

What Healthcare Institutions Owe After Preventable Harm: A Relational Account of Disclosure, Reparative Responsibility, and Patient Participation in Organizational Learning

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Abstract

Preventable healthcare harm creates obligations that persist after immediate clinical stabilization. Existing responses commonly organize these obligations around disclosure, compensation, investigation, or future safety improvement. Each addresses an important aspect of the aftermath, yet none alone explains what healthcare institutions owe when preventable harm also damages the relationship through which patients receive information, recognition, explanation, and opportunities to influence institutional sense-making. This theory-building article develops Relational Reparative Responsibility Theory to specify that additional ethical terrain. The account treats preventable harm as capable of becoming a relational institutional wrong when institutional action or subsequent response diminishes a patient's epistemic standing, practical agency, recognition, or justified expectations of responsible institutional engagement. Reparative responsibility consequently extends beyond acknowledging that an event occurred. It can include competent disclosure, responsive forms of practical or material repair, supported opportunities for participation, and institutional learning that remains answerable to the people affected. These duties are connected but non-identical: one cannot automatically substitute for another, and their appropriate form varies with patient preference, institutional control, evidentiary uncertainty, proportionality, and the burdens participation may impose. Patient participation is therefore framed as an opportunity for supported influence rather than compulsory involvement or a universal transfer of decision authority. The resulting account links post-harm ethics to organizational learning while preserving limits on institutional responsibility. Healthcare institutions meet reparative obligations most adequately when they respond to the damaged relationship as well as the safety event and when learning remains connected to, rather than detached from, those who experienced the harm.

Keywords: Preventable harm, Reparative responsibility, Open disclosure, Patient participation, Organizational learning, Patient safety

Introduction

Preventable harm remains a central problem of healthcare quality even in institutions with mature

patient-safety systems. Contemporary record-review evidence continues to identify adverse events that were judged preventable among hospitalized patients [1]. Population-level patient reports broaden the problem further by showing that people may experience harm not only through treatment itself but also through failures of access, communication, or response [2]. These literatures establish the continuing burden of harm, but the ethical problem considered here begins after that initial recognition. Once harm has occurred, an institution must decide what kind of response is owed to the patient and

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how that response relates to investigation, organizational learning, remediation, and future prevention.

The post-event period is ethically significant because institutional conduct can alter the meaning and consequences of the original event. Patients and families have described forms of compounded harm associated with how safety incidents are subsequently handled, including experiences of powerlessness, abandonment, dehumanisation, and manipulation [3]. Restorative approaches to adverse events similarly distinguish the institutional task of learning from the relational task of attending to people who have been harmed [4]. A response can therefore improve technical understanding of an incident while leaving important injuries to trust, recognition, or agency unaddressed.

Two adjacent bodies of scholarship help explain why this matters. Research on institutional betrayal examines harms that arise when organizations on which people depend fail to meet legitimate expectations associated with that dependency [5]. Work on epistemic injustice in healthcare shows how institutional control over information and credibility can diminish a patient's standing as a knower of their own care [6]. Neither literature, taken by itself, supplies a complete account of healthcare responsibility after preventable harm. Together, however, they identify a feature often obscured when an adverse event is treated primarily as an isolated technical failure: the institution remains in a relationship with the harmed patient, and its subsequent conduct can either address or deepen the relational consequences of what occurred.

This article therefore asks what healthcare institutions owe after preventable harm when the original event and the institutional response may both alter the patient-institution relationship. Relational Reparative Responsibility Theory is developed as an account of that obligation. Its central concern is not whether every adverse event creates an unlimited duty to restore trust or satisfy every requested remedy. The analytical task is narrower: to determine when institutional responsibility extends beyond disclosure and prevention because the institution controls information, investigatory procedures, practical remedies, or learning processes that bear directly on relational damage produced by harm. The analysis first clarifies preventable harm as a possible relational institutional wrong, then examines disclosure, repair, and participation before developing the reparative account and its consequences for organizational learning.

Preventable harm as a relational institutional wrong

A preventable adverse event is ordinarily identified through its clinical consequences, causal pathway, or avoidability. For the patient, however, the event may also change what the institution represents and whether future interactions can reasonably be experienced as trustworthy. Patients interviewed after adverse events in Norwegian hospitals described prolonged struggles associated with perceived negligence and with obtaining recognition and response from healthcare institutions [7]. Such experiences indicate that the ethically relevant aftermath may include a continuing relationship in which the patient must seek explanation, accountability, or acknowledgement from the same institutional structures implicated in the harm.

Disclosure provides one illustration. Patients and families who experience safety incidents may require more than information that an event occurred. Qualitative evidence concerning disclosure emphasizes mutual understanding, responsible communication, and follow-up after the disclosure encounter [8]. A technically accurate statement can therefore coexist with an inadequate relational response if the patient remains unable to understand what happened, why institutional actors regard it as significant, or what will occur next. The wrong at issue is not created merely by imperfect communication. It arises when an institution that controls clinically relevant knowledge fails to engage the harmed person in a manner proportionate to the dependence created by care.

Patient accounts of safety culture reinforce this relational dimension. Surgical patients describe safety through experiences that include communication, responsiveness, and the way professionals and institutions engage with them [9]. The patient-institution relationship is consequently part of the environment in which safety is interpreted. After preventable harm, failures of recognition or response may change how patients understand later information, invitations to participate, or assurances that learning has occurred.

The same point has an epistemic dimension. Patients and caregivers can contribute information about causal circumstances, transitions, symptoms, communication failures, and prevention opportunities that may not be visible in formal records or professional accounts [10]. Their knowledge does not displace technical expertise, but its relevance means that institutional processes can treat harmed patients either as contributors to understanding or primarily as recipients of conclusions

reached elsewhere. Patient and caregiver descriptions of safety as a partnership similarly emphasize recognition of experiential knowledge and meaningful opportunities for voice [11]. The institutional wrong becomes relationally deeper when preventable harm is followed by avoidable practices that discount the person's knowledge, render their concerns inconsequential, or exclude them from processes directly concerned with the event they experienced.

These dimensions do not imply that every preventable event produces the same relational injury. Some patients may primarily want an explanation and rapid practical remedy; others may seek participation in investigation; still others may prefer minimal further contact. What makes the problem institutional is the combination of

dependence and control. Healthcare organizations commonly possess the records, professional access, investigative authority, complaint mechanisms, and learning infrastructure through which the event will be interpreted. They therefore have distinctive capacity to influence whether the harmed patient encounters recognition, intelligibility, practical response, and an opportunity for appropriately bounded participation.

The distinctions developed above can be represented as different ways in which an index safety event may become a broader relational institutional wrong. They are analytically separable because each changes a different feature of the patient's standing in relation to the institution.

Table 1 summarizes the distinctions discussed above.

Table 1. Relational states through which preventable harm can become an institutional wrong

Relational state after harm	What changes in the patient–institution relationship	Institutionally controlled feature	Reparative significance	Boundary on the claim
Unresolved index injury	The patient bears consequences of an event attributed wholly or partly to care	Access to clinical explanation, treatment response, records, and remedial processes	Creates a prima facie reason for timely acknowledgement and practical response	Preventability and institutional contribution may remain uncertain
Recognitional injury	The patient experiences the event or its consequences as minimized, depersonalized, or treated as administratively insignificant	Manner of acknowledgement, interpersonal conduct, responsiveness, follow-up	Repair requires treatment of the harmed person as someone to whom an account is owed	Recognition cannot guarantee forgiveness or restored trust
Epistemic displacement	The patient's relevant experiential knowledge is discounted or excluded from institutional sense-making	Information-gathering rules, credibility judgments, access to records, investigation procedures	Repair can require opportunities to contribute, correct, or contextualize the institutional account	Experiential knowledge does not confer unrestricted authority over factual findings
Procedural marginalization	Decisions about investigation or response occur without a meaningful opportunity for the patient to understand or influence matters directly affecting them	Participation routes, timing, communication, support, role definition	Reparative responsibility may include a supported opportunity for participation	Participation should remain voluntary and proportionate
Compounded response harm	Post-event institutional conduct adds distress, mistrust, confusion, or loss of agency to the original injury	Disclosure practices, complaint handling, investigation, correspondence, delay, remedial pathways	The institution acquires reasons to address harms created by its own response as well as by the index event	Additional distress should not automatically be attributed to institutional wrongdoing without contextual assessment

Note: The table presents an original conceptual synthesis of the preceding analysis. The states are neither a mandatory sequence nor a severity ranking, and a single event may involve several, one, or none of them.

Disclosure, repair, and patient participation

Disclosure is usually the first formal point at which an institution can acknowledge an event to the person affected. Its reparative importance depends on what the

encounter accomplishes. Recent qualitative work on open disclosure shows that patient and family experience is shaped by the way information, engagement, expectations, and subsequent processes are handled [12].

A systematic review of patient and family experiences similarly identifies recurring concerns around explanation, apology, expressions of concern, listening, and information about prevention or follow-up [13]. Experience with statutory duty-of-candour processes further shows that formal requirements acquire meaning through how patients and families encounter the people and institutions responsible for implementing them [14]. Disclosure therefore matters both because truthfulness is independently owed and because it establishes conditions for what may follow.

The quality of disclosure is not reducible to whether certain words are spoken. Medical error disclosure requires communicative competence, including capacities relevant to explanation and relational responsiveness [15]. Realist synthesis in maternity care also demonstrates that open disclosure operates through context-sensitive mechanisms rather than through a single standardized interaction [16]. Institutional policy can create an obligation to disclose, but the ethical success of that disclosure depends partly on whether the patient can understand what is known, what remains uncertain, what the institution is prepared to do, and how subsequent questions will be addressed.

Participation in incident investigation introduces a different obligation. Patient and family perspectives on adverse-event investigations, hospital accounts of involving patients or next of kin, and qualitative evidence reviews of serious-incident investigations consistently show both potential value and significant practical constraints [17–19]. Involvement can give institutions access to information that might otherwise be missed and can provide patients with a means of understanding how the event is being examined. Yet desired roles vary, expectations may be unclear, and participation can become symbolic when institutions invite input without making its possible influence intelligible.

The distinction between representation and participation is especially important. Consumer representatives serving on investigation teams may challenge assumptions, broaden attention to the patient journey, and help teams interpret events through a patient-centred lens [20]. Their contribution can strengthen institutional perspective-taking, but a representative cannot automatically substitute for the person or family directly affected by a particular event. The two roles provide different kinds of knowledge and carry different relational significance.

Supported participation consequently requires more than a formal invitation. The Learn Together programme illustrates an effort to co-design guidance for involving patients and families in patient-safety incident investigations and to evaluate its use in practice [21, 22]. The significance of this work lies less in establishing one universally preferred model than in showing that engagement depends on organisational conditions: staff capability, role clarity, communication, preparation, continuity, and institutional willingness to receive contributions in ways that can affect sense-making. A process may appear participatory while retaining all meaningful interpretive control within the organization. Participation also has ethical costs when these conditions are absent. Qualitative research examining negative effects of patient participation in patient safety identifies burdens and adverse experiences that can arise through poorly designed expectations, insufficient support, or unsuitable modes of involvement [23]. A reparative account must therefore avoid treating participation as an unconditional good. Some patients will want substantial involvement, some limited contact, and some none. Requiring participation from a person who wishes to disengage can itself reproduce the loss of control that reparative practice is intended to address.

These distinctions clarify why disclosure, repair, and participation should not be treated as interchangeable terms. Disclosure concerns truthful and intelligible acknowledgement. Participation concerns whether and how the harmed person can contribute to processes through which the institution interprets and responds to the event. Repair is broader: it concerns what must be addressed because the harm or the response has altered the patient's position in relation to the institution. Depending on the case, repair may involve further clinical care, practical support, correction of records or explanations, apology, financial or other remedies available within legitimate institutional processes, or a supported opportunity to shape investigation and learning. None of those responses guarantees restoration of trust, and not every patient will want every form.

The important normative transition is therefore from offering isolated post-event practices to asking what makes those practices responsive to the specific relational damage at stake. An institution can disclose without meaningfully recognizing the patient, invite participation without creating influence, compensate without explaining, or learn without repairing its relationship with the person harmed. Conversely, the

patient may receive an appropriate explanation and practical remedy without wishing to participate in further organizational learning. The ethical problem is to determine how these distinct responsibilities are allocated, limited, and connected when the institution itself controls many of the conditions through which repair can occur.

A relational account of reparative responsibility

Relational Reparative Responsibility Theory begins from the proposition that responsibility after preventable harm should track more than causal contribution to the index injury. It also concerns institutional control over conditions through which the aftermath becomes intelligible and remediable. When the institution controls records, explanations, investigative procedures, complaint pathways, remedial resources, and opportunities to influence learning, its responsibilities cannot be exhausted by acknowledging that an adverse event occurred. What is owed depends on which aspects of the patient's relationship with the institution have been damaged and which of those aspects remain within institutional capacity to address.

Participation illustrates the distinction between responsibility and compulsory involvement. Organisational engagement requires knowledge, support, role clarity, and capability if participation is to become substantive rather than ceremonial [24]. Accordingly, an institution can owe a patient a meaningful opportunity to contribute without requiring the patient to accept that opportunity. The duty concerns the conditions under

which agency can be exercised: information must be sufficient, the proposed role must be understandable, participation should remain voluntary, and the institution must be prepared to receive contributions in ways that can influence appropriate parts of investigation or learning.

The form of such responsibility cannot be identical across healthcare systems. Reviews of patient and family engagement in different regions demonstrate variation in institutional resources, participation practices, and implementation environments [25]. Hospital engagement interventions likewise encompass heterogeneous designs and purposes [26]. Context therefore affects how a reparative duty can be enacted, although contextual variation does not erase the underlying obligation to respond to institution-mediated relational damage.

Comprehensive post-event programmes show how several responsibilities can coexist operationally. Communication-and-resolution approaches can integrate explanation, apology, recurrence prevention, compensation processes, and support for healthcare workers [27]. Qualitative evidence on patient participation similarly shows that opportunities for involvement depend on institutional practices that make participation practically possible [28]. These examples support an important distinction: disclosure, practical or material repair, participation, and organizational learning may be coordinated, but they answer different questions about what the institution owes.

Table 2 summarizes the distinctions discussed above.

Table 2. Distinct post-harm duties and the relational losses they are positioned to address

Reparative duty	Primary relational loss addressed	What adequate institutional action requires	What cannot substitute for it	Limiting condition
Truthful disclosure	Loss of intelligibility and informational trust	Timely explanation of what is known, what remains uncertain, and what follows	Compensation without explanation	Factual uncertainty must be acknowledged rather than concealed
Recognitional response	Experience of being minimized or treated as administratively insignificant	Acknowledgement of the person, consequences, concerns, and legitimacy of questions	Technical incident classification alone	Recognition does not require agreement with every interpretation
Practical or material repair	Ongoing burdens created or worsened by the event	Appropriate clinical, administrative, supportive, or remedial action within institutional authority	Apology without response to remediable consequences	Remedy depends on causation, authority, proportionality, and available lawful mechanisms
Supported participation	Loss of agency or exclusion from relevant sense-making	Voluntary, understandable opportunities to contribute, question, correct, and receive feedback	A generic invitation with no credible pathway to influence	Patients may decline, limit, or discontinue participation

Accountable learning	Separation between the patient's experience and institutional prevention activity	Investigation and improvement processes that can incorporate relevant patient-originated knowledge	Internal learning that never returns an intelligible account to the harmed person	Learning cannot guarantee recurrence prevention or restored trust
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Note: These duties are analytically distinct and may overlap in practice. Their presence does not imply a mandatory sequence, identical patient preferences, or unlimited institutional liability.

The responsibility structure can therefore be represented as an allocation problem linking the character of relational damage with the institutional resources and decision rights capable of responding to it. Participation

occupies one part of that field rather than the centre of every case.

Figure 1 illustrates the relationships discussed above.

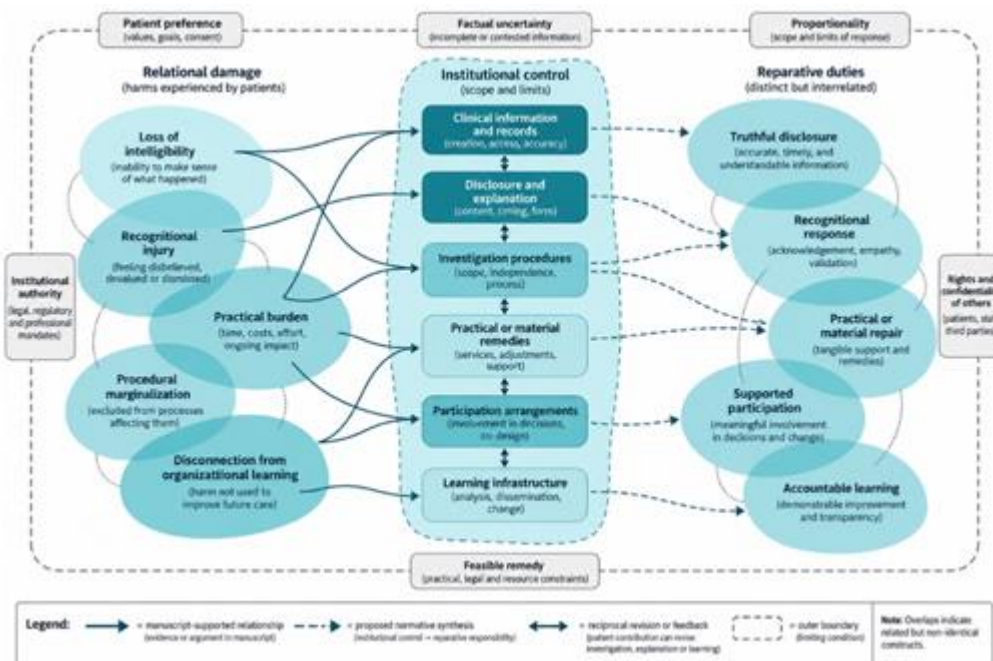


Figure 1. Where post-harm obligations attach: relational damage, institutional control, and distinct reparative duties

Implications for organizational learning

Reparative responsibility changes the purpose of organizational learning after harm. Investigation must still determine what happened and identify opportunities for prevention, but the process should avoid treating learning as sufficient merely because an internal causal account has been completed. Systems-oriented investigation helps resist overly narrow attribution by locating incidents within interacting clinical and organisational conditions [29]. At the same time, investigators themselves remain vulnerable to outcome bias when judging culpability after serious events [30]. Fair learning therefore requires both systems analysis and safeguards against interpretive practices that retrospectively exaggerate individual blame.

Patient complaints offer another route through which harmed people can contribute to organizational knowledge. Complaint systems generate useful learning only when organizations possess mechanisms for analysing, interpreting, acting on, and feeding back what they receive [31, 32]. Treating a complaint as closed because correspondence has ended can therefore be institutionally different from having learned from it.

No single safety-information channel is complete. Patient-level linkage of incidents, adverse events, and complaints demonstrates that different sources reveal partly different safety signals [33]. Routine complaint material can also contain information about harm that is not obvious from administrative categorisation alone [34]. A reparative learning system should consequently ask which information becomes visible when patients,

families, formal incident systems, and other sources are considered together.

Table 3 summarizes the distinctions discussed above.

Table 3. Organizational learning tasks that remain answerable to harmed patients

Learning task	Patient-linked question	Organizational requirement	Failure mode	Reparative significance
Incident reconstruction	Does the account include what the patient or family observed?	Combine system evidence with relevant experiential knowledge	Record-only reconstruction	Reduces avoidable epistemic exclusion
Attribution	Are responsibility judgments proportionate to the evidence?	Use systems analysis and safeguards against retrospective bias	Individual blame substituted for system analysis	Supports fair and credible explanation
Complaint interpretation	Has the concern been analysed rather than merely processed?	Translate narrative material into identifiable learning questions	Administrative closure without learning	Links grievance to institutional responsiveness
Cross-source synthesis	What becomes visible only when information channels are connected?	Compare incidents, complaints, patient reports, and other relevant safety data	Treating one reporting system as complete	Preserves plural sources of safety knowledge
Learning feedback	Can the harmed person understand what, if anything, changed?	Provide proportionate feedback about conclusions, uncertainty, and action	Learning detached from the person who experienced the event	Keeps improvement answerable to those affected

Learning should also extend beyond the reconstruction of failures. Reviews of learning from work that goes well identify strategies for understanding successful everyday performance [35], while patient-centred safety frameworks show that patients can identify diagnostic-process breakdowns not captured by conventional organisational measures [36]. Relational reparative responsibility therefore supports a plural learning system: one that learns from failure and successful adaptation while retaining patient-originated knowledge

as a legitimate source rather than treating it as an optional supplement.

This relationship is reciprocal. Patient participation can change what an organization learns, while the organization's capacity to explain what it learned can change the meaning of participation for the patient. Learning that remains entirely internal risks turning patient contributions into extractive information gathering.

Figure 2 illustrates the relationships discussed above.

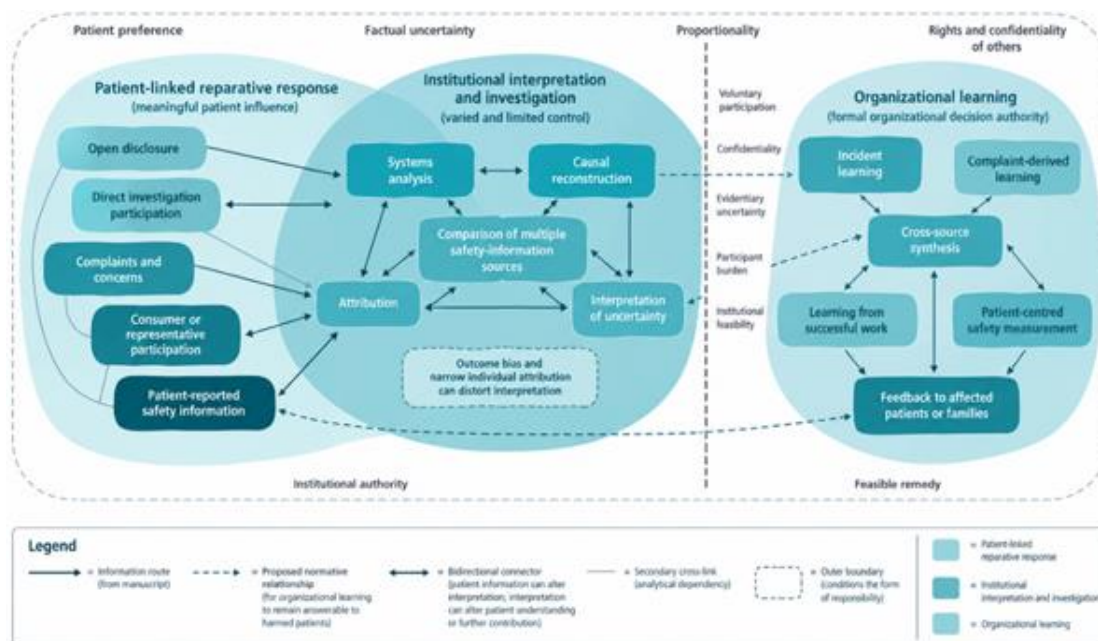


Figure 2. Keeping patient-linked repair attached to organizational learning after preventable harm

Results and Discussion

Relational Reparative Responsibility Theory explains why post-harm ethics cannot be reduced to a choice among disclosure, compensation, participation, or organizational learning. These responses address different dimensions of the institution–patient relationship. Disclosure concerns intelligibility and candour; practical repair addresses remediable consequences; participation concerns agency and epistemic standing; learning concerns what the institution does with what it comes to understand. Their ethical connection arises because the institution often controls the conditions under which each becomes possible.

The account nevertheless does not establish that more participation necessarily produces safer care. Randomised evidence concerning patient and family engagement interventions remains heterogeneous and context-dependent [37]. The normative claim is therefore narrower than an effectiveness claim. A patient may have a justified opportunity to participate because the process concerns an event they experienced and knowledge they possess even when evidence cannot establish that such participation will improve every measurable safety outcome.

The account also identifies circumstances in which reparative responsibility weakens or changes form. Participation may become burdensome, poorly supported, or unwanted. Investigative judgments may be distorted by retrospective bias. Regional, legal, cultural, and institutional arrangements affect what forms of engagement are practicable. Confidentiality and the rights of professionals or other patients can properly limit access to some information. Causal uncertainty may prevent an institution from making acknowledgements that exceed what evidence supports. These qualifications matter because relational repair cannot require false certainty, unlimited authority, or compulsory participation.

A further boundary concerns the meaning of successful repair. Institutions can create fair conditions for acknowledgement, explanation, remedy, participation, and learning; they cannot guarantee that trust will return or that a harmed person will experience reconciliation. The patient retains authority over whether renewed trust is warranted. Relational reparative responsibility is therefore best understood as an institutional obligation to

make ethically adequate response possible, not as an entitlement to secure a particular emotional outcome.

The theory also alters how organizational learning should be evaluated. An institution may implement technically sophisticated corrective actions while remaining unresponsive to those harmed, just as it may offer a compassionate disclosure without producing meaningful system change. The strongest post-harm response keeps these domains connected while preserving their separate purposes. Learning becomes reparatively significant when it remains capable of receiving patient-originated knowledge, acknowledges uncertainty about what has been learned, and returns proportionate explanation to those whose experience initiated or informed the process.

Conclusion

Preventable healthcare harm can become a relational institutional wrong when the event or its aftermath damages a patient's access to intelligible information, recognition, practical agency, epistemic standing, or meaningful participation. Healthcare institutions therefore may owe more than disclosure, compensation, or internal safety learning considered separately. Relational reparative responsibility links the form of the obligation to the relational damage at issue and to the information, procedures, remedies, and learning systems the institution controls.

The resulting duties remain bounded. Patients need not participate, influence does not imply unrestricted authority, factual uncertainty constrains acknowledgement, and institutional responsibility cannot guarantee reconciliation or restored trust. What institutions can reasonably be required to provide are fair conditions for truthful explanation, proportionate remedy, voluntary and supported participation, and organizational learning that remains answerable to those affected. Under those conditions, learning from preventable harm becomes part of repair without being mistaken for the whole of it.

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