Review

A case of error disclosure: a communication privacy management analysis

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Significance for public health

Much of the mission central to public health sits squarely on the ability to communicate effectively. This case analysis offers an in-depth assessment of how error disclosure is complicated by misunderstandings, assuming ownership and control over information, unwittingly following conversational scripts that convey misleading messages, and the difficulty in regulating privacy boundaries in the stressful circumstances that occur with error disclosures. As a consequence, the potential contribution to public health is the ability to more clearly see the significance of the disclosure process that has implications for many public health issues.

Abstract

To better understand the process of disclosing medical errors to patients, this research offers a case analysis using Petronios's theoretical frame of Communication Privacy Management (CPM). Given the resistance clinicians often feel about error disclosure, insights into the way choices are made by the clinicians in telling patients about the mistake has the potential to address reasons for resistance. Applying the evidenced-based CPM theory, developed over the last 35 years and dedicated to studying disclosure phenomenon, to disclosing medical mistakes potentially has the ability to reshape thinking about the error disclosure process. Using a composite case representing a surgical mistake, analysis based on CPM theory is offered to gain insights into conversational routines and disclosure management choices of revealing a medical error. The results of this analysis show that an underlying assumption of health information ownership by the patient and family can be at odds with the way the clinician tends to control disclosure about the error. In addition, the case analysis illustrates that there are embedded patterns of disclosure that emerge out of conversations the clinician has with the patient and the patient's family members. These patterns unfold privacy management decisions on the part of the clinician that impact how the patient is told about the error and the way that patients interpret the meaning of the disclosure. These findings suggest the need for a better understanding of how patients manage their private health information in relationship to their expectations for the way they see the clinician caring for or controlling their health information about errors.

Background

In recent years, best practices concerning informing patients about medical errors have advocated for open and honest disclosures.[1,2]

However, social science research shows that there is a complexity involved with disclosure of any kind, especially in cases where people do not expect negative information that has the potential to impact them.[3] Perhaps the complexity of the disclosure process is the reason for the proliferation of articles striving to understand the nature of error disclosure. For example, there are published works on such issues as the effectiveness of open disclosure in patient care, the unique conditions of disclosing medical errors within specialties, clinics, hospitals, for training medical students, among medical team members, and investigations into how patients feel about this disclosure.[4-6]

Despite the flurry of attention paid to disclosing medical errors, there still remains resistance to telling patients about mistakes, even though knowing about the mistake ethically belongs to the patient. Claims have been made that the estimates of unreported adverse events could potentially be in the millions.[1,7,8] A number of factors contribute to this lack of universal disclosure, among them, the possibility that the disclosure process itself may be misunderstood.[5] A better grasp on the disclosure process is likely to shed some light on ethical practices of communication for healthcare providers and to increase clinicians' understanding of choices that could prove productive where medical errors are concerned.[9-13]

Given these issues, this article offers a case analysis using communication privacy management (CPM) theory developed in communication science.[14] This theory is evidenced-based and has been widely used in research across multiple disciplines to better understand the nature and process of disclosure, including health communication.[15-18]

Using CPM theory allows for identifying process issues underling the disclosing or protecting of information that is considered private. CPM also allows the ability to account for both the patient and clinician within the context of ways each navigate disclosure interactions to better understand medical errors. From a CPM theoretical standpoint, a case study analysis is offered illustrating how disclosure interactions unfold and how meaning is communicated between patient and clinician when revealing medical mistakes. This case study analysis aims to facilitate a better understanding of information ownership between the patient and clinician, disclosure sequences that shift responsibility, and effective management of personal and professional privacy boundaries.

Principles of communication privacy management theory in the context of understanding error disclosure

From a large body of research on disclosure in communication, it is clear that revealing information that has a measure of vulnerability is

often a complicated experience.[3,14-19] Using the theoretical system of CPM provides a useful framework for analysis of medical error disclosures because the theory looks at privacy management and disclosure as an integrated system involving coordination of privacy rules and expectations among multiple co-owners, such as patients, family members, clinicians, medical teams, and hospital systems.[12,14] CPM gives apparatus to better see a productive way to achieve successful disclosure interactions. For example, in considering how disclosure is defined within the context of medical errors, knowing how clinicians make choices to reveal or protect information about errors, how they enact the disclosure of errors, why clinicians may withhold some or all of the pertinent information about errors, and how revealing medical errors impacts not only the patient but also the clinician disclosing a mistake is essential to good patient care.[12,14]

Communication privacy management theoretical assumptions

CPM argues that in considering the processes of disclosure, it is important to note that *disclosure* is not what is revealed; instead *disclosure* represents the process of telling. *Private information* is what people *disclose* within CPM theory. What constitutes private information is defined as information that has the potential to yield vulnerabilities if shared with others. Private information, *per se,* is not further defined in CPM theory because everyone has a different sense of what is private.[20] Nevertheless, once people start to manage and regulate private information by having conditions for who can know, how much they can know, and how freely they can share the information with others, the establishment of these types of *privacy rules* signals that the information shared has potential vulnerability. As a result, the owners have expectations for managing their privacy boundaries when others are involved.[21] Underpinning the CPM management system is the dialectical assumption that people need to be both social (through disclosing) and private (through protecting information) simultaneously leading to making choices about when to protect and when to tell.

Precepts of communication privacy management theory

From CPM research, we know predictively, that people believe they *own* their private information – it belongs to them and they assume they have the right to control their information.[14,22,23] For example, patients believe their medical information belongs to them and they have the right to control the flow of that information to others, including medical personnel.[19,23]

To better grasp the notion of ownership and control, CPM uses a boundary metaphor to represent where private information is housed and how revealing and concealing is managed.[14,24] While patients seeking medical care may not want to disclose certain information to a clinician, they also know that to receive healthcare, they must open their privacy boundary surrounding private health information. When patients' boundaries (defining ownership and control of health information) necessarily become permeable, thereby requiring health information disclosure such as symptoms or past health history, patients grant information *co-ownership* status to the clinicians.[25] CPM argues that issues such as context, motivations, and estimates of risk-benefit are used to make judgments about degrees of revealing or concealing information considered private.[14,26] When the choice is made to disclose, this is the process of *linking* others into their privacy boundary and granting access to private information. People allowed into a privacy boundary have responsibilities to fulfil the disclosers' expectations about how their private information will be treated and subsequently managed as a co-owner.

There are circumstances where privacy boundary regulation managing the information follows a somewhat different pattern. When treating patients, clinicians tend to consider health information about the patient as primarily being held in their care.[13] As such, clinicians make judgments about when to tell patients about test results, they consider how to frame the information in ways that are fitting to the needs of the patient, and serve in a stewardship role as co-owners.[27] Nevertheless, the responsibility for the *co-ownership* and control over private health information, as defined by the clinician, may be diverse from the way patients see ownership and control.[13,25] These differences may be more pronounced when considering disclosure of medical errors.

Patients reportedly respond to the lack of disclosure about a medical error by changing physicians, feeling less satisfied with healthcare, and experiencing diminished levels of trust.[11] Alternatively, when a clinician discloses a mistake, patients' responses are less negative, possibly due to the act of disclosure fitting with their expectations about being informed and their assumptions about the clinicians' co-ownership status.[28] At the same time, being involved in an error may be very personal to the clinician.[29] The information about an error, and the need to disclose to the patient, may be tempered by a desire to refrain from disclosing to protect the clinician's own integrity.

Accordingly, there may be an ethical conflict between how a personal privacy boundary is drawn and how the clinician's professional, co-owned patient privacy boundary is drawn. In CPM terms, this state creates a *privacy dilemma* for the clinician.[30,31] This privacy dilemma stems from the desire to both protect private information about the error for the clinician while also feeling an obligation to tell the *patient owner* all pertinent information related to this case.[31] When clinicians feel conflicted about where their privacy boundary lines are drawn in relationship to those of the patient's, it is difficult for the clinician to best judge how to handle disclose of the medical error to the patient.[29,32,33]

The trepidation about disclosing medical errors can be more complicated than deciding whether to disclose or not. Clinicians may desire to tightly control their boundaries around private information concerning a medical error to more fully analyse the situation before telling patients. There may be other considerations central to a clinician's decision to reveal, conceal, wait, or rush to tell patients about the mistake.[5,34-38]

These judgments are guided by the use of criteria that direct the development and implementation of privacy rules.[39] People use privacy rules to regulate their boundaries by making decisions about whether they want to tell or protect information, how much they want to tell, whom they tell, what information to tell, and who they want in their privacy boundary.[12-14,17,20,40] For example, one study found that physicians disclosed adverse events; however, they implemented privacy rules that avoided issues such as mentioning why or how an error occurred.[41] Successful disclosure of a medical error depends on a calculus that balances how much information to reveal, with whom the information should be shared, when the information should be shared, and under what conditions people should consider disclosing or concealing the information.[17,34]

The privacy rules relevant to disclosure of medical mistakes are complex for clinicians because once an error is known; there are decision points about others who should be informed. Privacy rules are generated by clinicians who depend on criteria such as motivations to tell or conceal and the medical systems in which they work. If clinicians are

motivated to reveal the error, their privacy rules for sharing co-ownership with others (such as selected medical staff members) may be tempered by whom they can trust to tell, whom they feel they have to tell, and whom they want to wait to tell. For example, physicians are more likely to restrict and limit co-ownership of such private information about medical mistakes among their peers because they perceive reputational risks.[29] Instead, some clinicians may turn to their spouse for emotional comfort because they perceive the spouse to be a trustworthy confidant.[12] When a physician is involved in a medical error, the details of that experience are problematic – albeit in different ways – for the patient as well as the clinician. Even when a clinician makes a commitment to reveal an error, research also shows that clinicians often find it difficult to actually make the disclosure and tell patients and their families about the unexpected events that lead to a mistake.[42]

Further complicating the issues are times when there is a conflict between the kind of privacy rules patients' use and those used by clinicians. Misunderstandings may occur.[5,42] Medical error disclosures can thus be complicated by *privacy turbulence* that results from situations where privacy rules used by a co-owner (clinician) to regulate disclosure of private information belonging to the patient are contrary to the expectations of the original owner (patient).[14,17,25,31] For example, a clinician may decide to withhold information about an error because he or she judges that the incident did not cause *any real harm* to the patient. If the patient learns about the incident, privacy turbulence may result depending on whether the patient feels the clinician acted contrary to expectations about the information ownership and control rights of the patient. Whenever there is discontinuity between what patients expect regarding the management of private medical information and the way the clinicians treat that information there is likely privacy turbulence that needs attention to thwart the possibility of patient distrust and dissatisfaction with their health care.

Having an effective grasp on how the disclosure process works overall, and how the management of privacy boundaries surrounding information about the medical error occurs, offers some additional insights into reasons behind the decisions that people make about reporting a medical error. Calling for *open disclosures* of medical errors glosses over the intricacies of a sophisticated management process. This process necessarily must take into account the calculus of revealing and concealing or protecting in addition to the reality that there are multiple stakeholders in the disclosure process.

As this brief overview of CPM theory suggests, the disclosure process affecting communication about medical errors can be complicated by the way patients and clinicians may differentially understand where the lines of ownership are drawn, by whom, and about information control issues. To illustrate some of the points identified through the use of CPM theory, a case is presented that tracks the management of disclosures about medical errors and the way communicative interactions take place in the course of revealing a medical mistake. The following case is a composite developed as part of a teaching tool for surgery residents at a large Midwestern medical school. The development of this tool was used in training communication skills to the residents. The readers should understand that although there are many different ways to assess the communicative behaviours, we are using the case to illustrate the process of error disclosure interactions from a CPM perspective.

Medical error disclosure: a case study using communication privacy management analysis

Case

Mrs. Brown is a 54-year-old woman with diabetes, hypertension, and chronic right upper quadrant symptoms, whose work up suggested chronic cholecystitis. Her diabetes has been relatively poorly controlled. She is scheduled for an elective laparoscopic cholecystectomy. She is taken to surgery in the morning and undergoes surgery, but the surgeon inadvertently transects the common bile duct during the operation. The operation is converted to an open procedure, and the bile duct is repaired via primary re-anastomosis.

Late in the evening on the day of her operation, Mrs. Brown develops severe abdominal pain and fever, and an emergency CT is performed. The CT demonstrates a bile leak, most likely from an anastomotic leak. The surgeon comes back to the hospital in the middle of the night and decides to take the patient back to surgery, where a second repair is performed, and a drain and bile duct tubes are left in place. The patient is transferred to the ICU and her husband waits by her side in the early afternoon.

Communication privacy management case analysis

Surgeon enters the ICU, where the patient appears ill, but awake and alert. The husband sits by her side.

Surgeon: «Mrs. Brown – that was quite an adventure you've been through over the past 24 hours, huh?!»

Analysis: The patient and her husband likely recognize that something is wrong by tone and possible other non-verbal cues. The physician's initial statement opens the conversation with the suggestion that communicates less of a partnership and more emphasis on Mrs. Brown's current problem. Though the statement seems empathic, there is some appearance of distancing from co-ownership related to her current health condition. Perhaps if he said *we have been through* … that may have made him seem more of a partner.

Mrs. Brown: «It sure has been. Right now, I just wish the pain in my stomach would go away. This pain medicine doesn't seem to be working very well. Can't I have something stronger?»

Analysis: Mrs. Brown's response underscores how trying the night was and accepts the surgeon's framing of the events which may prove misleading. Then she shifts the focus by disclosing her desire for medication to relieve her discomfort. This shift repositions a sense of control by the patient on her immediate needs. Mrs. Brown does not ask the surgeon to disclose more information about why she had a difficult night. She is focused on resolving the pain and securing relief by requesting pain medication. She wants the surgeon to fulfil his obligations by helping her feel better.

Surgeon: «Of course you can. What we'll do is adjust your pain pump settings a little bit so that you're getting more pain medicine continuously, and can get a bigger shot when you press your PCA button. How does that sound?»

Analysis: The surgeon, serving as a co-owner, is accommodating and communicates that he is responsive to the patient's request. This conversational turn illustrates that requests by Mrs. Brown for a commitment from the surgeon to take her disclosure about her medical needs seriously is being addressed.

Mrs. Brown: «Anything to get some relief…. (sighs)».

Analysis: Mrs. Brown accentuates her need for a commitment from the surgeon.

Mr. Brown: «Doctor, do you have any idea what happened? I was so worried last night when the nurse called me to tell me to come in…. Then she had to go back to surgery….Is she going to be all right?».

Analysis: The patient's husband reveals his worry about his wife and solicits information that requests the surgeon to reveal causes for the events. Mr. Brown uses a direct disclosure request for information that belongs to his wife. Since he has accompanied his wife, likely privacy forms are signed granting him legal access to her medical information. However, in this question, the husband requests two levels of co-owned information.

On one level, it is clear that the husband feels he is an authorized co-

owner of his wife's health information. His request signals that his privacy rules regulating the co-owned privacy boundary around his wife's health information are predicated by being granted control by her. He uses these rules because he is motivated to find out what happened to his wife. Hence, he does not hesitate to make that request of the surgeon. His wife does not interfere with this inquiry suggesting that she is comfortable with her husband speaking on her behalf. Thus, she sees him as having the right to take control over soliciting information to determine the reason she had difficulties the night before.

On the second level, the husband is also asking the surgeon to reveal information that he may wish to keep in his privacy boundary, either temporarily or long term. It is difficult to say whether the surgeon's privacy rules would have lead him to voluntarily offer a more detail explanation why the patient had multiple surgeries. Still, presuming the question was a disclosure trigger, the husband's request did call for information relevant to his wife that had not yet been suggested or disclosed by the surgeon.

The fact that the surgeon waited until prompted to share more private information about the medical error suggests that he may have experienced a privacy dilemma about whether or not to reveal it; how much information to reveal; how that information should be framed or situated; and how it should be shared with Mrs. Brown. Obviously, the surgeon could have revealed more information directly after the surgery. Instead, he took additional time for assessing the issues and did not appear as immediately forthcoming about sharing the private health information about Mrs. Brown's condition.

Feeling the need to make an explicit request for more information by the husband suggests the two parties may have different private rules and expectations about the sharing of private medical information at hand. The patient and her husband may have assumed that all her private medical information would be readily available and shared with them because they counted the surgeon within their collective privacy boundary surrounding this information. The surgeon, on the other hand, appears to have motivations leading to privacy rules that regulate in ways that hold back information until deemed appropriate or necessary. Consequently, he has a parallel privacy boundary that is thicker regarding information about the medical error than expected by the patient or her husband.

Surgeon: (Sits down at the foot of the bed). «You know, I'm really, really sorry about what happened to you. Actually, it's completely my fault. I told you when we first talked about doing the operation that the procedure is very safe, but that about 2% of people have a complication. And obviously you were one of the 2%. During the operation, the common bile duct accidentally got damaged.»

Analysis: After the husband requested specific information about the incident, the physician immediately takes responsibility for the problem and uses a direct apology signalling that he also acknowledged his role as co-owner and guardian of the medical circumstances leading to the additional surgery. However, he sets limits on the extent of his responsibility by then pointing out that he had warned her about being among the possible 2% of the population that might have complications. He clearly sees shared responsibility regarding the cause for additional surgeries. However, in his response, he does not appear to account for the fact that the error disclosure was prompted by the husband's direct request. Though not unusual to raise factors that complicate surgery, the language seems to suggest a subtext, particularly in the final disclosive statement about the operation. The surgeon modifies the ownership language and states that the *common bile duct accidentally got damaged* instead of declaring that he damaged the bile duct. From this conversation, it is likely that the surgeon is beginning to focus more on guarding his own privacy boundary surrounding the issues with this surgery and redefining his definition of co-ownership of Mrs. Brown's medical information.

Surgeon: (he continues to disclose the circumstances and his assess-

ment of the problem) «This duct is the pipe that carries bile from the liver down to the gallbladder. The injury occurred while I was trying to remove the gallbladder itself. This doesn't happen very often, but probably because you had inflammation there for so long, everything was kind of stuck together by scar tissue, and I had to work pretty hard to get it all peeled apart».

Analysis: The surgeon makes several more disclosures explaining the conditions of this medical error. He states that the injury occurred when he was trying to remove the gall bladder. However, he frames the injury incident as being unusual. Through this disclosure, he shifts responsibility onto the patient's condition. While the patient's condition likely was a factor, the question is whether doing so made the patient feel responsible or whether doing so might lead to the patient and her husband turning it around to blame the surgeon. As with other non-medical situations, blaming may be a response to feeling the surgeon did not accept his co-ownership obligations, however, for this analysis it remains a question.

Surgeon: (continuing his explanation for the error) «During that part of the operation, the bile duct was cut, and I had to open you up to sew it all back together. Also, because your diabetes hasn't been well-controlled, you don't heal quite as well as normal and I suspect that the area that I sewed back together came apart because of that. When the bile started leaking all over the place, you developed pain and fever last night, and we had to rush you back to the OR to sort everything out and get it all put back together. So the tubes you have in your belly – one is to drain any bile that might leak, and one is in your bile duct, to protect the place where the duct is sewn back together. So hopefully this won't occur again».

Analysis: As the surgeon persists in his revelations about the difficulties he had with Mrs. Brown's surgery, his statements appears to escalate the extent to which Mrs. Brown's conditions contributed to the need for multiple surgeries. He tells her that the bile duct was cut but without suggesting he cut it by mistake. Disclosure of each error incident is followed by revealing how hard the surgeon worked to repair the problem. On one level, these disclosures by the surgeon speak to taking expectations of information co-ownership seriously. On another level, each time there is another aspect of medical error incident disclosed, the surgeon tends to feature the central part the patient's condition played in the medical mistake. Doing so intensifies the implication that the patient should be held accountable for some of the problems leading to the error incident. While it is logical that the medical conditions of the patient likely did contribute to the complexity of the surgery, the way this information is being communicated by the surgeon indicates he sees the patient's conditions as being culpable and by implications the patient as well.

Though the information the surgeon discloses to the patient is rightfully the patient's to know, the stewardship the surgeon has as a guardian and co-owner of the information is not as clear in the way the disclosures take place with this patient. There are indirect messages that sound as though the surgeon is doing everything to help the patient. At the same time, he mentions the patient's medical conditions as contributing to the problems without directly pointing out where he made mistakes. Though he takes full ownership of the error up front, the surgeon's language in talking about his part is vague. Using indirect disclosure messages allows for more flexibility of interpretation. Perhaps that is the goal for this surgeon. On the other hand, indirect disclosure messages are often used when a person is concerned about how the message will be received by co-owners, also a possibility for the surgeon.

Surgeon: (he concludes his explanation) «But…it was completely my fault and, again, I'm very sorry that it happened».

Analysis: At the conclusion of this explanation, the surgeon ends his disclosure of the events and does not openly invite the patient or her husband to ask additional questions. Although patients need process-

ing time to fully understand the messages about error events, not asking if they have questions limits the possibility of the patient's involvement. However, by asking if there are any other questions, the surgeon could have sent a message that he recognizes his responsibilities as a co-owner of the error information and signalled he supports an open dialogue in his role as a stakeholder in the privacy boundary surrounding the error incident.

Mrs. Brown: «Well, Doctor, I understand that things happen and you certainly shouldn't be upset. Do you think everything will be okay now?»

Analysis: Mrs. Brown's reaction to the surgeon's implied request for forgiveness was to try to make him feel better by stating she understood the circumstances. She uses language that appears to take responsibility for her medical problems. The patient also offers a comforting statement to the surgeon. Finally, the patient turns back to the surgeon's guardianship role and asks whether everything will be ok from now on.

Surgeon: «I hope so. I think there is a good chance that you will eventually heal up and everything will go back to normal. The tubes will have to remain in place a few weeks, and because of the larger nature of the surgery, you will take longer to recover. I would guess you'll be good as new in 2-3 months».

Analysis: On more familiar grounds, the surgeon returns to a more customary script and focuses on the medical needs of the patient offering encouragement for a good recovery.

Mr. Brown: «Has this ever happened before to you, Doctor?»

Analysis: Mr. Brown seeks further explanations for the incident. He questions the surgeon's record and his experience with this kind of surgical outcome. The husband, therefore, is soliciting more personal kinds of disclosures about the surgeon's abilities as a doctor. In taking responsibility as co-owner to find out more information, the husband adopts a primary role to make sense of the errors his wife encountered. Given Mr. Brown is an authorized co-owner of his wife's medical information and shares rights of control, he feels comfortable asking the surgeon to disclose his history with situations like the one his wife experienced. Mr. Brown's request for additional information concerning the medical errors targets the goal of more transparency about the issues. Obviously, Mr. Brown did not feel satisfied with the explanation he just received from the surgeon. Mr. Brown's question also requests transparency about information in the surgeon's personal and professional privacy boundaries. Mr. Brown's question could be seen as a challenge to the surgeon's competence and a way of addressing whether there is more information to explain the circumstances of the error incidents.

Surgeon: «Well, I have certainly had a few complications from gallbladder surgery in my ten years of doing the operation, and this problem is well described. But I have never seen a bile duct injury like this where everything breaks down so quickly».

Analysis: The surgeon presents the context of such operations and offers a credibility statement by mentioning his ten year history of this type of surgery. He also frames the disclosures he made about the problems leading to the complications as unique conditions he faced in the patient's surgery. Using this strategy shifts the explanation from his skills and judgments to technical conditions of this surgery. In so doing, he incorporates the matters he stated to Mrs. Brown about her other medical problems that complicated this surgery. While he directly answers the question, he also links back to information that reminds the husband of why he believes the surgery was so difficult. The surgeon offers little personal information but errs on the side of framing the response in terms of his professional role. Doing so protects the surgeon's personal privacy boundary and manages boundaries using privacy rules that accomplish this goal protecting his information, yet, provides a response to the husband.

Mr. Brown: «Well, we certainly understand that things can go wrong

and we'll just pray for a quick recovery for my wife».

Analysis: Mr. Brown appears to accept the explanation. However, stating that they will pray for a quick recovery may suggest that they have lingering doubts.

Surgeon: «I will, too».

Analysis: By failing to ask if either Mr. or Mrs. Brown had additional questions, the surgeon determinedly moved toward closing the privacy boundary on further discussion regarding the medical error. Mr. Brown's lingering doubts about the situation suggests that the conversation has perhaps just begun for them. After further reflection and more time to digest the information provided, Mr. and Mrs. Brown may possibly want to know more about the issues and request further disclosures. Asking if the patients have questions shows interest in making sure the patient is fully informed with all the details available about the case and conveys concern for the patient.

Implications

This case demonstrates many of the complexities inherent in the error disclosure process that highlight ways private health information is managed among patients and clinicians. While there are many aspects of this process identified in the case analysis, two themes capture some of the nuance in the error disclosure interactions, they include; i) characteristics of patient-family-clinician co-ownership, and ii) disclosure sequencing.

Characteristics of patient-family-clinician co-ownership

Clinicians may not recognize expectations patients have for the care of the shared patient health information. Though confidentiality clearly is an ethical focus for clinicians, the extent to which clinicians know how patients expect them to *take care* of their private health information may rest on differing assumptions, yet, have significant ramifications for patient care.[27] Using the CPM concepts of co-ownership and privacy boundaries marking shared and personal ownership allows a language to talk about how to understand these differing assumptions. CPM also helps identify ways to understand ramifications that emerge when these differences interfere with patient care.[14]

The case analysis illustrates the way management of the patient's privacy boundary surrounding her medical condition and her husband's role as an authorized co-owner of her information function. The husband is the one who asks the probing questions of the clinician about the mistake. Often family members serve as stakeholders advocating for the patient and are the ones who frequently ask the difficult questions of the medical team.[43] Clinicians may find it uncomfortable or problematic when family members enact these behaviours, as a consequence, members' inquires may be disregarded.[43] However, the surgeon in this case answered the husband's question that, in turn, served as a catalyst for the surgeon's disclosure of the medical error. In this regard, the surgeon illustrated his understanding of the legitimate co-ownership role the husband enacted regarding the patient's health information. He also responded in ways that illustrated he knew he was considered a member of the patient's privacy boundary surrounding health information. Further, the surgeon recognized the husband's right and ability as an authorized co-owner to ask what happened to his wife and his (surgeon's) obligation to disclosure the information.

This case also demonstrates that the patient, her husband, and surgeon had different privacy rules for managing the private health information. The surgeon's opening statement upon entering the room appeared to aim for showing empathy. The patient, in turn, was motivated to reveal the need for relief from her pain which the surgeon

readily addressed. In these instances, the privacy management is working in a coordinated manner between the patient and surgeon. Not until the husband raises the question asking what happened to his wife do the privacy management strategies change. His question triggers a privacy rule shift where the husband holds the surgeon accountable for disclosing more detailed information about his wife's medical condition. The husband defines the surgeon as a co-owner of the medical information and expects the surgeon to reveal the cause for his wife's circumstance.

Given the surgeon did not initiate the disclosure about the medical error, it is reasonable to say that it appears he entered the patient's room having erected a thick or more closed privacy boundary wall surrounding the incidents that transpired in the operating room. This tendency is not unusual when physicians must give bad news.[19] However, because the surgeon did not initiate revealing the error in this case, being the only co-owner privy to the circumstance of the patient's medical distress, the expectations for his responsibility to initiate disclosure is great. This case exemplifies the level of assumed responsibility that co-ownership of information holds, especially when the clinician is the only key to the patient's private medical information. Consequently, the ethical expectations for clinicians include recognizing accountability for caretaking of patient private health information. Likewise, given patients have expectations for access to their information, clinicians need to understand the unique responsibility they have as co-owners of patient information. Knowing a patient's private health information before the patient is privy carries a heightened sense of responsibility.

Further, the case analysis illustrates that there can be a fine line for clinicians between managing privacy boundaries around personal information and balancing professional boundaries.[13] Research shows that clinicians often find it difficult to tell patients and their families about the unexpected events that lead to a mistake.[34,42] At times, clinicians may wish to protect themselves.[29,32] Yet, the emotional nature of telling patients about a medical error is complicated by the extent to which clinicians are held responsible or impose that responsibility on themselves.[44] Physicians may try to balance exposing their personal feelings with information in their professional role. However, medical errors often feel very personal to the clinicians.[29,44] As we see illustrated in this case, the disclosure process of revealing medical errors has the potential to compromise the personal-professional boundaries and likely interfere with how those disclosures are made to patients.

Impact of disclosure sequencing

The sequencing of disclosure messages observed in this case illustrates patterns of disclosure that help define management strategies the surgeon uses with the patient and her husband.

In this case, the surgeon responds to the husband's inquiry concerning why his wife had a difficult time with her surgery. The surgeon discloses that there was an error incident and takes full responsibility for the error followed by an apology. This initial sequence fits the expectations argued in the research literature about the appropriate way to disclose a medical error.[5,32] However, the pattern shifts after initially accepting responsibility for the problems. As the surgeon begins to explain the circumstances, his disclosures include allocating responsibility to the patient for the medical error because of her pre-existing medical conditions. Although existing medical problems likely compromise surgeries, the surgeon reiterates how the patient's medical issues were problematic a number of times. Further, when the surgeon refers to the patient's medical problems in the context of explaining what went wrong, it is always in juxtaposition to talking about what steps he took to solve the multiple problems that emerged with this case. Thus, the disclosure message was confounded by both taking and giving responsibility for the error. This ambiguity of accountability in the disclosure message blurs the boundaries of responsibility and ownership

regarding cause. As a result, messages of accountability seem conflicted. After a long description of the error events, the surgeon's disclosure makes another shift to closing the conversation. In this shift, the surgeon offers a final claim of full responsibility. While having made this claim brought closure to the conversation for the surgeon, the husband did not act as though the conversation about this problem was necessarily over. The husband makes one more attempt to solicit information about his wife's surgery, this time shifting the responsibility onto the surgeon asking if he ever had this type of problem before. The surgeon thwarts the attempt by establishing his credibility and circling back to the unusual nature of the patient's difficulties. Finally, the conversation closes with everyone hoping for the best. Likely, the conversations about this surgery are not over from the patient's perspective and it is possible that the patient and her husband will want more information in the future.

Understanding conversational patterns that emerge are important because they uncover implicit assumptions about how best to manage error disclosures. They often follow imbedded presumptions about appropriate management of private health information that may be different for the patient and the clinician resulting in the emergence of a problem for the patient-clinician relationship. For example, if patients perceive that their clinician is managing their co-owned privacy boundary by shifting responsibility for a medical error toward them, they may not be forthcoming in sharing how angry they feel about that to the clinician. The patient may respond with litigation or choose to seek another health care provider in the future. Such actions would thereby close the privacy boundary and reclaim individual privacy rights again over a patient's private information related to healthcare. If the privacy boundary is jointly managed in a fulfilling way, it is not likely that the boundary would be severed.

This case study analysis and discussion demonstrate how using communication privacy management theory as a framework can highlight ways to unpack the complexity of medical error disclosures.

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