Appendix 1: Relational Learning as a Teaching Methodology

The Program to Enhance Relational and Communication Skills (PERCS) has been developed to help clinicians from different professions improve their relational and communicative competence to meet the challenges of difficult conversations in a variety of healthcare settings. PERCS is based on the principles of relational learning and the idea that learning "which matters most in the professional development of health care professionals occurs in the context of relationships established among practitioners, patients, and family members"[36]. It therefore contrasts to approaches merely offering clinicians scripts they can use in conversations with patients and families. PERCS has been applied in numerous other contexts of challenging conversations, including radiology errors, end-of-life decisions and organ donation. In PERCS workshops, participants are encouraged to reflect on their own professional and personal experiences and to discuss their practice with interprofessional colleagues. Facilitators have been trained internationally, and the PERCS methodology has been adapted in various institutions in the US and other countries including Australia and Italy. PERCS principles were used for the planning and development of the workshops including live simulations, interactive discussions and reflection exercises. Ground rules for collaborative learning in PERCS workshops are illustrated in appendix 2.

Appendix 2: Ground rules for collaborative learning

- **Contribute to creating an atmosphere of trust and respect.** Promote the spirit of collaborative learning among all participants.
- **Listen attentively.** Create a climate in which participants feel comfortable sharing personal thoughts, reflections, and feelings.
- **Be clear and concise.** Maintain necessary time boundaries in group discussions.
- **Create space for "quiet voices".** Some participants may need "room" for expression.
- **Act according to the guiding ethic that there is rarely only one "right" answer.** The greatest learning is likely to occur when multiple and different perspectives are shared in respectful dialogue.
- **Be respectful of the personal, professional, and cultural frame of reference of other participants.** A curious attitude towards other perspectives will increase the likelihood that other participants will share their perspective.
- **Use discretion in regard to personal information that has been shared.** What has been shared in the room stays in the room.
- **Engage fully.** Your unique experience and perspective - professional and personal - is the resource which will foster the learning of all.
- **Like health care professionals, patients and family members are both teachers and learners, and share complete participation in the session.** This is what this workshop is all about.
- **Patients and family members, like professionals, may share aspects of their personal experience in the health care system.** Take the risk of making your professional learning personal and learn as a whole person.

Appendix 3: Detailed methods for the Patient TIPS model

As illustrated in Figure 1 of the main document, the Patient TIPS model comprises a sequence of four consecutive phases leading to the final workshop bringing together clinicians and P/F to learn about medical error disclosure and prevention. In the following section, we provide more in-depth information regarding the exploration, preparation and the implementation phase of the process. Details on the evaluation phase and survey design are provided in the methods section of the main document.

Exploration Phase

We held two focus groups with P/F to explore P/F perspectives on medical error disclosure, the idea of collaborative learning about error with clinicians, and P/F's views on their own potential role in this kind of program. Focus group questions were designed by a working group including a physician (SKB), a nurse (PF), social workers (DMB, BSL) and a patient/family representative (PV) each with expertise in patient safety and/or patient engagement. Each focus group began with a description of the proposed program and a brief opportunity for P/F to comment on experiences with error, and whether the program was a good idea. We used the construct of psychological safety to explore P/F willingness to participate, including what role P/F envisioned they could play in safety, perspectives related to power/hierarchy and how these affect patient safety, and factors which would influence comfort participating in the workshop. Finally, we asked what "take home messages" they would hope clinicians would learn as a result of the educational intervention. Focus groups were held in the fall of 2012 and each included 8-14 participants from our hospital Patient and Family Advisory Council (PFAC). Each

focus group was led by the same facilitator (SKB), audio-recorded, deidentified and transcribed.

Preparation phase

All PFAC members who volunteered to participate after the focus groups were invited to an orientation session preceding the first workshop; a total of 3 were held. These meetings served as the actual preparation of the workshops, and to help P/F develop an understanding of their roles as teachers (Figure 1). We reviewed "ground rules" for participation based on the principles of relational learning (Appendix 2), roles and contributions of P/F including "educational use of personal narrative", how to handle situations when workshop participants don't agree, and an opportunity to discuss any other concerns or suggestions. P/F reviewed possible cases for discussion to avoid any emotional harm from situations that were close to their own. We also discussed access to an "emotional time out" if needed at any point in the workshop. Finally, we discussed what success of the intervention would look like from a P/F perspective, and reviewed a preliminary evaluation strategy to include P/F input in design of surveys.

Implementation phase

Workshops featured live simulations of medical error disclosure with participating clinicians playing their own roles and professional actors playing the roles of patients and families, followed by a structured debriefing with input from clinicians, actors, and patient/family workshop participants. They also included video trigger clips about 1) P/F

experiences with error, 2) a doctor's disclosure of a medication error, and 3) P/F and clinician interactions about a late pain medication, to stimulate discussion among participants. A short didactic component reviewed the rationale for medical error disclosure, a brief review of the literature related to liability, and disclosure guidelines. We reviewed a series of shorter cases "across the spectrum" of event severity to examine participant views about disclosure threshold, what should be said, and opportunities for P/F and clinicians to speak up to prevent errors. Finally we ended with a discussion focused on building a culture of collective responsibility and fostering patient/family partnership in safety, where possible, followed by participant practice change commitments and takeaways.