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Bridging the Gap: Toward a Unified Framework for Transparent and Patient-Centered Error Disclosure

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ABSTRACT

Medical error remains a major global patient-safety concern and continues to contribute substantially to morbidity and mortality. Despite sustained international efforts to improve healthcare quality, disclosure of medical errors to patients remains inconsistent and operationally challenging. Although widely accepted as an ethical obligation and a cornerstone of patient and family-centered care, disclosure practices vary considerably across healthcare systems. We have previously described Canadian provincial initiatives promoting open disclosure and advocated for their integration into a no-fault framework. The objective of this study is to conduct a systematic comparative analysis of medical error disclosure policies across Canadian provincial and territorial health authorities and to propose a best-practice medical error disclosure model. Using a structured policy review, we evaluated existing frameworks across five indicators: timeliness and accuracy of communication; the presence of a supportive, non-punitive institutional culture; availability of formal education and training; and coordinated, team-based involvement in disclosure. While most jurisdictions endorse transparent disclosure in principle, substantial variability exists in training requirements, team coordination, and enforcement mechanisms. These inconsistencies contribute to persistent provider uncertainty driven by inadequate preparation, medico-legal concerns, fear of damaging therapeutic relationships, and organizational cultures that do not consistently support transparency. Our findings highlight disclosure as a complex, iterative process requiring alignment of ethical principles, communication strategies, patient safety practices, and institutional support. In the absence of a national framework, we recommend the development of a patient-centered, non-punitive disclosure policy embedded within the standard of care.

Keywords: Quality care, Patient safety, Medical error disclosure, Culture of safety, Patient-centered care

INTRODUCTION

Medical error is a major global patient-safety concern and causes substantial morbidity and mortality. Despite efforts to improve healthcare quality, errors

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continue to persist (Kumah, 2025). Since the Institute of Medicine (IOM) published To Err Is Human in 1999, medical errors have been recognized as a leading cause of death in the United States and a major contributor to preventable harm worldwide (Institute of Medicine, 2000). The report indicated that medical errors stem from systemic failures rooted in complex healthcare processes, organizational structures, and communication breakdowns, not individual blame. After the IOM report, patient safety initiatives focused on error prevention through system redesign, reporting, and quality improvement (Mutair et al., 2021). These efforts led to some improvements, but healthcare systems have made little progress in standardizing responses to errors (Kalra et al., 2011).

Disclosing errors to patients and families remains inconsistent, challenging, and emotionally difficult for providers. Disclosure of medical errors is widely recognized as an ethical obligation and a core element of patient and family-centered care (Bismark et al., 2006). Patients consistently seek timely, honest, and compassionate communication when harm occurs (Heidari et al., 2018). Transparent disclosure supports autonomy, informed decision-making, and preserves trust in the healthcare system. However, disclosure remains inconsistent, reflecting deficiencies in policy implementation, education, and organizational support, rather than a lack of moral awareness (Miziara et al., 2025).

In Canada, provinces and territories have developed their own disclosure policies. We have reported on initiatives promoting open disclosure and suggested integrating disclosure into a non-punitive, 'no-fault' model to increase transparency, learning, and system improvement (Kalra et al., 2024; Kalra et al., 2020; Kalra et al., 2013). However, Canadian disclosure policies remain fragmented, inconsistently applied, and lack the needed organizational support to guide healthcare professionals.

This study systematically compares current medical error disclosure policies across Canadian provincial and territorial health authorities and proposes a best-practice model. Using a structured policy review, we evaluated frameworks by five indicators: (1) timely and accurate communication, (2) a supportive, non-punitive culture, (3) formal provider education, (4) coordinated team-based disclosure, and (5) organizational support for implementation and enforcement. By focusing on these indicators, this paper aims to bridge the gap between ethical expectations, policies and practices.

MEDICAL ERROR, ADVERSE EVENTS, AND THE ETHICAL BASIS FOR DISCLOSURE

Medical error represents a challenge in patient management. It includes errors in planning, execution, or communication. Adverse events are injuries caused by medical management, not by the disease process (Bates et al., 1997). Canadian studies estimate 5% to 7.5% of hospitalized patients have an adverse event (Baker et al., 2004). Many of these errors are preventable. These findings align with international data, showing that error is a constant risk in complex healthcare systems (Sameera et al., 2021).

Disclosure of adverse events is both an ethical obligation and a practical necessity in quality healthcare. It is grounded in the principles of beneficence, nonmaleficence, autonomy, and justice, requiring clinicians to act in the patient's best interests, avoid further harm, and provide complete information to support justice and accountability (Nacu et al., 2025). Failure to disclose errors undermines these principles and erodes trust. Patients are more likely to maintain trust after honest disclosure, whereas nondisclosure or delay often leads to mistrust and potential complaints (Lawongsa, 2025). Despite widespread ethical imperatives, disclosure practices remain inconsistent, highlighting the need to examine not only the moral necessity to disclose but also the systems and structures that enable or hinder disclosure in practice.

BARRIERS TO MEDICAL ERROR DISCLOSURE

Healthcare providers face barriers to disclosing errors, primarily from legal, cultural, and organizational factors (Elseesy et al., 2025). Fear of litigation, disciplinary action, or reputational harm persists, especially in the absence of explicit institutional guidance or legal protection. Fears from the harms of the therapeutic patient-physician relationship further complicate disclosure of errors. Physicians fear disclosure will cause loss of trust, emotional distress, or difficulties aligning treatment plans with a patient's values and priorities (Mazor et al., 2006). However, literature findings suggest that transparent disclosure is more likely to preserve the patient-physician relationship than silence or avoidance (Anwer et al., 2012). Organizational culture also plays a key role in shaping disclosure behaviour for providers. Healthcare environments marked by blame and punitive responses can leave clinicians feeling isolated and unsupported (Machen et al., 2019). We have previously reported that policies lacking clear non-punitive language may discourage openness (Kalra et al., 2024). In such settings, providers may avoid disclosing errors to protect themselves rather than communicate openly.

A lack of education and training is another barrier to disclosure of an adverse event. Many providers are often in positions that require error disclosure but have not received structured training on difficult conversations. This lack of preparation causes anxiety, avoidance, and inconsistent disclosure practices. Unclear team roles and responsibilities also delay disclosure and increase stress (Chen et al., 2024). Adverse events in modern healthcare often involve many providers and system-level issues (Rodziewicz et al., 2024). Without coordinated teams, disclosure may be fragmented or delayed, further jeopardizing quality care delivery and patient safety.

STRUCTURED COMPARATIVE POLICY REVIEW

We reviewed medical error disclosure policies in Canadian provinces and territories. Policies were obtained from health authorities, public documents, and prior national analyses. Quebec was excluded due to data and language

barriers. Policies were measured using five indicators. These were taken from the study objective and prior Canadian disclosure research.

1. **Timely and accurate communication** - expectations for prompt, factual, and ongoing disclosure
2. **Supportive, non-punitive culture** - explicit avoidance of blame and encouragement of transparency
3. **Formal provider education and training** - availability of structured disclosure education for healthcare providers
4. **Team-based disclosure** - coordinated participation of interdisciplinary teams in disclosure
5. **Organizational support** - infrastructure supporting implementation, documentation, and accountability

Each policy was reviewed to see how these indicators were addressed. We focused on patterns, differences, and gaps to design a best-practice disclosure framework.

VARIABILITY ACROSS THE FIVE KEY INDICATORS

Canadian provinces and territories endorse transparent error disclosure. However, there is significant variability in how the five indicators are addressed and implemented (Table 1).

Table 1: Comparison of the five key disclosure indicators across canadian jurisdictions.

Key Indicator	Average Inclusion	Key Observations
Timely and Accurate Communication	High	Prompt disclosure endorsed; timelines often unspecified
Supportive, Non-Punitive Culture	Moderate–High	Non-blame language common; enforcement inconsistent
Formal Provider Education and Training	Low	Most consistent national gap
Team-Based Disclosure	High	Broad endorsement; limited procedural detail
Organizational Support	Moderate	Documentation emphasized; accountability mechanisms variable

Policies often state the ethical importance of disclosure but give little practical guidance. Many encourage timely disclosure but fail to set expectations for follow-up. Non-punitive language is common, yet most policies do not outline how to ensure psychological safety for healthcare providers. Formal education and training are the weakest points across jurisdictions. Few policies require disclosure training. Even fewer outline how to develop or test competency. In contrast, team-based involvement is widely endorsed across all of the policies reviewed. The inclusion of a team-based approach shows recognition that disclosure is rarely an individual task.

COMPLEXITY OF DISCLOSURE

The findings of this study highlight that effective medical error disclosure is a complex, iterative process rather than a discrete event. Initial disclosure often occurs when full details of an adverse event are not yet known. Policies that allow for honest acknowledgment of uncertainty while committing to ongoing communication are better aligned with clinical realities than those that emphasize a single disclosure conversation.

Timeliness and accuracy must be balanced carefully. Premature disclosure without adequate information may lead to speculation, while delayed disclosure risks eroding trust. Best-practice policies emphasize prompt initial disclosure followed by regular updates as investigations progress. The presence of a supportive, non-punitive institutional culture is central to enabling disclosure of an adverse event. Policies that explicitly avoid blame and emphasize system-level learning are more likely to foster transparency. However, without organizational reinforcement, such language may remain conceptual rather than actionable.

The lack of formal education and training represents a critical vulnerability across all of the disclosure policies. Disclosure is a skill that requires preparation, reflection, and practice. Expecting clinicians to navigate disclosure without training places an unreasonable burden on individuals and increases the likelihood of inconsistent or inadequate communication. Team-based disclosure approaches reflect the realities of modern healthcare delivery. Adverse events often arise from complex interactions among multiple providers, technologies, and processes. Clearly defined team roles reduce ambiguity, promotes consistency, and lessens individual emotional burden.

TOWARD A BEST-PRACTICE DISCLOSURE MODEL

Based on this comparative analysis, a best-practice disclosure model grounded in the five key indicators is proposed (Table 2).

Table 2: Best-practice disclosure model based on five key indicators.

Key Indicator	Best-Practice Characteristics
Timeliness and Accuracy	Prompt initial disclosure with ongoing updates
Non-Punitive Culture	Explicit avoidance of blame; focus on learning
Education and Training	Mandatory, longitudinal disclosure training
Team-Based Approach	Defined interdisciplinary roles
Organizational Support	Infrastructure for guidance, documentation, accountability

Embedding disclosure within the standard of care and aligning it with institutional infrastructure would reduce variability across the provincial and territorial bodies as well as support clinicians in fulfilling ethical obligations.

IMPLICATIONS FOR POLICY AND PRACTICE

In the absence of a standardized national framework, healthcare providers must navigate disclosure obligations without consistent guidance. A national, patient-centered, non-punitive disclosure policy would strengthen trust, reduce uncertainty, and promote system-level learning. Policymakers and accreditation bodies are well-positioned to advance transformative change by integrating disclosure expectations into quality and safety standards. Emphasizing education, team-based practice, and organizational support would lessen individual provider burden while reinforcing a culture of patient safety.

CONCLUSION

Although most Canadian jurisdictions formally endorse transparent disclosure of medical errors, significant variability remains across the five key indicators essential to effective implementation. Gaps in provider education and training, organizational support, and the promotion of a non-punitive culture all contribute to ongoing provider uncertainty and inconsistent patient experiences. This study highlights the need for a unified, patient-centered disclosure framework grounded in timely communication, supportive culture, formal education, team-based involvement, and institutional support. Transparent and compassionate disclosure remains essential not only to ethical practice but also to fostering patient trust and continuous system-level improvement in Canadian healthcare.

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