories they did disclose. The presence of a trusting relationship with patients seemed to support nurses' decisions to disclose errors to patients.

The theme Perceiving Expectations for Disclosure emerged from participants' stories describing the culture, policies, and practices surrounding disclosure in their work environments. Expectations were sometimes communicated through policies but more often through implicit means within the organizational culture. From participants' experiences of organizational expectations surrounding disclosure, two subthemes were identified: (1) cultures of openness and honesty; and (2) cultures of secrecy. The subtheme Cultures of Openness and Honesty emerged from participants' descriptions of organizations that supported openly communicating with patients about all aspects of care, including errors. While some organizations had explicit policies detailing actions to

support disclosure, other organizations showed more implicit support for disclosure through the organizational culture. The second subtheme was Cultures of Secrecy, which represented nurses' perceptions of organizational cultures that seek to keep errors hidden from patients. A culture of secrecy exists in an organization when nurses perceive a lack of support to keeping patients informed about all aspects of their care, including errors. When describing their perceptions of a culture of secrecy, participants described serious errors that they felt should have been disclosed but were not. Participants described organizational and unit cultures that they felt limited their ability to ensure errors were disclosed to patients. Power structures that exist in the hierarchical organization may limit nurses' willingness to raise concerns over non-disclosure. Nurses described feeling caught in the middle between patients and families that need to know about errors, and organizations that do not support disclosure.

The third theme, Not Disclosing Error, emerged from participants' stories of concealed errors. The theme Not Disclosing Error represents nurses' decisions to "turn away" from pursuit of the moral horizon and conceal errors. Participants' stories often involved situations where participants did not feel they were responsible for disclosing errors, and those persons they indicated were responsible for disclosure did not disclose the errors. In other situations participants shared contextual elements that may have influenced the concealment of errors. For the theme Not Disclosing Error, the subthemes include: (1) disclosing events but not errors; and (2) overtly concealing errors. The subtheme, Disclosing Events but not Errors, emerged from stories in which errors were concealed by telling patients about events, but not identifying these events as errors. It seemed that this partial disclosure of events or "complications" helped providers feel they

had been truthful with patients, even though errors were not disclosed. The second subtheme, Overtly Concealing Errors, emerged from participants' stories of concealing error. In these stories, no attempt was made to disclose events or errors to the patient. Some participants described stories of overt concealment that occurred when errors were not harmful, while other stories of overt concealment occurred with more serious errors. Overt concealment was also seen when nurses felt someone else was responsible for disclosure of the error. Some participants described concealing errors they felt should have been disclosed by peers, managers or physicians. Nurses' hesitance to disclose errors made by physicians may reflect perceptions of role expectations and professional boundaries. However, when errors were more serious, participants described a need for disclosure by those with more expertise in disclosing errors, such as physicians, managers or risk managers. Some serious errors were concealed when physicians, managers or risk mangers did not disclose the errors to patients.

The findings of this study held numerous implications for nursing practice and education. Implications for nursing practice and administration included the need for an organizational commitment to transparency and safety, involvement of patients in error prevention, clear disclosure policies, and mechanisms for providers to anonymously report concerns with non-disclosure of errors. This study has implications for nursing education for both academic and clinical educators. For academic educators, the curriculum should address the reality and frequency of errors followed by positive responses to error to include reporting, disclosing and healing. Ethics education should include multiple ethical frameworks and narratives to help students recognize the ethical aspects present in everyday nursing practice. The narratives of patients that have been

harmed by error and experienced both disclosure and non-disclosure can benefit students by sharing others' experiences. Implications for clinical educators include indoctrinating new nurses into the culture of the organization, disclosure policies and training, and strategies for empowering patients in their care.

This study has contributed to current knowledge by focusing on nurses' experiences with the disclosure of errors. By understanding nurses' experiences with error disclosure, interventions to increase the disclosure of errors to patients can be developed. Further research is needed to develop an instrument to assess nurses' perceptions on disclosure. This instrument would facilitate the study of nurses' perceptions on disclosure on a larger scale.

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Appendix A

Interview Guide

Interview Guide

The researcher will begin the interview by dialoging with participants about patient care errors. The following are examples of questions and prompts that may be used during interviews:

*"*Do you remember a time when a patient care error occurred?"

"How did the patient (family) respond?"

"How did you feel about talking to the patient about the situation (error)?"

"Could you tell me about your concerns?"

"Can you help me understand (your feelings)?

"You said…(participant's words)…help me understand your feelings in this situation."

"Some nurses tell me ….is this similar to your experiences?"

"Can you talk a little about how peers/charge nurses/MDs (discuss individually) might feel regarding disclosure of errors?"

"Can you say more?" or "Tell me about that."

"Do you think your being a woman made a difference?"

If error was disclosed

"When you talked to the patient about the situation, what made it easier for you? What made it harder for you?"

If error was not disclosed

Can you think of situations where nurses might be more at ease with disclosure?

Closing questions

“Are there questions I haven’t asked that would help me understand your experiences better?”

“What else might be important for me to know about your experiences?"

Appendix B

Consent Form

Georgia State University
Department of Nursing
Informed Consent

Title:	Nurse Experiences with Disclosure of Errors to Patients
Principal Investigator:	Ptlene Minick, Ph.D., RN
Student PI:	Debbie Greene, MSN, RN

I. Purpose:

You are invited to participate in a research study. The purpose of this study is to gain an understanding of nurse perceptions of error disclosure to patients. Specifically, we are interested in your experiences about telling patients or not telling patients about errors. You are invited to participate because you are a Registered Nurse with at least one year of experience in the area you currently work. You must also provide direct patient care at least 24 hours per week and be between the ages of 21 and 65. A total of 18-27 participants will be interviewed for this study. Participation will require one to one and a half hours of your time today. In addition, the researcher may contact you with further questions and to get your feedback on the findings of the study.

II. Procedures:

If you decide to participate, you will be interviewed in a private location by the student principal investigator, Mrs. Debbie Greene. You have the right to have your questions answered before the interview. The interview will be confidential. Your name will only be listed on this consent form and on the participant roster. Mrs. Greene and Dr. Minick will be the only people who know the identity of participants. Mrs. Greene will store the participant roster and consent forms in a locked file cabinet, and the interview data will be located in another locked file cabinet. Your name and interview will not be stored in the same location, so your name and the information you provide can not be linked.

Two audiorecordings will be made of the interview. Audiorecordings will not be identified with your name. Audiorecordings will be transcribed, your name will not be placed on the transcripts.

At the beginning of the interview, Mrs. Greene will ask for information such as your age, race, nursing education, years of nursing experience and practice setting. You will then be asked to recall and discuss a time when you remember a patient care error.

To thank you for the time you are taking to participate in this study, you will receive a gift card for $25 after completing the interview. No additional gift cards will be provided for follow-up interviews. You can decide not to participate in follow-up interviews.

III. Risks:

In this study, you will not have any more risks than you would in a normal day of life.

IV. Benefits:

Participation in this study may not benefit you personally. Overall, we hope to gain information about nurse experiences about telling patients about errors. Gaining information about nurses' experiences regarding errors may contribute to quality care.

V. Voluntary Participation and Withdrawal:

Participation in this research is voluntary. You have the right not to be in this study. If you decide to be in the study and change your mind, you have the right to drop out at any time. You may skip questions or stop participating at any time. Whatever you decide, you will not lose any benefits to which you are otherwise entitled.

VI. Confidentiality:

We will keep your records private to the extent allowed by law. We will use a participant number rather than your name on study records. Only Mrs. Greene will have access to participant names. Only the research team; will have access to the interview transcripts. Audiotapes and transcripts will be stored in a locked file cabinet. The participant roster will be stored in a locked file cabinet separate from the transcripts. Your name and other facts that might point to you will not appear when we present this study or publish its results. The findings will be summarized and reported in group form. You will not be identified personally. The participant roster and informed consent forms will be destroyed after five years. All audiotapes will be destroyed within one year of this date.

VII. Contact Persons:

Call Dr. Ptlene Minick at 404 651 4028 if you have questions about this study. If you have questions or concerns about your rights as a participant in this research study, you may contact Susan Vogtner in the Office of Research Integrity at 404-463-0674 or svogtner1@gsu.edu.

VIII. Copy of Consent Form to Subject:
We will give you a copy of this consent form to keep.
If you are willing to volunteer for this research, please sign below.

_____ _____
Participant Date

_____ _____
Principal Investigator or Researcher Obtaining Consent Date

Appendix C

Code Book

Code Book

1.	?error	Not sure if this meets definition of error
2.	Ambiguity	Not always sure if the error caused the problem
3.	Anger	Angry patient (not due to disclosure)
4.	Angerdc	Anger expressed by patient or family after disclosure
5.	Blamens	Nurse is blamed for error
6.	Blameother	Blaming others when errors are disclosed i.e. the nurse didn't tell me…
7.	Blaming	Nurse statements blaming another
8.	Careforpt	Care for patient after error
9.	Caring	Statements reflecting nurse cared about patient
10.	Coverup	Error is explicitly concealed from the patient/family
11.	Culture	Reference to the culture of the unit or organization
12.	Dcbeliefs	Nurse reflective statements on disclosing error
13.	Dcconcerns	Concerns expressed re: disclosing errors
14.	Dcexample	Example of error disclosure
15.	Dcown	Better if error disclosure came from person who made error
16.	Dcpolicy	Reference to institutional policy on disclosure
17.	Drabuse	Physician verbal or physical intimidation
18.	Drdc	Example of a doctor disclosing an error
19.	Drdecide	Statements reflecting the doctor should decide about disclosure
20.	Drneverdc	Doctors never/seldom disclose

21.	Drnotdc	Doctor did not disclose the error when nurse expected her/him to disclose
22.	Drpower	References to physician power, or physicians being believed more than nurses
23.	Drsupport	Doctor support for disclosure
24.	Educlevel	Contextual factor: patient/family education level
25.	Embarrass	Nurse is concerned about being embarrassed by error
26.	Errchar	Characteristics of the error contextual to disclosure
27.	Errnotdc	Describes error that was not disclosed to the patient
28.	Error$	Reference to the cost of errors or payment for services
29.	Errorpol	Organizational policy on actions after error
30.	Errprevent	Statement about what prevents error or measures to prevent error
31.	Everydayness	Not always noticing when we disclose or don't
32.	Excusenodc	Rationalizing reasons for not disclosing error
33.	Exdc	Patients told about error
34.	Falls	Fall related error
35.	Fammonitor	Family can monitor for adverse events/falls if they know
36.	Famresponse	Family response when error is disclosed
37.	Famsuspect	Family suspects error
38.	Fear	Fear of disclosure
39.	Fearsue	Fears regarding lawsuits
40.	Guilt	Nurse expresses guilt
41.	Harmerror	Harmful error is described

42.	Healing	Recovering from making an error
43.	Honesty	Honesty is the best policy
44.	Hospresp	Hospital response to error
45.	Hospsupport	Perceived hospital support for disclosure
46.	Howilive	“This is how I live” a way of being
47.	Individual	Each case is different, you have to look at them individually
48.	Informpt	Inform patients about everything (teaching, errors and all)
49.	Itstough	Caregivers are in difficult situations after error
50.	Litigation	Concerns regarding litigation
51.	Medease	Medical explanations that conceal error
52.	Mgrsupport	Manager support for disclosure
53.	Mostnotdc	Generalizing statement that most errors are not disclosed
54.	Newns	Discussion about new nurse
55.	Noharm	Not a harmful error
56.	Noreport	Incident report is not completed on an error
57.	Nospecific	Can’t remember specific details of patient or situation
58.	Notmyplace	Overstepping my bounds, not my place to disclose this error
59.	Nsapology	Nurse discloses and apologizes to patient for error
60.	Nsdc	Example in which nurse discloses
61.	Nspower	Areas in which nurses show power
62.	Nsprevent	Ways nurses prevent errors
63.	Nsupset	Nurse upset when makes an error
64.	Obviouserr	Error is obvious to the patient/family without disclosure

65.	Peersupport	Peer support for disclosure or when errors occur
66.	Powerover	Authoritative power over another person
67.	Ptcharact	Characteristics of the patient/family that may influence disclosure
68.	Ptmoreeduc	Patient/family these days are more educated than they used to be
69.	Ptresponse	Patient/family response when error is disclosed
70.	Ptunclear	Patient unclear that error had occurred
71.	Punitive	Punitive responses to error
72.	Punitiveno	Non-punitive responses to error
73.	Rapport	Establishing a positive relationship between caregiver and patient
74.	Roleunclr	Not sure what to do (legal, etc.)
75.	Rptfutile	Completing incident reports is useless
76.	Secrecy	Discusses culture of secrecy in organization
77.	Silence	Times when nurses are silent versus speaking up as advocate
78.	Takecare	Care for patient first
79.	Trust	Trust between the patient and caregivers