Apology in Medical Practice
An Emerging Clinical Skill

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THE IDEA THAT PHYSICIANS SHOULD MAKE FULL DISclosure of medical errors to their patients has grown in importance since the late 1980s and early 1990s. This movement gained momentum following the 1999 Institute of Medicine report, *To Err Is Human*,[1] an indepth study of the extent of medical errors, and the 2001 Safety Standards of the Joint Commission on Accreditation of Healthcare Organizations on disclosure of patient harm.[2]

As physicians were encouraged to disclose medical errors, offering an apology would inevitably seem to be the next step. What sense would it make to admit harm without acknowledging responsibility, offering explanations, expressing remorse, and discussing reparations—all parts of an apology? Without such offerings, most patients in response to such disclosures would more likely be offended than soothed.

Although the goals of policies regarding disclosure and apology were to enhance patient safety and fulfill an ethical commitment of honesty to patients, an outcome unexpected by many was a reduction in the number and cost of malpractice claims. Such findings have been widely published in newspapers,[3,4] popular magazines,[5] law journals[6] and nonrefereed medical magazines. A Web site, *The Sorry Works! Coalition*, which is committed to finding a solution to medical malpractice by "educating and helping all stakeholders understand the value of doctors apologizing for medical errors," received more than 400 000 hits in its first year, 2005.[7] Some institutions that pioneered disclosure of medical errors, often with accompanying apologies, include the Veterans Administration Medical Center of Lexington, Kentucky, the University of Michigan Health System in Ann Arbor, the Children's Hospitals and Clinics of Minnesota, The Dana Farber Cancer Institute in Boston, Massachusetts, and Johns Hopkins Hospital in Baltimore, Maryland.

Since 2003, 4 states have passed legislation that would make physicians' apologies, including admissions of fault, inadmissible in malpractice suits, and this inadmissibility law often included other health professionals. Such legislation, it was hoped, would encourage physicians to apologize more freely. Other states, beginning in 1986, passed alternative inadmissibility laws allowing physicians to express benevolent gestures, such as caring, regret, and consolation, but not admitting fault. Taft, an apology advocate, has offered an eloquent moral and psychological critique of the "inadmissibility" laws.[8,9]

Although an apology is a significant part of the dialogue between physician and patient following disclosure of a medical error, there are few, if any, systematic studies or comprehensive discussions of the apology process in medical practice, despite the burgeoning literature on apology in the behavioral sciences.

My interest in apologies began in 1993. During the 13 years since then, I have analyzed the apology process by studying more than 2000 nonmedical private and public apologies, mostly from US and other English-language newspapers and famous historical apologies, apologies in novels, and personal stories offered by friends and colleagues. Based on these studies, I have proposed a conceptual framework for analyzing apologies.[10] This commentary presents an overview of this framework in the belief that it is relevant to all apologies, regardless of context, and in the hope of encouraging dialogue between medical risk management experts[11-13] and behavioral scientists,[14,15] 2 groups who often approach apologies from different but complementary perspectives.

Framework for the Use and Study of Apologies

An apology is an acknowledgment of responsibility for an offense coupled with an expression of remorse. An offense refers to a physical or psychological harm caused by an individual or group that could or should have been avoided by ordinary standards of behavior. A failed medical procedure or action caused by a physician's poor judgment that would be so regarded by the medical community at large would be an offense. On the other hand, an unfortunate outcome, such as unsuccessful surgery or other medical treatment that is widely regarded as high risk by patient, phy-

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sician, and medical community is not ordinarily regarded as an offense for which an apology should be offered. In such situations, consoling comments by the physician, such as "I am so sorry for what happened," are usually appropriate but are not apologies, because there is neither an offense nor acknowledgment of one.

Structure of Apologies

Building on the core definition of an apology—offense and remorse—a useful structure of apology can be organized into 4 parts. The first part of any apology is the acknowledgment of the offense, which includes the identity of the offender(s), appropriate details of the offense, and validation that the behavior was unacceptable. The second part of an apology is the explanation for committing the offense. Explanations may mitigate the offense ("I was late because of a medical emergency") or aggravate the offense ("I left the operating room to go to the bank"). Sometimes saying, "There is just no excuse for what happened" or "We are still trying to find out what happened" can be the most honest and dignified explanation. The third part of an apology is the expression of remorse, shame, forbearance, and humility. Remorse is a deep sense of regret. Shame is the emotion associated with failing to live up to one's standards. Forbearance is a commitment not to repeat the offense. Humility is the state of being humble, not arrogant. Lack of remorse, shamelessness, unwillingness to address the future, and arrogance will undo most apologies. The fourth part of an apology is reparation, which can range from an early scheduling of the next appointment to canceling the bill to a financial settlement. All 4 parts are not necessarily present in every effective apology, but when an apology is ineffective, one can invariably locate the defect in 1 or more of these 4 parts.

How Apologies Heal

Within the 4-part structure described, the healing process of apology is mediated through several distinct psychological mechanisms. Just as with any medical treatment, any one or combination of mechanisms may be necessary for healing. I have observed the following 10 healing mechanisms.

Restoration of Self-respect and Dignity. The patient often experiences the offense as a humiliation that he or she may express with words, such as "I was treated with disrespect" or "as dirt" or "less than a person" or "like I did not matter." The healing factor must be the restoration of dignity, which may take the form of the physician humbling himself or herself.

Feeling Cared for. The patient or patient's family wants to know through the apology that the physician cares about the well-being of the patient. This is communicated through the quality of the apology, special attention afforded the patient, follow-up telephone calls, and even attending the patient's funeral when the outcome is death.

Restoration of Power. The patient often experiences the offense as a state of powerlessness. Showing the patient how his or her situation will lead to changes in office or hospital procedures is one way of validating the patient's newly gained power. Interestingly, the physician transfers power to the patient by explicitly or implicitly requesting forgiveness. At this moment, the physician needs the patient more than the patient needs the physician. The physician's position is greatly enhanced when it is based on a long-term positive relationship with the patient.

Suffering in the Offender. In many apologies, patients want to see the offending physicians suffer. This need may be met by watching the physicians' demeanor during the apology, or patients may actively attempt to inflict suffering by reporting physicians to the hospital administration, the state Board of Registration, or their lawyers. Patients may even try to force the resignation of someone on the treatment team.

Validation That the Offense Occurred. A serious or life-threatening event defines, in part, who a person is. Hearing a detailed account of the offense may validate that the offense occurred and is now a part of the history and identity of the patient. Such dynamics are observed in individuals who have experienced unimaginable hardships, such as prisoners of war and hostages.

Designation of Fault. It is common for offended parties to worry about their responsibility in causing the harm, particularly when they are parents of injured infants or children. Patients and parents can be comforted by the assurance that the problems were not their fault.

Assurance of Shared Values. Validating for patients that what they think is wrong is shared by the physician and the medical staff is a critical component for continuing trust in the relationship.

Entering Into a Dialogue With the Offender. The patient, and often the patient's family, needs the opportunity to ask questions and express feelings (commonly anger, fear, helplessness, frustration, and abandonment) to the physician. Physicians need to listen to such feelings and concerns and to respond appropriately and empathically.

Reparations. Sometimes tangible reparations are required to compensate, in part, for damages. Such reparations can be effected without legal recourse.

A Promise for the Future. The patient must have confidence that the physician or facility is committed to correcting faulty procedures and avoiding similar offenses.

Other Aspects of Apologies

Who Offers and Receives the Apology. In medical encounters, careful thought must be given to who offers the apology (the physician in charge, the nurse, the resident, the medical student, or the hospital administrator) and who receives the apology (the patient, family members, or both).

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Timing of Apologies. An important dimension of any apology is its timing. The apology should be offered as soon as it is ascertained that a medical error has occurred. Before such a determination is made and fault assigned, the physician may express concern over what happened pending further exploration. An unreasonable delay in communication is often perceived as disrespectful or deceitful. Follow-up discussions are often necessary to complete or restate the apology, because the patient may have been stunned over the initial disclosure or desires family to be present to hear the apology.

Apology as a Negotiation. An apology is not always what the physician offers to the patient but an exchange or negotiation, a back-and-forth between 2 parties over how much the physician is willing to offer and how much the patient needs. The subjects of negotiation include all the structures and functions of the apology described earlier, such as the specificity of the acknowledgment, the nature of the explanation, the expression of remorse, the kind and amount of reparations, the empowerment of the patient, and the suffering of the physician. Who is in the room and the timing of the apology are also subject to negotiation. Each negotiation, and therefore each apology, is a unique event between both parties.[16]

How Apologies Fail. Many apologies fail due to fraudulence, insincerity, or disingenuousness. They are commonly experienced by the offended party as insulting or offensive, not healing. They make bad situations worse.

The most common error in apologizing is the failure to adequately acknowledge the offense. Such apologies may be too vague ("I apologize" or "I apologize for whatever happened"); the compassionate "sorry" is used to avoid acknowledging the offense ("I am so sorry for what happened"); the acknowledgment is couched in the passive voice ("mistakes were made"); and the conditional "if" or "but" is used to mitigate the offense ("if there was an error" or "there was a mistake but . . . "). Failures in any of the other 3 structural parts of the apology can also undermine its effectiveness: unacceptable explanations ("the alcohol made me do it"), arrogance instead of shame or humility ("these things happen to the best of people"), and unacceptable reparations.

Resistance to Apologize. It is no accident that physicians often resist acknowledging offenses in the medical setting or fail to adequately apologize for them. An obvious and understandable reason for such resistance is the fear of consequences, such as an angry patient, a complaint sent to the state Board of Registration, or a malpractice suit. Initial evidence now suggests that admissions of harm and apologies strengthen, rather than jeopardize, relationships and diminish punitive responses.[3,11]

Another important explanation for such resistance is the need for physicians to maintain a self-image for themselves and others of being strong, always in charge, unemotional, and a perfectionist. The feared loss of this self-image may lead to the unbearable emotion of shame and subsequent feelings of depression. An apology may expose vulnerability, remove emotional armor, and allow emotions to be exposed. Medical professionals and colleagues need to work at tolerating and supporting their own humanity and that of their colleagues. They need to regard apologies as evidence of "honesty, generosity, humility, commitment, and courage."[10]

Apologies for Offenses Other Than Medical Errors

The apology process should not be limited to the acknowledgment of medical errors and the avoidance of malpractice suits, but should include any interaction in the medical setting in which one person offends or humiliates another. Such offenses are common in medical settings because of the power hierarchies of personnel and the time pressures involved in life and death situations. In decades past, the humiliation of medical students (especially females) by their superiors was a ritual practice. Such offensive behaviors between members of the treatment team diminish morale and hinder the educational process.

Physician behaviors that commonly humiliate or offend patients include excessive waiting times, failure to address the patient by his or her preferred name, violations of privacy of conversations and records, inappropriate body exposure of the patient, failure to listen to the patient and adequately explain the nature of the illness or procedures, inadequate communications among the treatment team, and making disparaging or condescending comments about the patient's medical conditions or habits. Patients who have been the object of such behaviors may conceal their anger, verbally assault the physician or other members of the treatment team, complain to hospital administration, or seek medical care elsewhere.[17]

Conclusions

An effective apology is one of the most profound healing processes between individuals, groups, or nations. It may restore damaged relationships or even strengthen previously satisfactory relationships. For the offender, offering an apology may diminish guilt, shame, and the fear of retaliation. For the offended party, receiving an apology may remove a grudge with its corrosive anger, thereby facilitating forgiveness and reconciliation.

With such healing qualities, apologies should be considered among the most profound behaviors of humankind. They have been described in preliterate civilizations,[18] in classic literature throughout the centuries,[19] in religions (through repentance)[20] dating back at least 2500 years, and in legal proceedings in which confession, motive, remorse, and reparations are crucial to outcome.[10] Even primates are believed to use apologetic behaviors.[21] It should come as no surprise that the practice of medicine, with its sacred rela-

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tionship between physician and patient and critically important relationships between members of the treatment team, should recognize and value the use of apology in medical practice. As with other activities that have the power to heal, it is essential that physicians develop skills and ethical principles to use apologies effectively and honestly in their interactions with patients and colleagues.

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