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MAPPING DISCLOSURE PRACTICES IN HOSPITAL ENVIRONMENTS: A SCOPING REVIEW

Mapeamento das práticas de disclosure em ambientes hospitalares: revisão de escopo

Mapeo de las prácticas de disclosure en entornos hospitalarios: revisión de alcance

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RESUMO

Objetivo: mapear as práticas de disclosure de eventos adversos para pacientes internados e seus acompanhantes, relacionadas à segurança do paciente, em ambientes hospitalares. **Método:** trata-se de uma pesquisa qualitativa, do tipo revisão de escopo, desenvolvida a partir da metodologia aplicada pelo Joanna Briggs Institute para revisões de escopo. **Resultados:** foram identificados 3876 artigos nas bases citadas; e 180 publicações na literatura cinzenta. Após a exclusão dos estudos duplicados, validação dos critérios de inclusão e leitura na íntegra, foram eleitas 25 publicações científicas para a análise. **Conclusão:** a partir da revisão de escopo, observou-se diversas estratégias para executar a prática do disclosure, dentre elas, o pedido de desculpas surgiu como uma forma de reduzir o impacto dos eventos adversos, e demonstrar empatia, respeito e responsabilidade, por parte dos profissionais de saúde.

DESCRITORES: Comunicação em saúde; Pacientes internados; Revelação da verdade; Segurança do paciente.

ABSTRACT

Objective: to map the practices of disclosure of adverse events for hospitalized patients and their companions, related to patient safety, in hospital environments. **Method:** this is a qualitative study of the scoping review type, developed from the methodology used by the Joanna Briggs Institute for scoping reviews. **Results:** 3876 articles were identified in the cited

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databases and 180 publications in grey literature. After exclusion of duplicate studies, validation of inclusion criteria and full reading, 25 scientific publications were selected for analysis. **Conclusion**: from the scoping review, several strategies were observed to carry out the practice of disclosure, among which the apology emerged to reduce the impact of adverse events and demonstrate empathy, respect and responsibility on the part of health professionals.

DESCRIPTORS: Health communication; Inpatients; Truth disclosure; Patient safety.

RESUMEN

Objetivo: mapear las prácticas de disclosure de eventos adversos para pacientes hospitalizados y sus acompañantes, relacionadas con la seguridad del paciente, en entornos hospitalarios. **Método:** se trata de una investigación cualitativa, del tipo revisión de alcance, desarrollada a partir de la metodología aplicada por el Joanna Briggs Institute para revisiones de alcance. **Resultados:** se identificaron un total de 3876 artículos en las bases de datos citadas, y 180 publicaciones en la literatura gris. Después de la exclusión de estudios duplicados, la validación de los criterios de inclusión y la lectura completa del texto, se seleccionaron 25 publicaciones científicas para el análisis. **Conclusión:** a partir de la revisión de alcance, se observaron varias estrategias para ejecutar la práctica del disclosure, entre las cuales la disculpa surgió como una forma de reducir el impacto de los eventos adversos y demostrar empatía, respeto y responsabilidad por parte de los profesionales de la salud.

DESCRIPTORES: Comunicación en salud; Pacientes internos; Revelación de la verdad; Seguridad del paciente.

INTRODUCTION

The practice of disclosure is directly related to the quality of health care. Thus, the quality of health care has as one of its definitions "the understanding that quality does not depend on a single factor, but on the presence of a series of components, attributes or dimensions".[1:31]

From this perspective, the World Health Organization (WHO) has adapted the set of dimensions developed by the United States Institute of Medicine to support the development of several indicators worldwide. Therefore, it is essential to consider the following aspects of quality health care: safety, effectiveness, patient-centeredness, access, efficiency and equity.[1]

Safety, as described above, refers to the absence of harm to the patient. Effectiveness, on the other hand, addresses the benefit to the population in relation to the scientific knowledge of health professionals. In terms of patient-centered care, this aspect alludes to considering the unique aspects of each person, their needs and values, so that these factors guide decision making. Access refers to service at pre-arranged times; efficiency promotes the avoidance of waste; and finally, equity reflects the unique characteristics of each patient, including gender and ethnicity.[1]

The factors that lead to adverse events in the hospital environment affect not only the health of hospitalized patients, but also the lives of their companions and/or family members, in addition to the negative impact on the professionals involved and the health care institution.[2]

From an ethical point of view, the practice of disclosure must be incorporated into the culture of patient safety, so that health care institutions are committed to implementing this practice among their professionals.[2]

Once the practice of disclosure is denied, the patient's right to have his or her health care needs addressed in a respectful and transparent manner is also denied. It is known that adverse events can occur, so the practice of disclosure has a direct impact on patient safety to minimize other adverse events.[2]

The occurrence of adverse events due to unsafe healthcare is probably one of the top ten causes of death and disability worldwide. In high-income countries, it is estimated that one in ten patients suffer some harm while receiving hospital care.[3]

This scoping review is justified by the need to discuss the practice of disclosure in hospital settings to improve communication between health professionals and patients, thereby enhancing patient safety and collaboration to prevent new incidents.

The aim of this study was to map the practices of disclosure of adverse events for inpatients and their companions, related to patient safety, in hospital environments.

METHOD

This is a qualitative study of the scoping review type, which is a type of study that attempts to map all available scientific literature on a given topic, both published evidence and grey literature. In the scoping review, the scientific evidence is synthesized in order to clarify the doubts raised in the research

question, making it possible to clarify in a broad sense what and how a particular concept or factor is studied.[4]

This research was conducted between February and April 2024. All the steps proposed for structuring the scope review, as outlined below, were followed. In addition, it should be noted that this study was guided by the PRISMA Scoping Review Checklist, which directed both the preparation of the review and the presentation of the results.[5]

This scoping review was developed using the Joanna Briggs Institute scoping review methodology, and its protocol was provisionally registered on the Open Science Framework (OSF) platform using the Digital Object Identifier (DOI): 10.17605/OSF. IO/B75DQ.

The first step of the scoping review is to define and align the objective with the research question. The research question is extremely important within a scoping review as it guides the entire process of mapping the scientific evidence. Thus, the question must be easy to understand so that there is no doubt about its reading and interpretation.[6]

In this context, the research question was formulated from the acronym PCC (Population, Concept and Context) as follows:

P - Patients and their caregivers;
C - Disclosure of adverse events;
C - Hospitals.

These terms led to the following question: What are the adverse event disclosure practices for hospitalized patients and their caregivers in hospitals?

Next, the inclusion criteria were aligned with the objective and research question. Inclusion criteria included experimental and quasi-experimental study designs, including randomized and non-randomized clinical trials. Prospective and retrospective cohort studies, case-control studies, and analytical cross-sectional studies were also included. Descriptive observational study designs, such as case reports, were considered as well.

This review also included qualitative studies, including designs such as phenomenology, grounded theory, ethnography, qualitative description, action research and feminist research. In addition, systematic reviews that met the inclusion criteria were included depending on the research question. Texts and opinion articles were also included in this scoping review.

There was no time frame or language restriction.

Appropriate terminologies were used for the search and selection of data, obtained through structured words recorded in the Health Sciences Descriptors/Medical Subject Headings (DeCS/MeSH) thesaurus (Chart 01).[7]

Chart 01- Selection of descriptors for the scoping review

DeCS	*Pacientes internados; Revelação da verdade; Hospitais*
MeSH	Inpatients, Truth Disclosure; Hospitals

Source: The Authors, 2024.

The search strategy aimed to locate published and unpublished studies and was conducted in three stages. First, standardized terms and synonyms were identified in controlled vocabularies. A preliminary search was conducted to identify articles on the topic and the existence of published or ongoing reviews. The text words contained in the titles and abstracts of the relevant articles and the indexing terms used to describe the articles were used to develop a complete search strategy, as applied in MEDLINE/Pubmed, for subsequent application and adaptation in the relevant databases/information sources:

LILACS, IBECS, BDENF, WPRIM, MULTIMEDIA, BINACIS, CUMED, colecionaSUS, HomeoIndex and MTYCI from the Regional Portal of the Virtual Health Library (VHL), MEDLINE/PubMed; EMBASE and SCOPUS/Elsevier; CINAHL and ASP/EBSCO, Scientific Electronic Library Online (Scielo) and Web of Science Core Collection/Clarivate Analytics. Pubmed Central (PMC), Epistemonikos, Google Scholar, and Science.gov.

After the searches, the evidence found was exported to the virtual tool Rayyan, which is a tool that allows the elimination

of duplicate evidence, the analysis of the titles and abstracts of the articles, in addition to allowing the review by more than one reviewer, independently. The review was performed by two reviewers in a double-blind manner according to the inclusion criteria. A third reviewer was asked to resolve any disagreements.

Then, the articles found were evaluated according to their titles and abstracts, and those that did not have the potential to be part of the study and did not meet the research objectives were excluded.

Finally, a third round of evidence evaluation consisted of reading the scientific evidence in its entirety. After this action, 25 articles were selected for analysis.

RESULTS

A total of 3876 articles were identified in the cited databases and 180 publications in the gray literature. After exclusion of duplicate studies, validation of inclusion criteria and full reading, 25 scientific publications were selected for analysis according to the PRISMA flowchart (Figure 01).

Figure 01- PRISMA Flowchart
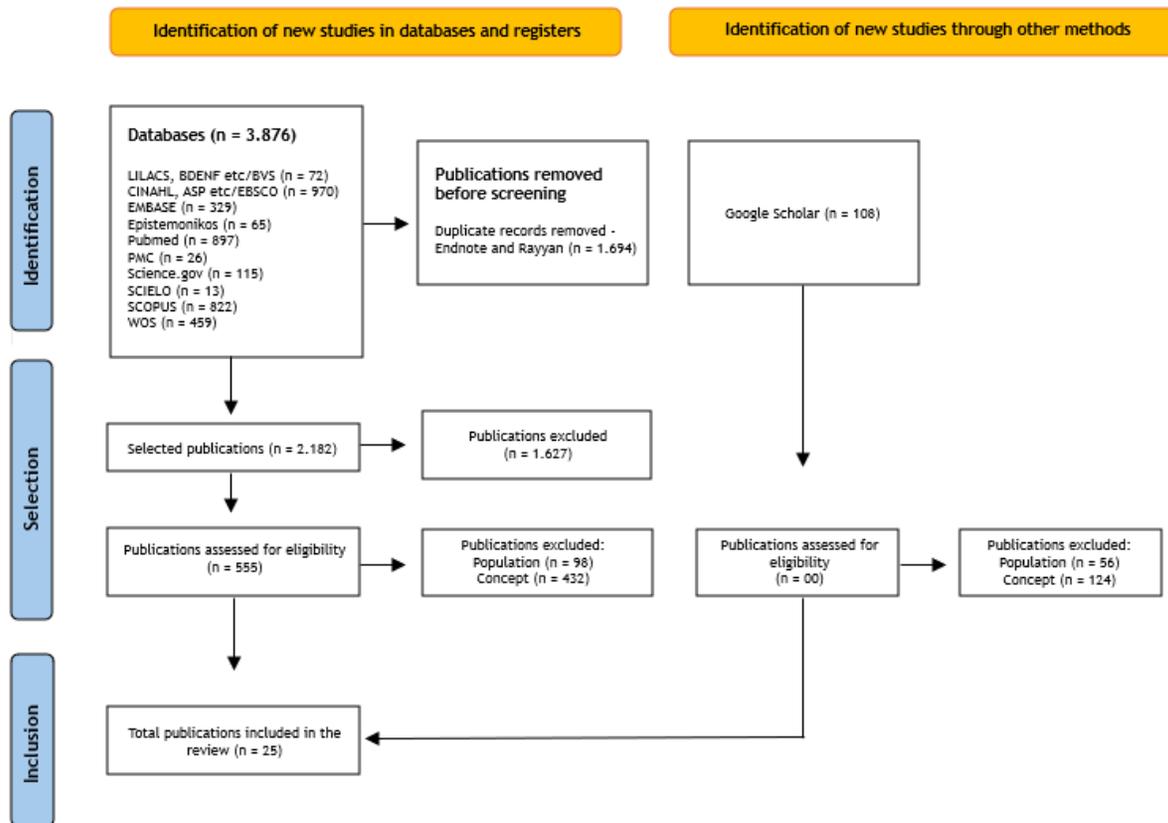
Source: Page, 2020 (adapted).

The articles used in the study were synthesized and organized according to authors, study design, year and country of publication, and disclosure activities described, as presented in Chart 02.

Chart 02 - Characterization of studies

ID	Authors	Study design	Year of publication	Country of publication	Disclosure measures described
A1	Wagner; Damianakis; Pho; Tourangeau.[8]	Cross-sectional study	2013	Canada	- Honest communication - Non-punitive, open dialogue
A2	Martín-Dlegado; Fernández-Maillo; Bañeres-Amella; Campillo-Artero; Cabré; Anglès et al.[9]	Observational study	2013	Spain	- Positive patient engagement - Training staff in communication and information skills for delivering bad news - Communicating with patients and their families in an open and honest way - Apologizing
A3	Petronio; Torke; Bosslet; Isenberg, MD; Lucia Wocial, RN, PhD; Paul R Helft, MD.[10]	Literature Review	2013	United States	- Physician Preparation - Formulating information delivery
A4	Birks; Harrison; Bosanquet; Hall; Harden; Entwistle et al.[11]	Scoping Review	2014	United Kingdom	- Open Outreach and Culture Change - Apologizing - Clarity
A5	Watson; Angus; Gore; Farmer.[12]	Observational study	2014	Australia	- Open Disclosure - Expressing regret - Providing financial and emotional support - Discussing the damage - Explaining the facts
A6	Birks.[13]	Publication in a scientific journal	2014	United Kingdom	- Providing a sincere and timely apology for what happened. - Keeping patients and/or their caregivers informed about the progress of the investigation into the incident - Reassuring patients and/or caregivers that the incident is being taken seriously - Ensure that steps are taken to prevent it from happening again - Honesty
A7	Elwy; Bokhour; Maguire; Wagner; Asch; Gifford et al.[14]	Cross-sectional observational study	2014	United States	- Prompt communication - Offering remediation - Preparing the facility - Training staff - Communicating with stakeholders
A8	Sukalich; Elliott; Ruffner.[15]	Observational study	2014	United States	- Timely and empathetic communication - Apologizing
A9	Mira; Lorenzo.[16]	Observational study	2015	Spain	- Apologizing - Allowing patients' involvement in the investigation - Honesty

ID	Authors	Study design	Year of publication	Country of publication	Disclosure measures described
A10	McLennan; Rich; Truog.[17]	Editorial	2015	Canada	- Honesty - Transparency - Apologizing - Training staff - Emotional support - Damage repair
A11	McLennan.[18]	Systematic review	2015	Argentina	- Apologizing - Honesty
A12	Dahan; Ducard; Caeymaex.[19]	Observational study	2017	France	- Apologizing
A13	Cernadas.[20]	Editorial	2017	Argentina	- Apologizing - Unspoken language - Building partnership with patients and families - Disclosure of information
A14	Mira; Lorenzo; Carrillo; Ferrús; Silvestre; Astier et al.[21]	Literature Review	2017	United States	- Organizational Policy - Apologizing - Disclosure - Preventing rejection by professionals - Preventing future incidents - Open communication - Empathy
A15	Hannawa.[22]	Scientific editorial	2017	Switzerland	- Apologizing - Informative content for disclosure of errors, humility, trust, transparency, chronological explanation in a clear and calm way, investing in a relationship with the patient, face-to-face disclosure, easy to understand terms, prevention actions and repairing the damage
A16	Kling.[23]	Scientific editorial	2018	United States	- Explanation of what happened - Intention to investigate what happened - Apologizing - Acknowledgement that harm has occurred - Education - Training
A17	Moffatt-Bruce; Ferdinand; Fann.[24]	Editorial	2018	United States	- Transparency - Appropriate disclosure
A18	Crimmins; Wong; Tsyrulnik; Jubanyik; Dziura; Dodge et al.[25]	Observational study	2018	United States	- Bond with the patient - Disclosure and apologizing - Offering support resources - Compromise
A19	Peterson et al.[26]	Observational study	2019	United States	- Standardization of dissemination - Developing educational resources
A20	Choi; Pyo; Ock; Lee.[27]	Observational study	2019	Korea	- Explanation - Apologizing -Training - Appropriate training

ID	Authors	Study design	Year of publication	Country of publication	Disclosure measures described
A21	Prentice; Bell; Thomas; Schneider; Weingart; Weissman *et al.*[28]	Cross-sectional observational study	2020	United States	- Open communication - Apologizing - Implementing communication and resolution programs
A22	Carmack.[29]	Case Report	2020	United States	- Apologizing - Admitting faults - Reward
A23	Dijkstra; Roodbeen; Bouwman; Pemberton; Friele.[30]	Scoping review	2020	United States	- Open disclosure - Patient as Partner - Need for financial Compensation - Complaint handling, mediation, communication and resolution program - Organization of policies - Support
A24	Ross; Newman.[31]	Editorial	2021	United States	- Apologizing - Communication - Transparency
A25	Albuquerque.[32]	Cross-sectional study	2022	Brazil	- Providing physical and mental health services to the patient and/or family member - Apologizing - A factual explanation of what happened - Allowing the patient/family member to share their experience - Discussing the possible consequences of the incident - Explaining the actions taken to address the event that occurred - Preventing future events - Empathy - Transparency

Source: The Authors, 2024.

DISCUSSION

Three chapters emerged from the data of the studies retrieved for the analysis so that the findings could be organized in an understandable way.

The patient's right to receive an apology

This term was addressed in 84% of the studies in the scoping review, including similar terms such as expressing regret and offering reparation and compensation.

Apologizing after an incident that caused damage demonstrates empathy for what happened and interest in the patient's well-being. However, there is a perceived need for an adequate protocol for this apology to occur. Additionally, legal protection of professionals is necessary to encourage effective communication, apologies, and disclosure practices, including regarding the punitive culture of some health institutions.[9, 11,13,16]

Above all, an apology should be the first action taken when an incident occurs, whether there is damage or not. It is also one of the first actions aimed at preventing further incidents. An apology is part of patient-centered care. By acknowledging an unexpected mistake, professionals and institutions reaffirm their commitment to transparency and honor the trust placed in them by patients.[1, 17, 25]

However, a study conducted in Canada revealed changes in local legislation. Now, an apology is not considered a mitigating factor in lawsuits involving patient harm, even if it was unintentional. To prevent this factor from discouraging professionals from reporting incidents, the practice of disclosure has become mandatory. This means that health institutions will need to invest heavily in training their employees to reduce incidents, as well as provide emotional support to professionals and patients in case of an incident resulting in harm.[17]

In the event of an incident with consequences for the patient, a simple apology may seem like just a formality to the patient and/or their family. Thus, the words and tone used must demonstrate real regret for what happened, empathy, and an offer to repair the damage as much as possible.[12,19, 28]

Open and honest communication

In the context of the high number of adverse events resulting in patient harm, some professionals find it difficult to openly discuss these events. This includes the absence of a disclosure protocol. They also do not feel safe sharing relevant information with patients or communicating errors to them.[8]

The scarcity of disclosure practices in health institutions leads to contexts that violate patients' rights. This scarcity disregards the benefits of communicating with patients and their families about damage that occurred during care provision.[32]

In this sense, communication emerges as one of the main actions described in the scoping review. It is the central element in establishing interactions between institutions, health professionals, patients, and family members. In the context of patient safety, communication errors are the leading cause of organizational accidents and may contribute to about 60% of adverse events in healthcare.[12, 20]

Communication involves verbal and nonverbal processes to transmit a message in a way that is understandable. Therefore, it requires concrete interaction between the sender and receiver. Significant elements such as language, gestures, facial expressions, and active listening are fundamental to successful communication. Thus, criteria such as understanding the care plan, meeting the patient's needs, and taking a holistic view of the clinical condition must be considered to ensure safer and more effective communication.[28, 30]

Open communication refers to patients' and family members' perception of the information they receive from health professionals and teams regarding errors, inviting them to discuss it.[15]

According to data from WHO, when patients are considered partners in their care, significant gains are made in safety, satisfaction, and health outcomes. Patients can contribute to the safety of their care and the healthcare system by becoming active members of the healthcare team.[20, 28]

Establishing open communication significantly reduces emotional impact. Dishonesty affects patients even more, causing them to lose trust in the people they should trust the most. This is one of the main factors that motivate lawsuits. Transparency in information and a willingness to discuss failures or complications are essential to improving care processes and ensuring quality care.[20,28]

Honesty strengthens the relationship of trust and is an essential pillar to ensure patient safety, promoting a more effective and humane environment. When professionals show empathy, patients feel more comfortable expressing their concerns. Empathy is a strong predictor of continued relationships between patients and health care providers after an error occurs. In fact, empathy may carry more weight than an apology in communication after an error.[20,29]

Therefore, it is extremely relevant and urgent to address disclosure and facilitate honest, empathetic, and timely dialogue between patients — as well as their family members and caregivers — and the healthcare team after an incident affecting patient safety.[32]

Training and qualification as strategies for preventing adverse events

Training health professionals in issues related to patient safety and effective communication is essential for achieving the necessary effectiveness in the disclosure process.[9,11]

In this sense, health professionals, including those in leadership positions, must undergo constant training. Training may include case studies, consultation of a database of successful disclosure practices, and capacitation of professionals responsible for communication within the educational institution, among other methods. Additionally, providing feedback related to an incident investigation promotes professional participation and informs them of all measures taken regarding the incident and those to prevent new incidents.[9,14]

Inadequate training is understood to be a primary factor in an ineffective patient safety culture. Thus, professional training and qualifications consist not only of technical aspects but also of promoting behavioral changes to encourage health professionals to report events, replacing punishment with learning from failures.[1:85] These factors contribute to identifying the causes of adverse events and consequently help prevent new occurrences.[1]

There is evidence that effectively training health professionals significantly impacts improving patient safety

culture in health institutions. Furthermore, the participation of health institution leaders and their employees enhances the safety culture. The training includes communication skills and a non-punitive approach to mistakes.[2]

CONCLUSION

From the scoping review, it was possible to map the practices of disclosure of adverse events for hospitalized patients and their companions, related to patient safety, in hospital environments, in scientific literature. Thus, it was possible to observe the different strategies to carry out the practice of disclosure, among which the apology emerged as a way to reduce the impact of adverse events and demonstrate empathy, respect and responsibility on the part of health professionals.

In addition, it was recognized that clear, transparent, and empathetic communication during the disclosure process is essential to inform patients about their clinical condition, available treatment options, expected benefits, and potential risks.

The results also showed that the training and qualification of professionals, both in the prevention of adverse events and in the practice of disclosure, has a significant impact on strengthening patient safety.

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