Linguistic Considerations for the Disclosure of Medical Errors

[*1]Maisarah Ahmad Kamil

[1]Academy of Language Studies, Universiti Teknologi MARA, 40450 Shah Alam, Selangor, Malaysia

***Corresponding Author**

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ABSTRACT

This conceptual paper examines the linguistic considerations necessary for effective medical error disclosure; an area where communication choices directly influence patient trust and the perceptions of professional integrity. Drawing upon theories of the Situational Crisis Communication Theory, Linguistic Category Model, and Communication Competence Model, this paper highlights how language use can shape the attribution of responsibility and affect relational outcomes in clinical settings. It proposes four core considerations to guide effective disclosure: sociolinguistic competence in tailoring language to diverse settings; clarity and comprehensibility in ensuring understanding; the demonstration of empathy; and the critical role of timing and sequencing in structuring disclosure interactions. Together, these considerations underscore the need for medical professionals to balance informational accuracy with sensitivity towards patients' emotions and expectations. The framework contributes to advancing understanding of how language can facilitate trust, reduce conflict, and support ethical practice in healthcare communication.

Keywords: medical disclosure; linguistic competence; professional communication; empathic communication; language

INTRODUCTION

Medical errors are occurrences of error within the healthcare system, with medication prescription error being one of the more common errors as cited in past literature (Lane & Roberts, 2020). According to para 2.2.6 of the Code of Professional Conduct by the Malaysian Medical Council (2019), "a medical practitioner who commits errors in the course of management of his patient must avoid concealing them from the patient or those in authority and must record such events in the patient records/notes. It is unethical for the practitioner not to be truthful and honest in such an event" (p. 29). This stresses the importance of error disclosure in healthcare settings in Malaysia.

According to Busetti et al. (2020), patients increasingly expect detailed information about treatments and procedures. This is especially prevalent in recent years, as technological advancements and generative artificial intelligence have increased patient health literacy, empowering them to take a more active role in their healthcare (Traylor et al., 2025). Consequently, it has become more challenging to hide medical errors, which can also result in negative repercussions towards healthcare professionals, hospitals, and the overall healthcare system.

Despite the importance of disclosing medical errors particularly in today's world of technological advancements, few studies have sought to examine the linguistic considerations of effective disclosure towards maintaining patient-physician relationships (Lane & Roberts, 2020; Busetti et al., 2020). Therefore, this conceptual paper draws on crisis communication and and communication competence theories to identify key linguistic considerations in disclosing medical errors. It synthesizes insights from the theories with reference to peer-reviewed studies on patient communication. Although not a systematic review, the scope of this paper focuses on works that illuminate how linguistic strategies shape perceptions of responsibility and trust in disclosure contexts.

LITERATURE REVIEW

Situational Crisis Communication Theory (SCCT)

The issue of medical disclosure can be examined through the lens of crisis communication, which is often defined as a dialogue between an organisation with the public before, during, and after a negative event (Tomić, 2024). The goal of any crisis communication is three-fold: to increase the knowledge and understanding of affected parties, enhance trust and credibility of the responding agencies, and facilitate dialogue to resolve disagreements (Hajime, 2020). Even though crisis communication employs one-to-many communication, there are principles within the study of crisis communication that can be contextualised to the physician-patient relationship on medical error disclosure.

One key contribution of SCCT is its typology of response strategies, which include denial, diminish, rebuild, and bolstering (Coombs, 2007). While these strategies were originally designed for organisational crises, they offer a useful parallel for the medical context. For instance, denial or minimisation of responsibility may protect the physician or institution in the short term, but such approaches are associated with loss of trust and long-term reputational harm. In contrast, rebuild strategies (such as providing an apology, compensation, or corrective measures) are aligned with ethical imperatives in healthcare and are more likely to restore patient confidence. This suggests that linguistic choices in disclosure are not merely semantic but function as crisis response strategies that shape relational outcomes.

Moreover, SCCT underscores the importance of matching response strategies to the level of responsibility attributed by stakeholders. In medicine, patients often perceive physicians as holding primary responsibility for errors, which means communicative strategies must acknowledge this asymmetry. The act of disclosure therefore involves managing both informational and relational dimensions by explaining what went wrong in clear, non-technical terms while simultaneously signalling accountability and empathy. From a linguistic perspective, this highlights the delicate balance between mitigating liability and preserving trust, where the framing, tone, and sequencing of disclosure statements become central to crisis communication in healthcare.

Linguistic Category Model (LCM)

While SCCT frames disclosure as a strategic response to a perceived crisis, a finer-grained analysis of how specific linguistic choices shape perceptions of responsibility is required. This is addressed by the Linguistic Category Model (LCM), which theorises that perceptions are shaped based on the linguistic choices that are used to describe and discuss events (Semin & Fiedler, 1988). Based on this theory, a negative event is attributed to situational variables and contexts when an agent's (i.e. the physician's) responsibility is perceived as low through the linguistic choices used in disclosure. In contrast, when the physician's responsibility is perceived as higher, the negative event is perceived as a product of the agent or organisation. In other words, concrete language leads perceivers to attribute outcomes to situational circumstances, whereas abstract language leads them to attribute outcomes to the inherent character or responsibility of the organisation (Borden & Zhang, 2019).

The LCM uses four levels of linguistic abstraction that influence the perceived attribution of responsibility for a negative event. The first is the Description Action Verbs (DAVs), where concrete and neutral language, which are least interpretive, leads to the lowest attribution of responsibility (e.g. "The physician prescribed the wrong dosage of the medication"). The second is Interpretive Action Verbs (IAVs), where words that are used can be defined as positive or negative, allowing a degree of interpretation to the physician's intentions thus increasing the level of responsibility attribution (e.g. "The physician fabricated the report"). The third are State Verbs (SVs), where an event is connected to an intrinsic attribute of the physician, which leads to high attribution of responsibility (e.g. "The physician was afraid of being blamed"). The last is Adjectives (ADJ), where permanent traits are used to describe the physician, implying the highest level of responsibility to the event (e.g. "The physician was careless"). This indicates that the LCM has theoretical potential to be applied in medical error disclosures.

In the context of medical error disclosure, the LCM offers a systematic way to analyse how physicians' word choices can either deflect or accept responsibility. Unlike broader crisis communication models, the LCM

directly accounts for the cognitive and perceptual consequences of language use, allowing a finer-grained examination of how patients may interpret explanations, apologies, or justifications. This positions the LCM as a valuable linguistic tool for understanding not only what is disclosed, but also how it is disclosed and how this shapes trust and accountability in the physician–patient relationship.

Communication Competence Model (CCM)

The SCCT and LCM help frame medical error disclosure from organisational and linguistic perspectives; however, it is also worth noting that effective disclosure requires communicative competence, particularly sociolinguistic competence, to ensure that messages are appropriate to the patient's cultural and interpersonal context. The Communicative Competence Model (CCM) was introduced by Canale and Swain (1980). The model examined four main competencies in demonstrating communication competence, which are linguistic, sociolinguistic, strategic, and discourse competence.

In the context of medical error disclosure, the most relevant of these competencies is sociolinguistic competence, which involves communicating following rules of discourse that is considered appropriate for a given audience or setting. While SCCT and LCM emphasise the strategic and linguistic dimensions of disclosure, CCM highlights effectiveness ultimately depends on whether the message is perceived as socially appropriate and relationally sensitive. This suggests that medical disclosure training should not only focus on accuracy and responsibility attribution, but also on the pragmatic skills required to convey difficult information in ways that align with patients' social and cultural contexts.

Taken together, these three frameworks highlight that medical error disclosure is both a strategic and a linguistic act. SCCT underscores the importance of aligning communicative strategies with perceived responsibility in order to preserve trust. LCM adds a micro-linguistic perspective, showing how specific word choices shape patients' attribution of responsibility and perceptions of sincerity. CCM extends these insights by emphasising that disclosure must also be socially and culturally appropriate, requiring physicians to exercise sociolinguistic competence in highly sensitive contexts. Together, these perspectives suggest that effective error disclosure cannot be reduced to simply admitting fault as it combines competence in strategy, linguistic precision, and communicative appropriateness to maintain trust and credibility in healthcare.

Linguistic Considerations for Medical Disclosure

In the disclosure of medical errors, the way physicians frame, sequence, and deliver information determines whether patients perceive the disclosure as transparent, trustworthy, and empathic, or, conversely, evasive and defensive. Research on error management in healthcare highlights that beyond systems for prevention, detection, and reporting, communication practices play a decisive role in sustaining professional relationships and public trust (Farnese et al., 2018). Consequently, this section highlights four key categories of linguistic considerations of medical disclosure, which are sociolinguistic competence, clarity and comprehensibility, empathy and relational framing, and timing and sequencing.

Sociolinguistic Competence

The first linguistic consideration with regards to medical error disclosure is the need to demonstrate sociolinguistic competence. Lane and Roberts (2020) found that emotional intelligence and situational awareness were essential for effective error disclosure, suggesting that physicians must exercise sociolinguistic competence. This involves selecting forms of address, tone, and register appropriate to the patient's social and cultural context, as well as recognising the emotional demands of the situation.

The principle aligns with SCCT, which emphasises matching communication strategies to the level of perceived responsibility. In medical disclosure, failure to calibrate language to patient expectations risks being interpreted as either dismissive or overly defensive. This indicates the need for physicians to demonstrate extensive understanding of the situational appropriateness of a situation, and be able to align the way they communicate with both the degree of responsibility perceived by the patient and the socio-emotional demands of the interaction.

Clarity and Comprehensibility

An equally important linguistic consideration is ensuring that patients fully understand what has occurred. Studies have shown that effective disclosure involves the use of plain, non-technical language, supported by active listening and clarification checks (Steimie et al., 2024; Lane & Roberts, 2020).

From the perspective of the LCM, the choice of concrete descriptive language (e.g., describing specific actions taken) rather than abstract attributions reduces the likelihood of misinterpretation and situates the error within procedural contexts rather than the physician's inherent qualities. This not only aids comprehension but also shapes patients' perceptions of accountability. This suggests that physicians should communicate with clarity by avoiding jargon and technical language, offering concrete explanations that do not obscure the event but instead make it understandable to patients and their families.

Empathy and Relational Framing

The third linguistic consdieration concerns empathy and relational framing. Empathic communication has been identified as a central component in managing medical errors. Busetti et al. (2020) highlight that a sincere apology and expressions of empathy are crucial for rebuilding trust, while Schoofs et al. (2019) argue that empathy can prevent destructive responses and reputational damage.

Linguistically, empathy is communicated through validating patients' emotions, using affirming language, and adopting a tone that signals care and accountability. In SCCT terms, such strategies mirror "rebuild" responses that seek to restore trust by acknowledging responsibility and offering repair. Even within the domain of sociolinguistic competence, empathy remains central, as in many cultures it is communicated not only through word choice but also through tone and manner of delivery. Physicians must therefore demonstrate empathy linguistically in ways that align with patients' cultural expectations to ensure that their disclosure is received as sincere and respectful.

Timing and Sequencing

Finally, the delivery of disclosure is shaped not only by what is said but when and how it is introduced. Shaw et al. (2012) identified three styles of delivering bad news: blunt, forecasting, and stalling. Each represents a different temporal pacing of disclosure, with implications for how patients process and evaluate the information. A forecasting style, for instance, may allow patients to prepare emotionally while maintaining a sense of transparency. From a linguistic standpoint, timing and sequencing underscore that disclosure is a staged communicative act, where the order and pacing of statements contribute to their perceived sincerity and effectiveness.

From an SCCT perspective, the sequencing of disclosure can be seen as part of the organisation's response strategy, where the timing and order of information released must match the level of responsibility attributed to the physician or institution. Poorly timed disclosures may appear evasive or defensive, while carefully paced disclosures align with "rebuild" strategies that aim to restore trust. Similarly, CCM highlights that the effectiveness of disclosure depends on sociolinguistic competence, where physicians must judge not only what to say but also when to say it in ways that are appropriate to the patient's cultural and interpersonal context. The timing and sequencing of information thus become pragmatic choices that influence whether the disclosure is perceived as considerate and respectful.

Operationalising the Considerations

Taken together, these considerations demonstrate that effective medical error disclosure requires more than willingness to admit mistakes. It involves the careful orchestration of linguistic resources that align with theoretical insights from both SCCT, LCM and CCM. Such an approach not only improves individual physician–patient interactions but also strengthens institutional credibility and public trust in healthcare systems. Table 1 provides examples of such expressions.

Table 1. Operationalising the Linguistic Considerations

Linguistic Consideration	Theoretical Anchor	Example Expression
Sociolinguistic Competence	CCM (sociolinguistic), SCCT (appropriateness)	"Encik, I am Dr. Hadi. I would like to explain what happened and answer any questions."
Clarity and Comprehensibility	LCM (concrete language), CCM (linguistic competence)	"The medication dose given was higher than intended. We are monitoring you hourly and will manage any side effects immediately."
Empathy and Relational Framing	SCCT ("rebuild"), CCM (sociolinguistic)	"I take full responsibility for this error; it was detected during my shift. I am very sorry this happened, and I will do everything to address it."
Timing and Sequencing	SCCT (response strategy), CCM (pragmatic timing)	"I need to share some difficult news. I'll explain what happened step by step and answer your questions as we go."

Limitations and Recommendations

This conceptual paper examined the linguistic considerations necessary for effective medical error disclosure by drawing upon theories of the SCCT, LCM and CCM. As a conceptual paper, it did not provide empirical evidence on the effectiveness of such considerations. Therefore, future research could evaluate the effectiveness of the proposed linguistic strategies through patient interviews, clinical simulations, or experimental studies. Such analyses could also be examined through institutional policies, medico-legal frameworks such as apology laws, and professional codes of conduct. Moreover, physicians' communication styles and patients' responses can be influenced by cultural background and individual communication competence, including tone and gesture. Future studies should therefore investigate how linguistic considerations intersect with these broader contextual dimensions to provide a more comprehensive understanding of effective error disclosure.

CONCLUSION

In sum, medical error disclosure is not only an ethical obligation but also a communicative act that requires sensitivity to linguistic choices, cultural expectations, and relational dynamics. By drawing on the SCCT, LCM and CCM, this paper highlights how physicians' ability to demonstrate responsibility, empathise, and sequence information shapes patients' trust and perceptions of sincerity. Together, these perspectives suggest that effective error disclosure must be understood as a form of strategic, context-dependent communication that safeguards the physician–patient relationship while upholding professional accountability.

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