

Disclosure as a tool for communication errors in healthcare

ABSTRACT

Introduction: Patient safety is currently the central focus of quality management, and patient care has evolved based on experiences, research and advances in the areas of education and healthcare. Among the countless tools that seek excellence in patient care and safety, Disclosure is the term that refers to the disclosure, revelation or sharing of information related to errors or adverse events with life-threatening consequences.

Aim: To understand the perceptions and experiences of healthcare professionals working in Brazilian hospitals in relation to the use of Disclosure.

Methods: This is a descriptive study with a qualitative approach. The participants were professionals who work in the Patient Safety Centers of general hospitals in Curitiba, Paraná, Brazil. Information was collected through semi-structured interviews.

Results: The participation rate in the research was 80%, totaling twelve professionals. The ideas that converged were extracted from the interviews and observations, indicating a categorical analysis approach to identify patterns and trends in the participants' responses, from which five categories could be constructed, namely: (Mis)knowledge, Disclosure, Quality and Litigation, Professional Alignment, Work Process.

Conclusions: By revisiting the proposed objective, it was possible to understand the professionals' perceptions about Disclosure in light of the five categories mentioned in the results, mainly regarding the lack of knowledge on the subject and the work process still under construction. Regarding experiences, a procedural gap was observed between hospitals that implement Disclosure and those that do not, and the prevalence of hospitals with health accreditation seals is driving the increasing increase in compliance with these requirements, mainly through the teaching and research.

Keywords: Medical errors; Adverse events; Patient safety; Disclosure; Education

1. INTRODUCTION

In the current scenario, where patient safety is central to quality management and the care provided, the term Disclosure has emerged as a protocol adopted by institutions committed to patient safety. Its purpose is to share with patients and families the occurrence of errors in health care, providing an honest account of what happened, as well as the measures taken to minimize damage and preventive actions [1].

Patient safety is a critical measure for the quality of health services, aimed at preventing harm and injury resulting from the care provided. In most definitions, patient safety is not limited to the mere absence of errors, but is intrinsically linked to the absence of accidental injuries. From this perspective, experts argue that focusing on reducing the number of injuries is more pragmatic and productive than concentrating exclusively on the errors made during healthcare provision [2]. Annual estimates of the number of preventable adverse events vary substantially, ranging from 1.3 million to 15 million. This disparity is partly attributable to the complexity of conceptualizing these events and the variety of monitoring systems in place.

46 Globally, the regulation and implementation of safety practices are fundamental, and various
47 measures are adopted on a daily basis to strengthen this commitment. In this regard, different
48 countries are seeking to improve health care, particularly by highlighting the importance of
49 Disclosure. This structured process of communicating with patients and their families in cases
50 of serious unintentional harm is recognized by healthcare professionals as a fundamental
51 practice for promoting transparency and trust in the care environment.

52 Although there is no specific legislation or precise definition for Disclosure, its effective practice
53 requires ethical and moral reflection, with a respectful attitude that values patients' complaints
54 [3]. This strategy is considered to be excellent for promoting patient well-being and reducing
55 economic backlogs due to legal issues. In a survey carried out among healthcare
56 professionals and patients/family members, it is mentioned that the Disclosure process does
57 not receive enough attention in the scientific community or in healthcare institutions globally,
58 with few countries adopting formalized and institutionalized practices through protocols or
59 guidelines on this effective but primarily human communication technique [4].

60 Above all, disclosure stands as a fundamental foundation for building and maintaining trust in
61 the provision of healthcare. Patients expect to receive complete and transparent information
62 about the care process, including the risks, benefits and potential failures. The right to
63 information is fundamental to the doctor-patient relationship. Hiding such failures only
64 intensifies the suffering of patients and their families, preventing them from understanding
65 what happened, seeking proper follow-up and even making crucial decisions for their health
66 [5, 6].

67 Disclosure, therefore, transcends the mere communication of facts and becomes an essential
68 element of the care process. Through transparency, patients become active agents in their
69 own health, actively participating in decisions that impact their well-being [7].

70 It can, therefore, be said that Disclosure, as a process of revealing adverse events and errors
71 to patients, is a practice that has been the subject of considerable reflection and investigation
72 in the healthcare area. Several ethical and legal aspects involve this process, influencing the
73 quality of health care and the relationship between health professionals and patients.

74 This global scenario, still under construction, motivated the search for in-depth knowledge of
75 a specific context, considering that the researcher is a nurse who works with patient education
76 and safety and in this context, the question is: what is the perception and experience that
77 health professionals have on this topic? We therefore set the objective of understanding the

78 perceptions and experiences of health professionals about Disclosure and its application in
79 their respective institutions, an opportunity to discuss and add comprehensive ideas about
80 how health institutions work with Disclosure and also how they play their role in reporting
81 adverse effects. errors. This study also intends to contribute to the improvement of health
82 communication practices, promoting a transparent and ethical approach in disseminating
83 information to patients and their families.

84 **2. METHODS**

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86 In order to achieve the proposed objective, this study was carried out using descriptive
87 research with a qualitative approach, which consists of a methodology aimed at exploring and
88 understanding complex phenomena, behaviors, opinions and human experiences [8].

89 To carry out this study, the structure was divided into three phases: 1) pre-analysis, where a
90 precise work scheme is established and the material to be analyzed is organized; 2)
91 exploration of the material, involving floating reading, selection of documents, formulation of
92 hypotheses and objectives, referencing of indices and development of indicators; and 3)
93 treatment of the results, including collection, interpretation and condensation of information for
94 analysis [9].

95 The participants were employees responsible for Patient Safety Centers or those designated
96 for this role, identified through a search on the website of the National Health Surveillance
97 Agency in Brazil. The aim of this initial survey was to identify healthcare establishments
98 characterized as general hospitals that declared they had a registered Patient Safety Unit

99 (PSU). After the initial collection of information, in which results were obtained from all over
100 Brazil, it was necessary to delimit the sample with hospitals in the city of Curitiba, state of
101 Paraná, Brazil and finally, an additional refinement was carried out to exclude hospitals that
102 reported providing care exclusively in specific areas, such as maternity wards, pediatrics,
103 cosmetic surgery, ophthalmology, nephrology and orthopedics. The final sample included
104 public and private hospitals, with no distinction made between the size of the institution or the
105 level of complexity of the care provided, in the city of Curitiba, and with a Patient Safety Center
106 in place for six months or more.

107 The project was submitted for ethical appraisal and was approved under number 5.931.390.
108 The information was collected through semi-structured interviews with the following guiding
109 questions: 1- What do you know about Disclosure, 2- What is your perception of Disclosure
110 and the quality of care? 3- In the Patient Safety Center, how do you contribute to the
111 development of the Disclosure process? 4- Is there a memorable fact for you related to
112 Disclosure in this Institution and 5- What does the implementation of Disclosure change in the
113 routine or work processes in the Institution? and finally, for the third and last part, the question
114 was: in one word, how would you describe the Disclosure process?

115 The interviews were carried out between May and August 2023 after obtaining the consent of
116 the participants, but it is worth noting that two nurses took part beforehand to validate the
117 interview, which underwent minor adjustments.

118 Data collection ended when new information no longer provided additional ideas, reaching the
119 densities and diversity needed to answer the research objective. This point of theoretical
120 saturation indicates that the quantity and variety of data collected was sufficient to support the
121 study's analysis and conclusions [10].

122 After the transcriptions were made, without the use of software, they were returned to the
123 participants for their final consent.

124

125 **3. RESULTS AND DISCUSSIONS**

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127 As we begin to present the results, it is important to note that the study design was based on
128 the Eight Big Tent Criteria to support the research with excellence, using the COREQ
129 qualitative checklist [11, 12].

130 Twelve professionals responsible for the NSP or Quality sectors actively participated in this
131 research, providing a comprehensive analysis of the practices related to Disclosure in the
132 institutions studied, achieving a representativeness of 80% in relation to the estimated
133 audience.

134 During the process, we sought to understand healthcare professionals' perceptions and
135 experiences of Disclosure. Of the data obtained and compiled, 41.7% of those interviewed
136 said that they carry out Disclosure internally in their institutions, 25% carry it out partially,
137 recognizing its importance but still unable to fully implement it, while 33.3% do not carry it out,
138 as shown in Graphic 01. In addition, the Table 01 also shows that the size of the institutions
139 interviewed was six large (50%), four medium (33%) and two small (17%). As for the
140 complexity of the care provided, ten were high and medium risk (83.3%) and two were low risk
141 (18%).

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143 **Table 01. Hospitals with active Disclosure.**

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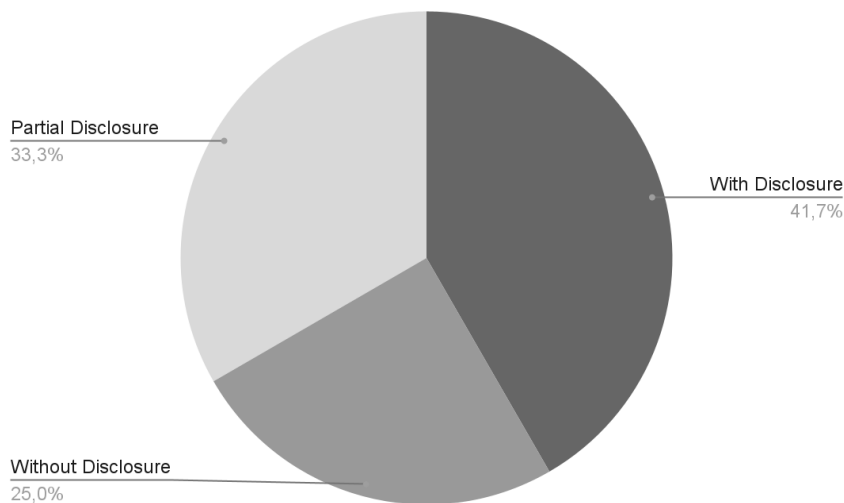
Hospital	Disclosure	Size	Complexity
H01	No	Large	High
H02	Yes	Large	Medium
H03	Partial	Large	High

H04	Yes	Medium	High
H05	No	Small	Medium
H06	Partial	Small	Low
H07	Partial	Large	High
H08	Yes	Medium	Medium
H09	Yes	Large	High
H10	Yes	Large	High
H11	No	Medium	Medium
H12	No	Medium	Low

*Source: the authors

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Graphic 01: Percentage of hospitals with active Disclosure.



*Source: the authors

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The information obtained through the semi-structured interview was analyzed according to the theoretical framework and it was possible to didactically describe the content in five categories, which will be presented individually.

3.1 Category I - (Un)knowledge

When asked what they knew about Disclosure, some of the participants showed ease of comprehension, answering in an enlightening manner, as exemplified below:

“It’s a process for when we have an adverse event for the patient, from the moment we are sure that it was an adverse event, that there was a flaw in

165 the process or a breach of conduct, which led or could have led to some
166 damage, we need this transparency with the family, with an apology.”
167 (H11)

168 However, with regard to other participants, it was clear that they did not have in-depth
169 knowledge of the subject, since their answers were brief or evasive:

170 “The concept, but I understand that it's about working transparently both
171 with the team and with the family.” (H01)

172 “We don't apply in hospital.” (H05, 06 e 12)

173 In order to carry out Disclosure effectively, it is very important to know how to communicate
174 the news to family members and the patient, but first you need to know its concept, recognize
175 its causes and take an in-depth look at the fact. In this study, we observed that this is not
176 always the case, because some professionals, although they already have a certain familiarity
177 with the subject, don't know it properly. The professional responsible for carrying out the
178 Disclosure must be aware that they are sharing information that is not always pleasant, and
179 they need to approach it carefully in order to keep those involved comfortable during the
180 conversation. Otherwise, there is a risk of causing greater trauma and jeopardizing the
181 relationship of trust [13].

182 Disclosure aims to promote transparency, accountability and trust among stakeholders.
183 However, it is important to note that the effectiveness of disclosure depends not only on the
184 amount of information disclosed, but also on the clarity, accessibility and honesty with which
185 it is presented. If the professionals involved don't know, don't reflect, don't improve on the
186 subject, as was highlighted in some of the speeches, it is understood that disclosure will be
187 hindered. Integrity and ethics play a fundamental role in conducting Disclosure at all levels
188 and knowledge, sharing and dissemination of this practice is of great value if the goal of
189 improving processes and quality of care is to be achieved [14].

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192 **3.2 Category II - Disclosure, quality and litigation**

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194 By recognizing and communicating errors, unnecessary litigation can be avoided, promoting
195 organizational learning and ensuring that patients receive the support they need after adverse
196 events occur. In addition, organizational learning is not restricted to simply informing patients
197 about adverse events; it also involves analyzing these events to understand their causes and
198 implement improvements. This learning process is vital for improving the quality of care,
199 identifying risk areas and preventing future incidents. Quality in healthcare is a continuous
200 process of improvement [15].

201 Below is an answer obtained in relation to an interviewee's view of the Disclosure process:

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203 ““A tool to share with them the cases that don't have a satisfactory outcome
204 in their institution” (H04)

205 Disclosing information about safety incidents to patients and their families not only reinforces
206 transparency, but is also a determining part of patient-centered care. This practice not only
207 meets ethical requirements, but also contributes to maintaining trust by demonstrating a
208 genuine commitment to patient well-being and safety [15]. The speeches reveal this extremely
209 important issue, as can be seen:

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211 “Having a family member at the meeting so that patients and/or their families
212 can give ideas for improving activities is a way of building patient loyalty to the
213 hospital.” (H02)

214 Legal disputes in healthcare often arise from allegations of medical negligence, diagnostic
215 errors, inadequate treatment, among other problems related to the quality of care. Proper
216 disclosure of information and detailed documentation are crucial in cases of litigation [16]. In
217 addition, health legislation, based on the National Health Council's Charter on the Rights of
218 Health Users, guarantees people the right to adequate treatment, clear information about their
219 state of health and respect in communication [17].

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221 "We communicated with the family, informed them of everything that had been
222 done, and even so, after a while the lawsuit arrived." (H11)

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224 "We had a situation in which we were first notified by the event team, we
225 began to investigate the process, and we had already taken it to the
226 management, we had already brought in others involved, those responsible
227 for the processes in the situation, and we had already come to the conclusion
228 that we were going to have to talk to the family because of the failure that had
229 occurred. Then, before we called the family in to talk, the family came in
230 nervous..., quite armed and realized that we already knew about the situation
231 and that we already had some options for resolving the problem for them, so
232 the family calmed down, and the perception was that, as much as the fault
233 was (...) a very serious flaw, something that there was no going back to fix,
234 but we still managed to show the family that the measures had already been
235 taken, so that it wouldn't happen to others.... that's the idea, it's exactly that
236 we managed to put some options on what to do from then on with that family
237 or another patient (...) so the family calmed down a bit and it didn't end up
238 generating a legal case." (H07)

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240 The interviews revealed that the Patient Safety or Patient Risk Management sector is an active
241 arm of the Quality sector in the institutions surveyed. This integration facilitates the
242 implementation of preventive measures and technical adjustments to the conduct needed to
243 guarantee patient safety.

244 Without a doubt, Disclosure plays a critical and transformative role in promoting the quality of
245 healthcare. Its essential contributions include creating an environment of trust, stimulating
246 learning and reinforcing responsibility, providing significant benefits for patients, healthcare
247 professionals and healthcare institutions as a whole [18]. By adopting Disclosure, healthcare
248 institutions demonstrate a clear commitment to transparency and honesty. This open and frank
249 approach builds trust with patients, who feel safer receiving care from professionals and
250 institutions that recognize and report adverse events [19].

251 By taking responsibility for adverse events, healthcare institutions and professionals
252 demonstrate a proactive stance towards transparency. This not only strengthens patient trust,
253 but also reinforces ethical and professional responsibility in the provision of healthcare [19].

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255 **3.3 Category III: Professional alignment**

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257 The active involvement of the patient in decision-making about their care is recognized as an
258 essential component for improving healthcare [20]. In addition, the effective participation of
259 hospital staff in communicating Disclosure in situations of adverse events or medical errors is
260 extremely important. The staff's transparent and ethical approach plays a fundamental role in
261 managing these situations, contributing to building a relationship of trust between healthcare
262 professionals and patients.

263 The effective participation of hospital staff in communicating Disclosure is equally vital.
264 Healthcare professionals, including doctors, nurses, psychologists, social workers and
265 administrators, play specific roles in managing these situations. The team's transparent and
266 ethical approach contributes to building a relationship of trust with patients.

267 Effective collaboration between these professionals is essential to ensure a comprehensive
268 approach, taking into account different perspectives and needs [21]. Along these lines, a good
269 comment from one of the participants:

270

271 “Since the integration, we have talked about what Disclosure is and how we
272 work with it within the Institution.” (H02)

273 Hospital staff play a crucial role in providing psychosocial support to patients and their families
274 during the Disclosure process. Offering emotional support, clarifying doubts and making
275 referrals to counseling services are important aspects of this support, especially when it is
276 clear that professionals are aligned in their approach to healthcare [22].

277 The presence of a professional who has established a bond with the patient or family member
278 during the Disclosure process is highlighted as effective. This professional, through the
279 relationship built up, can provide additional support in clarifying doubts, contributing to a more
280 humanized experience [23].

281 It is essential that hospital staff are instructed on how to prevent adverse events and, equally
282 important, how to report them if they occur. Clear knowledge of the procedures to be followed
283 provides an efficient response to adverse events, ensuring that communication is carried out
284 properly and effectively [24].

285 In order for the team to be aligned and provide assistance in an equitable manner, we can say
286 that the presence of established and systematized criteria is highlighted as a fundamental
287 element. This implies having clear policies, well-defined procedures and systematized criteria
288 that contribute to a more effective and ethical approach to Disclosure. These practices not
289 only facilitate open communication with patients, but also promote organizational learning and
290 the prevention of future adverse events [25].

291 Error analysis must go beyond individual accountability and seek to understand what went
292 wrong in the system. This systemic approach is of great importance in identifying gaps in
293 processes, system failures and areas for improvement. Healthcare professionals play a central
294 role in identifying opportunities for improvement in processes and practices and engaging in
295 continuous improvement initiatives contributes to a safer care environment [26].

296 An organization with an effective safety culture is characterized by openness and fairness
297 when incidents occur. This implies not seeking immediate blame, but understanding the
298 systemic factors that contributed to the adverse event. Healthcare professionals must feel
299 motivated to notify or report errors when they occur. This is related to trust in the organization's
300 approach to dealing with incidents constructively, without excessive penalties [27].

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303 **3.4 Category IV: Events**

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305 In this research, it was possible to observe that in all the institutions involved, there have been
306 adverse events in recent years. Examples of participant reports follow:

307

308 *“We had an elderly 80-year-old patient who had been discharged. The family*
309 *was approached so that the patient could be discharged in accordance with*
310 *the routine established by the hospital, which was to take a wheelchair to the*
311 *exit and after checking he would be released, the family commented on the*
312 *patient's stubbornness and that they wanted to guarantee his support, and at*
313 *the end of the day he did what he wanted and almost as soon as he left the*
314 *hospital there was a fall and consequently he died.” (H04)*

315 *“We had an exchange of urine results between an adult and a child, where*
316 *when evaluating the response of the test, the presence of spermatozoa was*
317 *noticed, where it was at first imagined possible violence to the minor, with this,*
318 *when talking to the mother, the child spent part of the day with the father, this*

319 *fact generated an uncomfortable suspicion about it, compliance and legal*
320 *were involved to talk to the family and inform the failure that was the exchange*
321 *of results in the laboratory sector of the Institution.” (H01)*

322 Here, we only present two events that took place. However, during the interviews, we noticed
323 that each individual had something to relate or exemplify. Most of the time, these experiences
324 went beyond a single situation, thus highlighting the importance of a Disclosure process that
325 is systematized, clear and ethical.

326 It is estimated that adverse events are among the top ten causes of health problems resulting
327 in death or permanent injury, and it is even recognized that adverse events are significant
328 concerns and that the notification and reporting of these incidents are essential to improving
329 patient safety, as well as preventing future occurrences.

330 It is imperative that organizations establish a documented policy that clarifies to everyone the
331 significance of the notification or reporting system. This policy should address the
332 consequences associated with this, clarify the rights, privileges, protections and obligations
333 that individuals can expect. Encouraging people to notify/report security incidents is key to
334 building trust, based on the premise that information provided in good faith will not be used in
335 a harmful way against the informants [28]. From these perspectives, the facts described
336 demonstrate the importance of clear communication between the different team members and
337 point to the need to establish protocols that everyone can follow effectively and effectively.

338

339

340 **3.5 Category V: Work processes**

341

342 The work process related to Disclosure begins with the identification of the adverse event or
343 error. This process can be triggered through security monitoring, incident reporting, patient
344 complaints, or other detection mechanisms. Once identified, the adverse event is reported and
345 recorded, involving the completion of reporting forms and documentation of the circumstances
346 of the event, as well as the collection of relevant information. Concomitantly, an internal
347 investigation is conducted to understand the causes and circumstances of the adverse event
348 or error [29].

349 This investigation process involves reviewing medical records, interviewing the team involved,
350 and identifying any potential flaws in the process. The health team associated with the adverse
351 event is informed and participates in the Disclosure process, including internal meetings to
352 review the results of the investigation. After this stage, the health team prepares to
353 communicate the adverse event to the patient and family in a sensitive and transparent
354 manner. Where appropriate, remedial measures are discussed and implemented, such as
355 additional treatment, psychological support, or financial assistance. Throughout this process,
356 it is essential to provide support to the patient and family [30].

357 Finally, the healthcare team communicates how they can learn from the adverse event or
358 error, highlighting the implementation of corrective measures to prevent similar errors in the
359 future. This process is vital to ensure transparency, accountability, and continuous
360 improvement in the quality and safety of patient care, and can be understood in the following
361 speech:

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363 *“An easy practice, we have event notifications, there is an underreporting and*
364 *sometimes we do active search, so events that reached the patient, those that*
365 *have priority for Disclosure, events in patient safety that we take from the*
366 *quality improvement report or we identify by active search (...) for example, I*
367 *am there evaluating a case of infection and suddenly there is a hematoma*
368 *that was not notified here by the report of quality.” (H02)*

369 The Disclosure, by addressing the open and transparent disclosure of adverse events or
370 medical errors to patients and their families, is intrinsically linked to quality in patient safety.

371 This practice aims to promote trust and effective communication between patients and
372 healthcare professionals, contributing to the establishment of a culture of safety. Authenticity
373 in communication during Disclosure is essential to ensure that patients receive safe and
374 effective health care [28]. The practice of Disclosure not only builds trust but also plays a
375 significant role in quality and safety improvement initiatives in the healthcare industry. By
376 recognizing and reporting errors, unnecessary litigation can be avoided, promoting
377 organizational learning, and ensuring that patients receive the necessary support after
378 adverse events. In addition, organizational learning is not restricted to simply informing
379 patients about adverse events; It also involves analyzing these events to understand their
380 causes and implement improvements. This learning process is vital for improving the quality
381 of care, identifying areas of risk, and preventing future incidents. Quality in health care delivery
382 is a continuous process of improvement [15].
383 To complement the answer to the last question of the interview, a visual representation of the
384 words provided by the interviewees was made, forming from a free evocation of words. Three
385 of the institutions, as they do not have the Disclosure process active, refrained from
386 conceptualizing. In this question, six words were mentioned, namely: Transparency (3
387 mentions), Responsibility (2), Challenge (1), Respect (1), Learning (1), and Essential (1), as
388 you can see below:
389



*Source: the authors

Image 1: List of words

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395 The representation shows that transparency is essential for patient safety, however, it
396 presents itself as a challenge to be overcome immediately. Time is pressing. The promotion
397 of safe care must be boldly recognized in the contemporary scenario, outlining a strategy to
398 improve the services offered and transform care practices. This allows for critical, reflective,
399 purposeful, committed, and technically competent action [31].

400
401

402 **4. CONCLUSIONS**

403

404 It was possible to apprehend relevant and up-to-date facts, experiences and reports on
405 Disclosure, a process that is not yet widely adopted in hospitals in Curitiba, Paraná State,
406 Brazil. This gap reflects the need to consolidate this capability to facilitate the communication
407 of adverse events or possible errors to patients and their families, not locally, but can be
408 expressed to other healthcare settings globally.

409 Initially, it was observed that health professionals were unaware of the practice of disclosure,
410 resulting from the lack of training aimed at professional training and discomfort in admitting or
411 disclosing adverse events. In accredited institutions, however, there was a growing demand
412 for compliance with this requirement, driving investments in continuing education programs.
413 This not only strengthens patient safety but also improves the quality of care and promotes a
414 fair culture in hospital institutions.

415 Although still in incipient stages, some institutions already have systematized protocols for
416 carrying out Disclosure, following pre-defined regulations. Others, however, did not pay due
417 attention to this crucial point for the quality of care, evidencing the need for preparation and

418 updating of professionals in the face of the evolution of the care process and the central role
419 of the patient in health care.

420 It is essential that health institutions invest in continuing education programs to disseminate
421 the culture of Disclosure among professionals, overcoming resistance and promoting
422 transparency in relationships with patients. The implementation of clear protocols and the
423 creation of an organizational culture that values patient safety are essential steps for the
424 consolidation of this practice. In addition, it is necessary to encourage research on the subject,
425 in order to identify the best practices and challenges to be overcome. The construction of a
426 support network among health institutions can facilitate the exchange of experiences and the
427 development of innovative solutions for the implementation of Disclosure.

428 We highlight, at the end, that organizational culture plays a fundamental role in the
429 implementation of Disclosure. A culture of transparency and accountability is essential for
430 building safer and more reliable health institutions. The implementation of Disclosure requires
431 a profound cultural change, which involves all levels of the organization.

432 Although the shortcoming of this study is the fact that it was carried out in few health
433 institutions, it is necessary to recognize that Disclosure is not only a legal requirement, but an
434 ethical commitment to the quality and humanization of care. Therefore, we point to future
435 opportunities regarding the implementation of disclosure, highlighting the role of managers
436 and health professionals in promoting this practice.

437

438 Consent

439 As per international standards or university standards, Participants' written consent has been
440 collected and preserved by the author(s).

441

442 Disclaimer (Artificial intelligence)

443 Option 1:

444 Author(s) hereby declare that NO generative AI technologies such as Large Language Models
445 (ChatGPT, COPILOT, etc) and text-to-image generators have been used during writing or
446 editing of manuscripts.

447 Option 2:

448 Author(s) hereby declare that generative AI technologies such as Large Language Models,
449 etc have been used during writing or editing of manuscripts. This explanation will include the
450 name, version, model, and source of the generative AI technology and as well as all input
451 prompts provided to the generative AI technology

452 Details of the AI usage are given below:

- 453 1.
- 454 2.
- 455 3.

456

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