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## Practising Open Disclosure: clinical incident communication and systems improvement

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**Abstract** This article explores the way that professionals are being inducted into articulating apologies to consumers of their services, in this case clinicians apologising to patients. The article focuses on the policy of Open Disclosure that is being adopted by health care organisations in the US, Canada, the UK and Australia and other nations. Open Disclosure policy mandates 'open discussion of clinical incidents' with patient victims. In Australia, Open Disclosure policy implementation is currently being complemented by intensive staff training, involving simulation of apology scenarios with actor-patients. The article presents an analysis of data collected from such training sessions. The analysis shows how simulated apologising engages frontline staff in evaluating the efficacy of their disclosures, and how staff may thereby be inducted into reconciling their affective and reflexive sensibilities with their organisational and professional responsibilities, and thereby produce the required organisational apology. The article concludes that Open Disclosure, besides potentially relaxing tensions between clinicians and consumers, may also affect how staff experience and enact their role in the overall system of health care organisation.

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### Introduction

The past two decades have seen governmental and political institutions increasingly colonise the discourse of the interpersonal apology. As exemplified in a recent story about Fijians apologising for cannibalising a missionary in 1838 ('Fiji villagers say sorry for eating British missionary', *Telegraph* U.K., 12 Sep 2007), the apology has become common socio-cultural currency for negotiating, repairing and strengthening relationships between nations, between politicians and the public, and between governments and citizens. Indeed, this recent colonisation of 'sorry' as a means to public reparation has been described as 'a wave of apologies' which is 'an integral part of the democratisation process that accompanied the end of the Cold War' (Borneman 2005: 53). Examples often cited in this regard include Tony Blair's apology for the Irish potato famine (1997) and Bill Clinton's apology for the

Tuskagee experiments<sup>1</sup> (1997). Examples also abound of the public fruitlessly calling for acknowledgement of wrongs and for apologies from wrongdoers, such as the US public demanding an apology from Richard Nixon for the Watergate affair (1973), and Korea demanding an apology from the USSR for shooting down a commercial airliner (1983). Clearly, from its growing prominence in contemporary consciousness as a legitimate form of public discourse, the 'apology has become a form of political speech with increasing significance and power' (Luke 1997: 344), even if the apology's ultimate impact on affected people's lives may remain purely symbolic.

Sociolinguistic analysis of apologising has mostly focused on the interpersonal domain involving two individuals ('I'm so sorry'). Here, the apology is deployed to manage local social circumstances and relationships, and to maintain the social economy of everyday and formal politeness relations (Austin 1962, Lakoff 2003). More recently, the literature has begun to engage with the discourse of the political apology as increasingly prominent and publicised performance (*e.g.* Harris, Grainger, and Mullany 2006). In such public announcements, the apology shifts from utterances realising everyday interaction and personal intention towards forms suiting the genres of public speeches and (broadcast) media reports. The public apology differs from its interpersonal counterpart in three main ways: it is enunciated by someone who was not solely (and sometimes not at all) involved in the wrong-doing; it is enunciated with the intent of being publicly consumed (*i.e.* in the presence of not just 'third' parties, but parties who are connected with media organisations, as well as a general public); and, therefore, it need not even take place with offended parties being present or within a reasonable timeframe following the occasion of harm (as would need to be the case in personal apologising).

The recent apology issued by the new Rudd government (2007–) to Aboriginal citizens in Australia offers a prime example of such ceremonial apologising: 'For the pain, suffering and hurt of these stolen generations, their descendants and for the families left behind, we say sorry. To the mothers and fathers, the brothers and the sisters, for the breaking up of families and communities, we say sorry. And for the indignity and degradation thus inflicted on a proud people and a proud culture, we say sorry'.<sup>2</sup> The controlled rhythm of this statement and the poetic iteration of 'sorry' are emblematic of the public apology's ritual nature. Here, emotion is not simply part of everyday experience, but it is re-presented for the purpose of cultural legitimation and widespread consumption.

This shift in focus towards the colonisation of apologising for public and political purposes leaves unaccounted for, however, the proliferation of apologising across professional and organisational spheres. When a service has deleterious consequences for the consumer, the organisational-consumer relationship is now frequently mediated by an 'organisational apology' – a complex half-way interactive space in between the interpersonal and the public-political apology. In health care, for example, unexpected outcomes resulting from a complication, a known risk or an error resulting in a patient's temporary or permanent disability or death, now incur disclosure and an apology to those harmed by staff members (Canadian Patient Safety Institute 2008, National Patient Safety Agency 2005). Staff are to arrange special meetings with patients (and/or family members) during which they explain and express regret for what went wrong, and then negotiate what will happen next, potentially including forgiveness, reparation, or the formalisation of a complaint. In hospitals, these discussions cut across the dense and complex fabric of trust, hope, anxiety and suffering that accompanies disease and the difficult decision to submit to medical treatment. Complicating this further is that full disclosure of incidents is not necessarily a standard component of clinicians' communication practices. It is not surprising, therefore, that mandatory disclosure of incidents and disclosure training

confront clinicians with considerable practical and personal challenges and demands (Iedema *et al.* 2008a).

The present article explores these issues by focusing on how clinicians respond to disclosure simulation training; in this case, role plays involving staff participants being open about scenario-style adverse events with actor-patients. Simulation is widely used in medical and nursing education, but simulation training has thus far received limited sociological attention (see Seale *et al.* 2007 for an overview). As Seale and colleagues note, ‘simulated encounters place particular demands on participants to manage a communicative form that hybridises educational or skills training discourse with personalised and clinical discourse’ (2007: 184). As the data below demonstrate, the skills training discourse can be central to moving trainees into a new interactive-discursive space. As a result of this ‘frame shifting’ between training and ‘realistic’ discourses, simulation gains what Thrift terms ‘a projective capacity’, which enables people to experience ‘other entities and thereby generate *additional* concepts and conceive unobservable mental states which, in turn, provide it [human intelligence] with high degrees of flexibility in both the physical and social realms’ (Thrift 2005: 467, italics in original).

Our purpose is to explore this ‘projective capacity’ of Open Disclosure simulation. Accordingly, our paper is structured as follows. In the next section, we provide a background to Open Disclosure as an emerging kind of health-reform policy centred on being honest and apologising for clinical harm, and realised by engaging frontline staff in simulation of these conducts. In the body of the paper we analyse the interactive space that the simulation of clinical incident disclosure by frontline clinicians produces. We draw on data from Open Disclosure training sessions which offer insight into how professionals design and negotiate disclosures and apologies, and into how they position themselves vis-à-vis (questionable outcomes achieved by) colleagues and the organisation generally. In the subsequent discussion, we explore the social and interpersonal implications of this analysis for, first, communication about organisational failure as modulator of professionals’ autonomy, and second, simulation training as an emerging policy implementation tool. In parallel with arguments that the clinician-health system relationship is reconfigured by the emerging practice of internal incident investigation (Iedema *et al.* 2006), our conclusion considers the possibility that simulated learning about being responsive to (one’s own *and* colleagues’) patients’ experiences through adverse event disclosure may reconfigure clinicians’ position in relation to ‘the system of care’.

### **Open Disclosure as policy**

In 1987, in response to rising legal bills due to litigation following adverse events, the Veteran Affairs Hospital in Lexington, USA, began to experiment with an approach adopted from a Montreal hospital (Peterkin 1990): ‘to maintain a humanistic, care-giving attitude with those who had been harmed, rather than respond in a defensive and adversarial manner’:

As the policy was implemented and ethical issues regarding disclosure arose, the risk management committee had some tough decisions to make. Ultimately committee members decided the hospital had an obligation to reveal all the details of its investigations to patients and family members affected by errors or negligence, even if they otherwise would not have known that a mishap had occurred.

(Woods 2007: 81)

Just over 10 years later, the practice of apologising for errors and complications was shown to have led to a drop in court cases and claims (Kraman *et al.* 2002, Kraman and Hamm 1999). Open Disclosure now forms part of health policy reform in different US states, Canada, Australia, and the UK.

In brief, Open Disclosure involves clinicians in signalling to the patient and/or the patient's family that an adverse event has occurred. In the UK, Open Disclosure is outlined in the National Health Service's National Patient Safety Agency policy entitled 'Being Open – Communicating patient Safety incidents with patients and their carers' (National Patient Safety Agency, 2005; UK Department of Health, 2005). The Being Open Policy highlights good communication as a principle that is central to this aim: 'openness and honesty can help prevent events from becoming formal complaints and litigation claims' and 'Being open when things go wrong is clearly fundamental to the partnership between patients and those who provide their care' (National Patient Safety Agency 2005). On the matter of how clinicians are to perform 'being open', the document refers to the National Health Service Litigation Authority (NHSLA) circular 02/02. This document states:

It seems to us that it is both natural and desirable for those involved in treatment which produces an adverse result, for whatever reason, to sympathise with the patient or the patient's relatives and to express sorrow or regret at the outcome. (National Patient Safety Agency, 2005: 5)

The terms 'natural' and 'desirable' play a double role here. They acknowledge that our hope for a cure and professional success can sadly remain unfulfilled. They also place our reactions within the realm of the 'personal'. Implicitly opposing the 'personal' to the 'organisational', the remainder of the document articulates the constraints that bear on how staff should frame their disclosures and enunciate their apologies (as 'sorrow' or 'regret'). Were staff to contravene these directives, they may forfeit the right to insurance and indemnity protection.

The Australian National Open Disclosure Standard (2003) harbours parallel tensions between the need to acknowledge patients' pain and the care that needs to be taken not to transgress legal limits for fear of incurring liability. Here, the clinician who does the disclosing is advised they should restrict themselves to the benevolent or partial apology ('We regret it happened'). For its part, Alberta's Open Disclosure framework (Health Quality Council of Alberta 2006) frames Open Disclosure within what initially appears to be an unreserved communicative ethic. After outlining the information that needs to be communicated to patients (an account of what happened, test results, consequences, and a plan), the document emphasises the importance of the apology.

One of the most critical elements of the disclosure conversation is the apology. An apology demonstrates compassion and that the health care system and provider care about the patient and harm that occurred. (Health Quality Council of Alberta 2006: 10)

The document then stipulates that the enunciation of the apology should depend on whether there was a 'deviation from the expected standard of care' or not:

The nature of the apology will be dependent upon whether or not there was a deviation from the expected standard of care. A further apology may be made in subsequent disclosure meetings as more information is learned. (Health Quality Council of Alberta 2006: 10)

What distinguishes the enunciation of a benevolent from that of a full apology in this document is ‘whether the expected standard of care was met (benevolent apology) or not met (full apology)’ (Health Quality Council of Alberta 2006: 10). As in the other two policy documents discussed, the way the apology is to be performed here is made to depend purely on organisational factors: did the care go as planned? Was everyone acting appropriately? The affective consequences of the unexpected outcome may thereby become invisible.

But when the frontline clinician confronts the victim of an adverse event, these affective dimensions are likely to be most prominent for all involved. The rule about clinicians being restricted to particular apology utterances confirms that organisational matters are of greater importance to clinicians when it comes to discussing failure than acknowledging patients’ (or their own) needs and feelings. Equally, the rationalisations offered in the policy literature seen above promote a view of ‘the system’ as constituted of technical processes and pre-planned procedures, with no under-determined remainder. Given the emotional nature of health care work generally (James 1992) and the affective impact of failure on patients (Duclos *et al.* 2005) and on health care staff themselves (Newman 1996), referring only to organisational factors when determining the appropriateness and shape of the disclosure’s apology is likely to run into problems, both because the victim of harm may feel short-changed, and because it prevents the clinicians from apologising in ways that connect them on an affective level to those involved in the incident and to its consequences.

To shed further light on these issues, the next section moves on to consider empirical data. It presents an analysis of a selection of training data in an effort to shed light on how frontline staff navigate between the organisational and affective dimensions of disclosure and apology, or, in the words of one of the trainees, how staff learn ‘to be sorry on an organisational basis’.

### **Open Disclosure as therapy**

‘I think Open Disclosure is a therapy’. [Nursing Manager 2007]

Open Disclosure training programmes have the aim of nurturing a contingent of staff practised in disclosure of incidents and capable of guiding colleagues through the difficult encounters with patients and families (and with other clinical team members who are affected by the incident). The training involves volunteer frontline clinicians who will spend anything between half a day and two whole days discussing and enacting with actor-patients Open Disclosure scenarios that are modelled on actual incidents.

The data analysed for the purpose of this paper are derived from 28 hours of observation of such Open Disclosure sessions across different States in Australia.<sup>3</sup> The ethnographic field notes made during those sessions by the observer (first author) were transcribed into a digital format and extended with additional commentary on the day of their collection. The focus of the simulation sessions was the Open Disclosure discussion as well as its apology, and these were therefore also the focus of our observation and analysis. Besides general comments, the field notes contained verbatim transcriptions of simulation interactions, and it is on these data components that the analysis below focuses. The transcript data were discourse analysed (Iedema 2007), with special attention being paid to how the adverse event was disclosed, whether an explanation was provided, whether an apology was offered, to what extent the victim of the harm was offered support, and whether and why

the disclosure was deemed to be successful. For the purposes of the present article, and with the limited space available here in mind, the analysis presented below hones in on how one group of clinician-trainees role-plays disclosing an incident.<sup>4</sup> Their particular training trajectory is of interest because it shows participants experimenting with disclosure, and it presents evidence of the training eliciting what appear to be novel conducts as a result of the simulation ‘widen[ing] the margin of play’ (Thrift 2004: 70).

The simulation focused on below is based on a scenario about a patient whose notes show that an X-ray made one year earlier had already revealed lung cancer. This diagnosis was not acted on nor communicated to the patient at the time – a serious omission given the nature of the disease. The simulation involves a senior consultant (SC), a registrar (R), the actor-patient (P), and (in later extracts) the Facilitator (Fac). The exchange below was initiated after the Registrar discovered the X-ray and realised that there had been a serious omission – the patient should have been told about it and treated for lung cancer without delay.

### Extract 1

- SC: Pleased to meet you. . . . R mentioned to me that when he was going through your notes there was an X-ray [ . . .
- P: [Yes.
- SC: Did you ever discuss the X-ray?
- P: No.
- SC: It appears on the facts that we have, that clearly there should have been a report.
- P: You mean that X-ray showed there was actual cancer?
- SC: Yes there was a shadow noted 12 months ago and that was overlooked [ . . .
- P: [that was overlooked?
- SC: Yes.
- P: They said I should come back after a week and I felt okay.
- SC: Just to clarify, nobody mentioned that there was something wrong with your lung?
- P: No, but if there was evidence 12 months ago why was it overlooked?
- SC: Well we need to go into a process of working out what happened.

The focus of this exchange is on the problem of ‘the X-ray being overlooked’ and on the need to ‘work out what happened’. Given that Open Disclosure requires planning on the part of the clinicians with regard to how the incident will be presented to the patient (or their family), who does the disclosing, who apologises, how and whether the patient or family members will be offered *ex gratia* forms of support (follow up treatment, tests, and so forth), the exchange captured in extract 1 cannot be considered as conforming to existing guidelines (e.g. NSW Health 2007, Queensland Health 2006) even though the exchange was enacted in full knowledge that it was to be as close as possible to a formal disclosure. In effect, SC confronts the patient with the bad news (that the hospital should have done something about his cancer a year ago), makes no effort to apologise, provides no explanation, and makes no moves to establish what the patient might need to plan ahead.

The exchange captured in extract 1 was interrupted by the facilitator to allow the group to reflect on its effectiveness. The discussion digresses towards the relationship between the senior consultant and the registrar, and the problem of the patient appearing to want time out from his treatment to come to terms with this new information (that his cancer could have been treated a year ago). The discussion makes no progress until someone in

the group raises the issue of the apology – ‘should we not apologise to this patient?’ At this point, the discussion begins to turn from medical treatment concerns, inter-professional politics and demarcating specialty responsibilities, towards the patient’s sensitivities and needs. First up, the person acting in the role of senior consultant concludes after a second and very awkward attempt:

**Extract 2**

SC: It’s a complex message to get across. You have to be sorry on an organisational basis. It would be very empty. What could an apology mean on an organisational basis?

The implication of this comment is that because the doctor cannot envisage being sorry ‘on an organisational basis’, he is unable to understand what a performed apology could ever mean to someone in the patient’s position. He clearly regards the apology as a discursive performance that is per definition motivated by an authentic, clearly experienced sense of personal regret. What could be the meaning of an apology that is enunciated but not ‘felt’? Someone in the audience (A) replies:

**Extract 3**

A1: But it would be an empathetic sorry. The word sorry would have a positive effect.

A1 emphasises that even in cases when ‘sorry’ may not have the benefit of being ‘felt’, at least it will have a ‘positive effect’ on the victim of harm. The concern that what is being learned here lacks in authenticity simmers on in the background. Nevertheless, apparently driven by something other than authenticity, another person from the audience offers to role play the apology (extract 4):

**Extract 4**

A2: [Patient] what I would like to say to you is that though the information is still to be investigated, as senior clinicians we’d be offering you a sincere apology and say we’d go about finding out how it all happened.

The facilitator looks questioningly at the patient-actor, who responds with ‘[This makes] No difference’. The group persists. A third member of the audience stands up and offers the following (extract 5).

**Extract 5**

- 1 A3: [Patient] um this may not come out very well because we’re shattered by what happened. We’re very sorry this happened. We don’t know how or why. But on behalf of the organisation we’re very sorry, and we’ll make sure that we’ll look after you from now on.
- 2 P: [to Fac] That still feels like I’ve been chucked out of a plane without a parachute.

At this point, the Facilitator diagnoses why this apology is also met with disapproval on the part of the actor-patient: ‘[Name A3] moved too quickly. [Patient] was not ready to

move into the present'. This comment sparks discussion among group members about how to take the patient's needs and feelings into account as part of their apology:

### Extract 6

- 4 A4: Nobody's really found out what his [patient's] feelings are. We haven't connected with him today, we've just shoved disclosure down his throat . . . he hasn't had any sleep . . . he's had no time to come to terms with where he is at.
- 5 A5: I agree with those comments, and I agree that [SC's] silences at first were very important. There is a temptation to fill silences with words and that means we're not drawing enough out of the patient.
- 6 A6: That stuff about pause, that's what we're taught, but can we ever really feel what they're going through? I don't think we can.
- 7 Fac: [offers a story about medical students displacing responsibility for problems onto 'the system', and encourages them to make up for shortcomings of 'the system' by approaching patients as if they were close neighbours]

While the Facilitator's story provides a metaphor for the performance that is evoked ('pretend they are your neighbour'), and A6 again articulates reservations about the lack of authenticity inherent in this whole exercise, the group moves towards considering silence as a means of enabling the patient to connect with and express 'where he is at'. As the group's discussion about, and experimentation with, the silent pause as interactive technique unfolds, they are experientially confronted with its affective and 'creative' effects. This becomes particularly evident when A7 assumes the role of discloser (extract 7):

### Extract 7

- 8 A7: I certainly appreciate that that's how you might be feeling. [long silence]  
Perhaps there's some anger? [silence]
- 9 P: [shifts in his seat, takes glasses off, rubs eyes] I'm sure I'll be very pissed off when I get out of here.
- 10 A7: I'm sure it's tough, just after we've given you the other news [that he's got cancer]. I'm sure there are a lot of answers that you want, and we'll be keen to help you find them. . . .  
[Pause]
- 11 Fac.: [Patient], can you tell us how you're feeling now?
- 12 P: Don't know.
- 13 Fac.: You took your glasses off . . .

The significance of this brief exchange is that the question ('Perhaps there is some anger?') and the pause produces a visible, tangible response in the patient/actor: he shifts in his seat, takes his glasses off and rubs his eyes. The Facilitator summarises the effect of A7's talk by construing the patient's reaction as signifying that he is engaging with the person apologising. In effect, he says, the silent pause and the focus on 'you – the person harmed' have created a space where he is enabled to connect affectively with A7: 'I'll be very pissed off'.

The group has two more attempts at engaging the patient, with the Facilitator guiding them towards deploying questions and pauses to free up space for the patient's feelings. Over the entire simulation period, the group has shifted from deflecting responsibility for

the error, wanting to find out who was responsible for missing the X-ray, to saying they are sincerely sorry and intending to find out what happened, and finally towards designing and performing into being an interactive space that allows the patient to engage with the incident scenario affectively, and to begin to articulate those affects. Correspondingly, the extracts move through a series of apologies that harbour a clear discursive trajectory. The earlier ones privilege what 'I would like to say' as 'senior clinicians', what *we* feel ('we're shattered'), and what *we* will do ('we'll look after you from now on'). The last apology foregrounds *you*; it deploys affect-discourse ('feeling', 'anger', 'tough'), and it experiments with questions and silences to get the patient to engage with the apologist. Discursively and affectively, it would appear, the trainees have begun to move into a new communicative space.

### Open Disclosure as relational praxis

The learning trajectory described in the previous section took place over a very intensive two-hour component of one of the simulations that we observed. Collectively, and with difficulty and reservations, the group inched towards a greater appreciation of what the patient/actor might need: some interactive space to begin exploring and expressing sentiments about what happened, and some time to assess the full extent of the clinical, social and financial implications of the error. Let us briefly reconsider, first, the reservations expressed, and, secondly, the learning that potentially took place during the training. Both harbour important implications for clinical incident communication specifically and for clinicians' organisational engagement generally.

First, then, the group's experimentation progressed despite repeatedly articulated reservations about the point of offering an apology if no 'real' regret or sorrow is experienced. These reservations might arise from the following reasoning: because the patient was not 'ours' it is difficult to experience and impossible therefore to show sincere regret. This, in turn, reveals that the interpersonal question 'How can we be sincere in apologising to a patient on behalf of an organisation?' is closely connected to the ideational question 'Why should we apologise for something that happened to a patient who is not our direct responsibility?' The general reasoning is that there can be no question of identification on our part with other staff, their work, and their outcomes, because their services and outcomes are unconnected to ours. The principal unit of calculation, in this thinking, is the autonomous professional who has self-defined and self-validated accountabilities and standards that are not necessarily commensurate with those adhered to by others (Degeling 2000).

Logically, the quality and outcomes of the services of such 'autonomous' professionals should remain unaffected by their organisational context, unless they are in fact part of and supported by a complex ecology of practices. Thus, Waring (2007) reports that the doctors he interviewed recognise 'that in many cases . . . dangers were brought about by . . . poor communication or time pressures [necessitating] broader systemic changes' (2007: 42). In his study, 'the system' is comprised of 'external' factors that negatively affect people's 'autonomy' by proving to be immune to influence or change. Problematising the logic of autonomy in a situation where one's practice is contingent on others' practices, Jorm and colleagues (2007) write that

when doctors become marginalized from changes in 'the system', they may espouse discourse that reinforces the dichotomy between their identity and personal medical

work on the one hand, and the looming system encroaching on their practice, on the other hand (2007: 193)

In Waring's account, clinicians hesitate to engage with the system of care because it is experienced as jeopardising the integrity of their practices. In Jorm and colleagues' analysis, however, clinicians naturalise their disconnect from the system to obviate engaging with the intersection and interdependence of what they do with what others do. This latter argument does not deny clinicians their treatment decision-making autonomy, but it does question their extension of autonomy rhetoric to the co-organisation of clinical work among staff and units. Applied to our argument, such reasoning would classify a person's declining to apologise for an adverse event brought about through an error-prone confluence of individuals' actions and organisational circumstances as a tactic to divorce their role from the ecology of practices in which they are entwined.

Let us now consider again the simulation trajectory analysed above. Despite repeatedly articulated reservations about acting out an organisational apology (*cf.* A6), the group above was seen to collectively create a space that goes beyond the opposition between pretence and authenticity. Reminiscent of psycho-therapeutic training (Egan 2006), learning to perform apologising using 'apology resources' (such as the silent pause, the question, the pronoun 'you') enables the group to come to grips with the force of the affective conducts that they are performing into being, and discover the dialogic power of the apology. This power becomes evident as participants enact apologising in a way that is unhinged from 'genuine' personal feelings of sorrow. Personal experience is now neither guarantor for nor arbiter of the apology's effectiveness: instead, the apology is experienced as inherently a dialogic and social dynamic.

Being able to enact affect into being through disclosure and apology gives participants a sense of personal achievement; as one clinician interviewed said, it is 'a kind of therapy'. Our interviews with clinicians who had attended the training (conducted as part of a national evaluation of the Australian Open Disclosure Pilot Program (see Iedema *et al.* 2008b)) revealed that they experienced the training as enabling them to shape their own and patients' circumstances. These responses suggest, in effect, that clinicians gained appreciation of how their actions (can) act as environments for others. The full significance of the simulation therefore is not just that certain affects can be enacted into being on the part of consumers or staff themselves, but that individuals' actions generally can affect and reconfigure the broader circumstances and context in and through which they are operating. This realisation, we suggest, is at several removes from the desire for 'autonomy' described above, according to which the individual is positioned (or positions themselves) in opposition to their context, the system of care. Acquiring the skill to create an 'on-demand environment' (Thrift 2004) through disclosure of an adverse event and apology to a victim of harm is indicative, we contend, of accepting that one's activities as actor and the 'behaviour' of the wider system are not dichotomous.

Clearly, the two positionings just described espouse different kinds of 'systems thinking'. First, there is a 'systems thinking' that predominates when staff are concerned to segregate themselves from others and their work. This thinking is one that isolates the individual actor (to greater or lesser degree) from what are construed to be the 'structural' dimensions of their context. Secondly, there is the 'systems thinking' that emerges when actors experience their ability to create (or at least contribute meaningfully to the constitution of) their environments, contexts, circumstances, or systems. Of interest for the present argument is that a parallel difference between kinds of 'systems thinking' appears to underpin the tension between sociological scepticism about systems change and the optimism that characterises contemporary patient safety policy.

Sociologists argue that safety problems are unlikely to be alleviated through the combination of technical improvement and improved vigilance of healthcare practitioners. But by drawing on high-reliability theory, policy analysts claim that this is possible. Similarly, sociologists are highly sceptical of changes in 'culture', which fail to take into account the economical, institutional and political environments in which cultures are embedded, but the [1999 Institute of Medicine] report views this as feasible. (Jensen 2007: 10)

To the sociologist, the patient safety policy agenda (*e.g.* US Institute of Medicine 1999, 2001) may be naïvely optimistic in pursuing system improvement, because it disregards the complexities foregrounded by sociological analyses of organisational failure, and it places undue faith in individuals' ability to make a difference to health service outcomes. For example, patient safety policy invests too much optimism in mechanisms such as incident reporting, epidemiological analysis, and error investigation, because such mechanisms are unlikely to overcome the myriad in situ constraints, politics, routines and unpredictabilities that affect everyday work (Dekker 2005). Sociological reasoning recognises 'the system' to emerge not just from what people choose to do in the present, but also from what people have done historically, materially and technologically. The sociologist is therefore more sober in the assessment of human influence over failure, less in awe of scientific analysis and evidence, and less persuaded by policy makers' enthusiasm for practice intervention and improvement.

The tension identified by Jensen between sociological emphasis on the in situ complexity of organisational failure and discourses advocating patient safety and health service improvement provides an important corrective to the assumption that health reform will result when individual clinicians' enthusiasm is harnessed to produce better, scientifically measurable, outcomes (also see Dekker 2005). But if organisational complexity mitigates the efficacy of employees' intentionality (and therefore of policy whose implementation is contingent on such intentionality), complexity equally demonstrates the insufficiency of lawlike explanations, the potential of agency, and the centrality to action of unpredictability and affect. Accounts of the full complexity of practice and failure reveal that individuals' actions and feelings contribute to shaping their own and others' environments, even if the effects of these contributions are neither linear nor fully determinable (Dekker 2005, Haynes 2003). In short, the absence of a simple causal relationship between the intention and the outcome of people's actions and feelings does not warrant discounting the ways in which conduct can come to have a contextualising effect, as did the exchanges analysed above.

The central implication of this point for our argument is that the apology may accrue significance beyond its in situ enactment. Above, we saw that the group chose to ignore people's reservations in favour of moving ahead with the simulation, as if they were aware that there was something to be attained by persisting with the exercise. Participants experimented with their disclosures and their apologies, as if their reference point was no longer personal sincerity, but performing communication such that it would *connect* with the victim, produce dialogue, a response. Outweighing the apology's authenticity requirement, this dialogic promise was sensed to harbour the means par excellence through which reevaluation of (and, potentially, forgiveness for) the incident might become possible. Mobilising questions, silences and related devices in newly responsive ways, the group projected itself into a different interactive space. Indeed, we suggest that by being open to the actor-patient's sense of what had happened and what the incident meant, those communicating the disclosure and the apology initiated a responsiveness, and thereby a responsibility, that connected them to several others involved in the adverse event: the

patient, their colleagues originally there at the time of the incident, and the staff in charge of the disclosure.

The fact that our data are drawn not from real-life practice but from simulation might be seen to weaken our argument. Indeed, two reservations spring to mind: one, what is described here is people enacting a way of saying and being that, as learned conduct, has no relevance for what these people experience nor for what they will do once back at work; and two, what people learn here is 'emotional labour' (Hochschild 1983), or the pretence of being apologetic, which makes them not just complicit in the organisation's priority to silence victims' grief and complaints, but also inauthentic with regard to their own 'real' sentiments. Where the first reservation underplays the effect of the simulation saying it is unlikely to sustain these dialogic apologies in the long term, the second reservation overestimates the effect of simulation, positing that staff will let themselves be automated to betray personal sentiments and interactive dynamics. In short, simulation either has too much impact, producing people who will fake apologising, or it has no impact, producing negligible outcomes. These are two possibilities that we do not rule out. The point of our analysis above, however, was to suggest that there was a third possibility: that simulation can have an ethical effect, made available thanks to its 'projective capacity'.

The projective capacity of simulation lies in its ability to 'point beyond itself to other entities and thereby generate *additional* concepts and conceive unobservable mental states which, in turn, provide it with high degrees of flexibility in both the physical and social realms' (Thrift 2005: 467). Play, in other words, has the potential to engender conducts in and from people that were heretofore considered unthinkable and impossible. As the analysis has suggested, experimenting with how to disclose an adverse event to a victim of harm may envelop participants in a zone<sup>5</sup> where not just imperfect conduct is condoned (Lave and Wenger 1990), but also where people are allowed to 'lapse' into heretofore unexperienced and innovative conduct. Considered in these terms, Open Disclosure simulation, and simulation generally, may constitute a powerful experimental space.

Of course, play has long been recognised as crucial to learning culture (Huizinga 1971 [1938]), because the creative vitality of play and the imaginative behaviours it calls forth do not remain locked within play itself (*e.g.* Bateson 1973).<sup>6</sup> This points to a 'serious' dimension of play, and this dimension is capitalised on in simulation. Not surprisingly, simulation has sparked considerable interest among those engaged in organisational training (Schrage 1999, Thrift 2006): 'The essence of "serious play" is the challenge and thrill of confronting uncertainties. Serious play is about improvising with the unanticipated in ways that create new value' (Schrage 1999: 1/2, cited in Thrift 1999: 681). This 'real play' dimension may also explain the predominance of simulation in all manner of clinical training. Moreover, enacted with and in front of others, simulation tends to engender a reflexive or 'therapeutic' moment as a result of being seen, further intensifying the impact of such experimental conduct. On that basis, we suggest, Open Disclosure simulation need not be arbitrary to people's everyday conduct, and can have an ethicising impact.

If our argument holds, we have identified an important development in (health) service relationships with the public. When participating in the kinds of training described and analysed above, group members do not necessarily uncritically act out the scripted disclosures and risk managerial rationales set out in their training materials and reinforced by facilitators. On the contrary, the affective creativity of the role/real play described above prevented participants' relational and ethical sensibilities from being subjected to a dull morality of organisational prerogative and authoritative command. Construed in these terms, Open Disclosure training embodies the potential to engender intensities that open staff to new ways of being, doing and relating, and these intensities reveal for staff their

connectedness to the broader dimensions of what might previously have appeared to them as ‘the (unchangeable) system’.

## Conclusion

Where clinical incidents have conventionally been accepted as being part and parcel of the risks of health care provision, they are now shifting into a new space where the public’s right to know requires their revelation, discussion and resolution. Importantly, this emerging consumer-centredness is not accomplished procedurally (operating on the assumption that services can be pre-determined for all types of consumers and all manner of outcomes), but *communicatively*, in acknowledgement of the complexities that come into play as soon as consumers’ experiences and perspectives are taken into account. In this regard, Open Disclosure is not an extension of normal service provision but a new practice that institutionalises service responsiveness and reflexivity as a dialogic ethos that crosses professional and organisational boundaries.

Communicating about organisational failure takes staff into a highly complex and as yet little understood communicative space. Given disclosure is likely to touch on the consequences of failure, this communication potentially includes discussion of harm, anxiety, anger, depression and guilt. Disclosure communication, therefore, encompasses dialogic negotiation of matters that *affect* people (even if they were not involved in the incident, attached to the clinical service, or present at the organisation where the incident took place). Our use of the notion *affect* heralds a shift towards the realisation that ‘the greater our power to be affected . . . the greater [is] our power to act’ (Hardt 2007: x).

. . . every increase of the power to act and think corresponds to an increased power to be affected – the increased [agency] of the subject . . . always corresponds to its receptivity. (Hardt 2007: x)

On this view, activity and affect are not dichotomous but mutually constituting and enabling. While this may sound abstract, it was empirically evident in the group’s learning seen above. The participants gained first-hand experience of the correspondence between their receptivity to others’ needs and feelings, their own reactions, and the power to act and think.

In this context, the simulated, mandated, organisational apology acts as a complex and powerful feedback mechanism, enabling a closer, more rapid and affect-oriented engagement between organisations, their employees, and those who rely on their goods and services. In that regard too, policy, in its urge to strengthen health services’ approaches to risk-managing failure and minimising litigation, may in fact be pursuing a humanist course: confronting staff with the victim and their experiences is unlikely to engender purely self-protective conduct, unperturbed by the performance and dynamics of affect. Importantly, with the apology unhinged from the pre-conditions of personal involvement, responsibility and sincerity, staff may appreciate that effective disclosure turns on a dialogically performed apology. On this basis, we suggest that the Open Disclosure process in general and the apology in particular may be able to invest the relation between individual and system with renewed responsiveness and vitality.

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## Notes

- 1 Conducted over several decades from the 1930s, these experiments involved medical scientists in Tuskegee (Alabama) denying hundreds of African-Americans treatment for syphilis to enable them to observe the natural progression of the disease.
- 2 This is an extract only.
- 3 The training sessions were organised by the States' health departments as part of contractual agreements entered into with the Australian Commission on Safety and Quality in Health Care to implement an Open Disclosure pilot in local health organisations. The first author attended these training sessions as a non-participant observer, having been contracted to evaluate this national Open Disclosure pilot. This evaluation included in-depth interviews with staff involved in Open Disclosure as well as a questionnaire survey (Iedema *et al.* 2008a). Ethics approvals for the evaluation were obtained from 21 participating sites (out of 42 Australia-wide).
- 4 As the nation-wide evaluation involving interviews with 131 health care staff has shown (Iedema *et al.* 2008a), the data presented here are representative of what participants say they experienced in these workshops.
- 5 Cf. Lave and Wenger's (1990) 'zone of peripheral participation'.
- 6 Bateson addresses the significance for social theory of the nip/bite distinction in animal behaviour, in that it takes specific differences (in biting) to 'make a difference' (Bateson 1973: 286).

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