

The Power of Apology¹

Dr Marie Bismark²

Introduction

Justin Micalizzi was a healthy 11-year-old boy, who loved to play basketball, race BMX bikes, and go bowling with his friends. One day, Justin came home from school with a fever and ankle pain. Over the next two days he saw three different doctors, and was eventually taken to hospital for surgery to incise and drain the swollen ankle. Justin was dead by 8am the next day, leaving behind two grieving and bewildered parents who desperately wanted to know why their son had died. But medical care was to fail the Micalizzis twice — first their son died, and then no-one would explain to them why, or apologise for the loss of their son.³ The silence from the doctors and nurses in the days, months, and years that followed Justin's death was deafening.

Nearly eight years later, Justin's mother - Dale Ann Micallizi - writes *"I am still waiting for, and still need that conversation. Not receiving an apology and explanation from someone caring for your child when something goes wrong is incomparable to any form of inhumanity in medicine or in society. It is simply not right. Justin was our child and we were owed an explanation and an apology. We didn't expect anyone to say "I'm sorry that I screwed up", but perhaps simply "I am so very, very sorry that your son has died in our care. I will do everything in my power to help you and your family heal and explain to you everything that I honestly know about the event." Justin's surgeon would have been my hero if he said that to us but instead they said "these things happen in medicine" and we were expected to accept that. As a parent, I couldn't."*

"I'm sorry." The phrase is one of the most commonly used in the English language, and at the same time one of the most complex. It can roll off the tongue as easily as it can catch in the throat. It can be heartfelt or aching dishonest.⁴ Aaron Lazare, author of *On Apology* writes: *"One of the most profound human interactions is the offering and accepting of apologies. Apologies have the power to heal humiliations and grudges, remove the desire for vengeance,*

¹ This paper was presented as part of the Centre for Compassion in Healthcare's Humanity in Healthcare Lecture Series. 16 February 2009. Waitakere Hospital. More information on the Centre for Compassion in Healthcare is available at www.compassioninhealthcare.org/

² Senior Associate in Health Law, Buddle Findlay, Wellington, New Zealand. The views expressed in this paper are the author's own, and should not be taken as legal advice. Please feel free to send any questions or comments to marie.bismark@buddlefindlay.com.

³ Randolph, A. A Family's Search for Truth. Patient Safety and Quality Healthcare. Nov/Dec 2006. Personal communication with Dale Ann Micallizi.

⁴ Kellog, S. The art and power of apology. Washington Lawyer. June 2007.

*and generate forgiveness. For the offender, they can diminish the fear of retaliation and relieve the guilt and shame that can grip the mind with a persistence and tenacity that are hard to ignore. The result of the apology process, ideally, is the reconciliation and restoration of broken relationships.*⁵

Wall of silence beginning to crumble

Historically, health practitioners – and in particular doctors - have been noted for their reluctance to offer apologies. For generations, medical errors were rarely acknowledged to patients, and apologising for a poor outcome was almost unthinkable. Health practitioners have high expectations of themselves and, not surprisingly, many find it difficult to acknowledge errors openly before patients. Some are afraid of losing patients' trust, while for others the fear of medico-legal consequences and professional sanctions is cited as an impediment to apologising. Whatever the reason, for many health practitioners *“sorry seems to be the hardest word”*.

But the “wall of silence” is beginning to crumble, as health practitioners are increasingly called on to provide patients with full information about adverse events, apologise for the harm caused, and acknowledge responsibility if an error has occurred. The Dean of one medical school writes: *“the formally forbidden idea that physicians should apologise to their patients for medical mistakes has become a subject of discussion”*.⁶

Five key factors have played a role in bringing down the “wall of silence”, one brick at a time. First, is an increasing awareness of the fallibility of medicine. While health practitioners' propensity to err probably hasn't changed much in the last few decades, the public have grown more aware of the risks and limitations of medical care. In New Zealand, Peter Davis' adverse events research has forced us to face the frightening reality that around one in ten hospital admissions is associated with an adverse event, of which around one third are preventable.⁷

Second, is the development of patient rights, and in particular the Code of Health and Disability Services Consumers' Rights. Under the Code of Rights, patients have a legal right to be treated with openness, honesty, and respect, and to receive the information that a reasonable patient, in that patient's circumstances would expect to receive. Alongside this duty of candour, stands an

⁵ Lazare, A. On Apology. 2004. Oxford University Press: New York.

⁶ Lazare, A. On Apology. 2004. Oxford University Press: New York.

⁷ Davis, P et al. 2003. Adverse events in New Zealand public hospitals II: Preventability and Clinical context. NZMJ. 116(1183).

expectation from the Commissioner that health practitioners will apologise when patients are harmed as a result of a breach of the Code.⁸

The third major influence in bringing down the “wall of silence”, is an improved understanding of the hopes and needs of patients and families who have been injured by medical care. Those who deal with such events on a regular basis have long believed that “*patients primarily want two things when things go wrong: first, an apology; second, reassurance (to the extent possible) that steps have been taken to reduce the likelihood of a repeat of the event. Responding in a blaming, distancing way is unlikely to create such a reassuring picture for the patient's family.*”⁹ And indeed, research in New Zealand and internationally¹⁰ supports the view that injured patients who take legal action following an adverse event are primarily seeking communication and corrective action, rather than financial compensation or sanctions against the health practitioner. For example, a review of letters to the Health and Disability Commissioner¹¹ found that 40% of complaints were motivated by a desire for more satisfying communication, such as an explanation or apology. (A further 50% of complainants sought some reassurance that corrective action would be taken to protect future patients from similar harm.)

Fourth, is the gradual breaking down of medico-legal barriers to apology (whether real or perceived). Internationally, a number of so-called “*apology laws*” make it quite clear that saying “I’m sorry” is not the same as admitting legal liability for a patient’s injuries.¹² Indeed, those organisations who have adopted policies that support open disclosure and apology have found that, even in the highly litigious United States environment, candour about medical error may actually reduce the likelihood of time-consuming and expensive litigation.¹³ In New Zealand, the combination of a Commissioner who believes in “*resolution, not retribution*”; a system of medical regulation focused on supporting safe practice, and the availability of no-fault compensation for

⁸ Paterson R, van Wyk M, Candour and the code. *Obstetrics and Gynaecology*. 2002;June:100–1.

⁹ Phipps, G. Complaints need systemic response. *New Zealand Doctor* November 2006.

¹⁰ Vincent C, Young M, Phillips A: Why do people sue their doctors? A study of patients and relatives taking legal action. *The Lancet* 1994, 343:1609-1613.

¹¹ Bismark, M, Dauer, E, Paterson, R and Studdert, D. Accountability sought by patients following adverse events from medical care: the New Zealand experience. *Canadian Medical Association Journal* 2006. 175(8): 889-894.

¹² Levinson, W. & Gallagher, T. H. (2007) Disclosing medical error to patients: a status report in 2007. *Canadian Medical Association Journal*. 177.

¹³ Kraman S, Hamm G 1999. Risk management: extreme honesty may be the best policy. *Annals of Internal Medicine* 131(12): 970-972.

treatment injury, come together to create an environment in which an appropriate and well-timed apology will often reflect positively on the health practitioner in the eyes of the law.

And fifth, and perhaps most importantly, is the force of morality and compassion. Saying sorry when you have hurt someone is simply the right and caring thing to do. One defence lawyer who initially advised her clients to break off communication after bad outcomes explains: *“At some point, it just struck me that a non-communicative, dehumanizing, adversarial process was at complete odds with the mission of healing, delivering compassionate care and treating patients with dignity and respect.”*¹⁴ Or put more simply, in the words of Justin’s mother, Dale Micalizzi, *“It’s about being human and treating each other with respect and kindness, nothing else”*.

Why are apologies important to patients and their families?

So, why are apologies so important to patients and their families? When we listen carefully to people who have suffered an adverse event, a number of common themes emerge.

Following an adverse event, many patients and families feel abandoned by the very people they entrusted with providing them care. They may also feel hurt, betrayed, devalued.¹⁵ The person whom they literally trusted with their life has let them down. By apologising, the health practitioner acknowledges these feelings, helps to restore the patient’s trust and dignity, and provides reassurance to the patient and the family that they will not be shut out at this most vulnerable time. Paradoxically, some patients have more trust in the healthcare system after an adverse event, than before, if an adverse event is handled openly and honestly.

For others, an apology may provide important confirmation that the health system, and not the patient or family, was responsible for the injury. Many patients and families (particularly the parents of children who have died or suffered permanent disability) wonder whether they were in some way to blame for the harm that occurred. By truthfully acknowledging the extent to which the injury was caused by healthcare, health practitioners can lift that burden of uncertainty and guilt from their shoulders, and provide an understanding of how and why things went wrong.

In cases involving a clear medical error, an apology also serves as an important signal that the health practitioner regrets his or her actions and wishes to avoid repeating them. This reassures

¹⁴ Sorry Works! Interview with former Hospital Defense Attorney.
www.sorryworks.net/ruddell.phtml

¹⁵ When things go wrong: responding to adverse events. A consensus statement of the Harvard Hospitals. March 2006.
www.taskforce.org/JustinHope/respondingToAdverseEvents.pdf

the patient that the unsafe behaviour will not continue. When an apology is absent *“The lack of remorse and forbearance indicates that the wrongdoer may not share the moral standards of the rest of society and, thus, is at risk to repeat the wrongful act.”*¹⁶

And finally, an apology can help to facilitate the process of forgiveness, grieving, and healing. Forgiveness requires an acknowledgment of the past and a willingness to move on in a new way. Hearing an apology helps families to stop endlessly speculating about what happened, and begin to grieve the loss they have suffered.¹⁷ With a heartfelt *“I’m sorry, we made a mistake”* healing can begin.¹⁸

Why are apologies important to the health provider

Patients are not the only ones who can benefit from an apology after an adverse event. Wayne Cunninghams’ research regarding the effect of complaints on doctors in New Zealand demonstrated the deep impact of adverse events and complaints on health providers. Typical feelings were anger, shame, guilt, and a loss of confidence in their abilities and their competence.¹⁹ According to Aine McCoy from the Medical Protection Society: *“Doctors tend to cope in varying ways with the realisation that an error has occurred. Typically negative strategies are denial, discounting, distancing oneself from the issue and one’s colleagues and family and covering it all up. Needless to say these do nothing to promote a resolution.”*²⁰

For the health practitioner, the benefits of an apology can be divided into two categories: internal and external. The internal benefits of apologising include alleviating shame and guilt, and maintaining self-esteem. The debilitating effects of remorse can eat away at us until we become emotionally and physically ill. A heartfelt apology, particularly when followed by forgiveness from the patient, can lift that burden of self-reproach and guilt. As explained by an oncologist whose team accidentally gave a breast cancer patient a double dose of medication: *“When something like this happens, you feel guilty, you feel angry, you feel terrible ... I checked all the facts and I put myself in the shoes of the patient and asked myself what her concerns might be, so I could prepare truthful answers ... [I]t’s a tremendous relief to be able to share the truth.”* Taking responsibility for our actions, by offering an apology, may also help health practitioners to restore a sense of self-control over events that may otherwise feel overwhelming.

¹⁶ Lazare, A. On Apology. 2004. Oxford University Press: New York.

¹⁷ Lazare, A. On Apology. 2004. Oxford University Press: New York.

¹⁸ Gibson, R and Singh, J. Wall of Silence. 2003. Lifeline Press: Washington DC.

¹⁹ Cunningham, W.. The Immediate and Long-term impact on New Zealand doctors who receive patient complaints. NZ Med J. 2004. 117 (1198).

²⁰ McCoy, A. Errors in Practice. NZFP Volume 34 Number 1 February 2007.

The external benefits of apologising relate to the way that a health practitioner is perceived by his or her patients, colleagues, and community following an adverse event. It takes great strength of character to face someone we have hurt, acknowledge responsibility, and to show compassion for his or her suffering.²¹ Health practitioners who apologise are demonstrating their commitment to enduring principles of medical ethics: telling the truth, and acting with charity and kindness. In addition, the process of apology invariably calls for candid self-reflection and, as a result, may lead to better and safer care.²² The courage and humility of a practitioner who takes responsibility for his or her actions is more likely to earn the respect of others than a policy of deny and defend.

Why are apologies important to the relationship?

One common fear is that apologising will result in a complaint or other form of legal action.²³ In the New Zealand context, where no-fault compensation can be obtained without the requirement for malpractice litigation, it seems likely that patients who know that they have been harmed will in fact be *less* likely to take legal action if health practitioners communicate openly and apologise appropriately, than if the patient perceives a “cover up”. For example, the mother of a baby who required surgery after delayed diagnosis of an imperforate anus wrote to the Commissioner: *“Had the doctor apologised as soon as he found out about the problem, or had he enquired after baby’s health, I would not be making this complaint now.”* Similarly, the mother of a child whose cancer was left undiagnosed for three months explains her motivation for taking legal action: *“When did I get an attorney? When the doctors wouldn’t apologise to an eight year old girl ... I can live with the mistake, but I can’t live with the fact they won’t apologise to my daughter, who is permanently disabled.”*²⁴

²¹ Engel, B. The Power of Apology. Psychology Today Magazine July/Aug 2002.

²² Stevens, D. Healthcare system error: beyond apology. Quality and Safety in Health Care. 2008 Aug;17(4):234-5.

²³ Research by Studdert and colleagues’ alerts us to the possibility that, in the United States context, there is a risk that open disclosure may prompt more claims and complaints than are averted, even though disclosure is the ethical thing to do. Studdert, D et al. 2007. Disclosure of medial injury to patients: an improbable risk management strategy. Health Affairs, 26(1), 215-226. Others have criticised this study, on the grounds that it pays insufficient attention to *“the substantial evidence that communication and relationships between staff, patients, and family are critical”*. Wakefield et al. 2007. Open Disclosure: Details matter - A Response to Studdert et al 2007. Health Affairs, 26(3), 903-904.

²⁴ Gibson, R and Singh, J. Wall of Silence. 2003. Lifeline Press: Washington DC

According to the Health and Disability Commissioner: *“The way a practitioner handles the situation at the outset can influence a patient’s decision about what further action to take, and an appropriate apology may prevent the problem escalating into a complaint to HDC”*.²⁵ And indeed, there is mounting evidence and research showing that a policy of candour, coupled with a sincere apology, can prompt dialogue, create trust, and reduce adversarial disputes.

One particularly interesting study was carried out by Jennifer Robbennolt, a Professor of Dispute Resolution in the United States. In Robbennolt’s study,²⁶ participants were read a scenario describing a situation where a bicycle rider collided with a pedestrian. Participants were asked to take on the role of the injured person, and decide whether or not they would accept a settlement offer from the other party. Robbennolt found that a full, responsibility accepting apology improved the participants' perceptions of the situation and the offender, and increased the likelihood that the offer would be accepted. A partial apology (expressing sympathy, but not accepting responsibility) improved perceptions only if responsibility was unclear, or the injury was minor. Perhaps unsurprisingly, the more severe the harm, the more extensive the apology needed to be to alleviate the victim's anger. Robbennolt found that *“An offender who offered a full apology was seen as experiencing more regret, as being more moral and more likely to be careful in the future than one offering a partial or no apology.”*

Forms of apology

Some health practitioners are hesitant to say sorry because they are unclear as to the difference between being sorry for the harm that their patient has suffered, and an admission of fault or liability. A number of medical schools have now instituted training programmes to help medical students who are *“illiterate in the language of apology”*. These students learn that, broadly speaking, there are three types of apology: the non-apology, the partial apology (or expression of sympathy), and the full apology.

The non-apology

In its simplest form, an apology is an encounter between two parties, in which one party acknowledges responsibility for an offense or grievance, and expresses regret or remorse for his or her actions. However, it is important to remember that not every sentence that starts with *“I’m sorry ...”* is an apology.²⁷ Non-apologies are typically used when people want to take the heat off

²⁵ Paterson, R. Saying Sorry. New Zealand Doctor. 23 March 2005.

²⁶ Robbennolt, J. Apologies and Legal Settlement: An Empirical Examination. Michigan Law Review, Vol. 102, No. 460, 2003

²⁷ Pullum, G. Pete Rose and sorry statements of the third kind. 13 January 2004.
<http://itre.cis.upenn.edu/~myl/language/og/archives/000327.html>

a situation and keep the offended person quiet, without actually demonstrating humility, remorse, or a commitment not to repeat the offense.²⁸ In effect, the offender is trying to reap the benefits of apologizing without having earned them.

Consider for example, the case of a woman who underwent a pelvic ultrasound at a public hospital. She was upset that a male registrar in training observed the procedure, without her consent, and she felt that the consultant radiologist spoke to her in a brusque way that made her “feel demeaned”. The radiologist said “*I am sorry that she has misinterpreted my voice and manner*”²⁹ and went on to say that Ms A was the only patient to criticise the radiologist’s bedside manner in 20 years of doing similar examinations.

In another case, a baby was seen at a general practice three times over the space of four days with vomiting, diarrhoea and coughing spasms leading to apnoea. The baby was misdiagnosed with an ear infection, when in fact she was suffering from whooping cough. The GP called the baby’s mother to “*express his disappointment at the way things had turned out*”. The mother found the phone call intimidating: “*He was very quick to let me know his qualifications. He also pointed out that I did wait two days, after seeing him, before taking my baby to hospital. I resent his implications very much . I find it unacceptable to try and make me feel guilty ... I was not prepared to return to that surgery for a 4th time, just to be sent away again!*”³⁰

A common feature of non-apologies – present in both of these cases - is that the so-called “apology” is in fact a deflection of responsibility, which implies that the victim is the one who is in the wrong. In other cases, the non-apology may offer explanations that are dishonest, arrogant, manipulative, or an insult to the intelligence of the patient or the family. In all of these situations, the non-apology may actually escalate the situation.

Partial apology / expression of sympathy

The second form of apology is the partial apology or expression of empathy: “*I’m sorry for your suffering.*” Saying sorry does not automatically imply fault or error – it’s all about context.³¹ This second form of “*I’m sorry*” is all about empathy, compassion, and re-establishing trust and

²⁸ Kellog, S. The art and power of apology. Washington Lawyer. June 2007.

²⁹ Health and Disability Commissioner. Consultant Radiologist / Hospital and Health Services <http://www.hdc.org.nz/files/hdc/opinions/00hdc06794.pdf>

³⁰ Health and Disability Commissioner 97HDC9123 <http://www.hdc.org.nz/complaints/opinions?97HDC9123>

³¹ Wojcieszak, D, SorryWorks. December 1 2008 Newsletter. <http://www.sorryworks.net/newsletter20081201.phtml>

communication with patients and families in the aftermath of an adverse event. It shows that we share - at an emotional level – care and concern for the hurt person, without accepting responsibility or acknowledging fault. This is the form of partial apology that Justin’s mother Dale was seeking when she explained that she just wanted to hear the doctor say: *“I am so very, very sorry that your son has died in our care.”*

Full apology

The third type of *“I’m sorry”* takes the form of *“I’m sorry that I hurt you. I accept responsibility for my mistake.”* Depending on the circumstances, a full apology is likely to involve an acknowledgement that aspects of care fell below the expected standard of care, acceptance of responsibility for those failings, and a commitment to doing things differently in future. One recent example of a full apology comes from the Beth Israel Deaconess Medical Centre, where a middle aged patient undergoing an orthopaedic procedure had the wrong side operated on. The mistake was not discovered until the patient was in the surgical recovery area. As soon as the patient was fully awake, the surgeon offered a full apology. The Medical Centre’s Chief Executive, Paul Levy, explained: *“People want to trust the doctors and the hospitals they go to ... and I think people also know that we’re not infallible and that by admitting our mistakes and demonstrating our desire to improve, it helps the public understand that we really care about them.”*

Good apology

So what makes for a good apology? There is no fool-proof, guaranteed technique to successfully apologise, and the requirements for an effective apology will vary from case to case, depending on the injured person’s hopes, needs, and fears, and the relationship between the two parties. Nevertheless, it can be helpful to think of an authentic apology as having four parts:^{32,33}

The first step requires recognition of the patient or families’ feelings, and clarification of the event that caused offence or injury. Recognising and acknowledging harm is not always an easy task. Often, the need for an apology arises when two people do not share the same perspective, and it is important to seek a common understanding of what was perceived as wrongful before trying to move on.

Next comes an expression of regret; an empathetic response that lets the patient know that we understand his situation and feel badly about it. Words such as, *“I am so sorry. This is not the outcome that either of us had hoped for”*, may be effective. As discussed above, such an offer of

³² Woods, M. *Healing Words: The Power of Apology in Medicine*.

³³ Paterson, R. *Saying Sorry*. New Zealand Doctor. 23 March 2005.

empathy and compassion does not admit guilt, but does allow the healing of the relationship to begin.

The third element is the one that distinguishes a full from a partial apology: recognition of responsibility and accountability. In situations where a medical error has clearly occurred, this may indeed be the most important part of the apology. In the right circumstances, thoughtful admissions of responsibility can facilitate forgiveness and potentially even strengthen the therapeutic relationship. Without this element, the apology may be viewed as hollow and meaningless. However, as discussed below, ill-prepared or misplaced admissions of fault can have harmful consequences for both health practitioners and their patients. When deciding how best to address issues of responsibility and accountability, practitioners are therefore well advised to seek early support and assistance from their legal advisor and senior colleagues.

And finally, an authentic apology involves some form of reparation. Ideally, the remedy should both address the problem the patient is experiencing, and outline the steps that are being taken to protect others from the same untoward result. In the New Zealand context, assisting the patient to obtain compensation and access rehabilitation services through an ACC treatment injury claim, will be an important part of the remedy in many cases.³⁴

Who should apologise?

Every health practitioner will, at some point in a successful career, have to confront at least one unanticipated, serious, or even catastrophic outcome. Ideally, we should all be equipped with the skills to step up and apologise for our own mistakes – the believability and sincerity of apologies is far greater when they are offered in-person, by the person who caused the harm, rather than through a third party. In some cases, it will also be appropriate for the person ultimately responsible for that episode of healthcare (whether that be the consultant, the practice manager, or even the chief executive) to apologise.³⁵

As alluded to earlier, apologising can be a formidable challenge for many healthcare practitioners. It is therefore important for hospitals to arrange adequate support for staff in the aftermath of an adverse event,³⁶ and to ensure that health practitioners have enough time to prepare – both factually and emotionally – for these difficult conversations. One anaesthetist who approached a

³⁴ For more information see www.acc.co.nz.

³⁵ When things go wrong: responding to adverse events. A consensus statement of the Harvard Hospitals. March 2006.
<http://www.taskforce.org/JustinHope/respondingToAdverseEvents.pdf>

³⁶ Phipps, G. Complaints need systemic response. New Zealand Doctor November 2006.

patient's family following an intra-operative cardiac arrest explains: *"I felt personally responsible for what had happened and compelled to communicate with the family. I thought I would be able to provide a factual account of the event to the husband but to my shock, the husband came at me with full emotional and physical force ... I was now forced to confront my own emotional distress and I realised my complete lack of training in how to manage this situation."*³⁷

An important part of the emotional preparation for an apology, involves an acceptance that the other person may indeed be upset and not yet ready to forgive. Injured patients and their families should not feel pressured by subtle – and not so subtle – reminders that 'good' people are 'forgiving', or assurances that, after all, nobody *meant* to harm them – at a time when they remain profoundly distressed by not knowing what really happened, or by inadequate acknowledgment of their suffering.³⁸ We need to be prepared to allow the other person to express their disappointment and frustration, and to validate their feelings, rather than expecting instant forgiveness.

When should health practitioners apologise?

When thinking about the timing of an apology, it can be helpful to think of it as taking place in three parts – an expression of sympathy as soon as the harm has been identified; followed by a full apology once the facts are fully understood; and finally, one or more opportunities to meet again after a period of reflection, to discuss and understand the meaning of what happened, the appropriate reparations, and the future of the healthcare relationship.

Partial apology / expression of sympathy

Immediately after an event, the primary concern will be to ensure that the patient is safe and that an appropriate treatment plan is in place. As soon as the patient's ongoing safety has been assured, the responsible health practitioner should express regret for what happened. Patients are likely to feel hurt and vulnerable after an event, and the expression of empathy and compassion is an essential, humane response to an adverse event, regardless of the cause.³⁹ This initial expression of sympathy can take place without knowing exactly what went wrong or why, in the same way that we would express sympathy and concern for any injured human being.

³⁷ Van Pelt, F. Peer support: healthcare professionals supporting each other after adverse medical events. *Quality and Safety in Healthcare* 2008. 17: 249-252.

³⁸ Berlinger, N. 2005. *After Harm: Medical Error and the Ethics of Forgiveness*. Johns Hopkins.

³⁹ When things go wrong: responding to adverse events. A consensus statement of the Harvard Hospitals. March 2006.

<http://www.taskforce.org/JustinHope/respondingToAdverseEvents.pdf>

In the words of David Costa: *"People need to stop being so worried about communication of compassion for those we serve."*⁴⁰

The conversation might go something like this: *"I am so very sorry this happened. The doctors and nurses caring for your son will work with you to ensure he receives the best possible care. We are carrying out an investigation to find out what happened, and we will share that information with you as soon as we can. Is there anything else we can do for you or your family at this point? I will be back in touch with you in the next day or so. In the meantime, if you have any questions, you can call me on this number at anytime of day."* Notice that the health practitioner has said sorry, without admitting fault, assigning blame, making guesses, or jumping to conclusions. This initial conversation is all about expressing heartfelt sympathy, conveying compassion, and rebuilding trust. It brings the injured patient and family closer, rather than pushing them away, and promises to maintain open lines of communication.

Full apology

The second phase of an apology, involves a full apology, including an acknowledgement of accountability or responsibility where appropriate. If a simple and obvious error has occurred, it may be appropriate to immediately acknowledge that a mistake was made, apologise, and commit to ensuring that it does not happen again.

However, in many situations, a quick admission of guilt, even when expressed with genuine feeling, will be the wrong choice. Once a full apology has been made, it cannot be taken back, and trying to retract information that was wrongly given in the heat of the moment only gives rise to suspicions and mistrust. If emotions are high, the healthcare situation is complex, or the facts are not yet clear, it is important that health practitioners take time to reflect on what has happened before offering a full apology. The Medical Protection Society recommends that as soon as practitioners become aware of a problem they contact the Society for advice on the prudent approach to take. It may also be appropriate to use this time to speak with senior colleagues, risk managers, or insurers. The extent of further information that is required may range from reviewing the medication chart, to carrying out an in-depth formal investigation.

Taking time to reflect on what has happened before offering a full apology has advantages for both the patient and the health practitioner. Such reflection can help to ensure that health practitioners do not unfairly blame themselves, in situations where no error has occurred, or jump to wrong conclusions about the cause of the adverse event. It also helps to ensure that patients

⁴⁰ Costa, D, SorryWorks. December 1 2008 Newsletter.
<http://www.sorryworks.net/newsletter20081201.phtml>

and their families receive a factual, constructive, cohesive response⁴¹ from all those involved rather than being subjected to the shifting sands of assumption and speculation. The inquires that are required before a decision is made regarding the need for a full apology may be completed within hours, or may require several weeks if the circumstances leading up to the adverse event are complex. During this time, every effort should be made to ensure that the patient feels safe and that channels of communication remain open.

If the investigation shows that the patient received appropriate care, the patient or family should be provided with full information and offered an opportunity to ask any further questions. If the investigation shows that an error has occurred, a full apology should be offered. The patient needs to know why it happened, to the extent that that can be answered, and he or she needs to know what is going to be done to reduce the potential of such a mistake happening again.

Further opportunities to meet

Finally, it is important to remember that offering and accepting an apology may require time and patience. Just as a wound does not heal the moment that treatment is started, so too can it take time for both parties to experience healing after an apology is extended. We need to be patient. The injured patient may need days, weeks, or longer to understand and psychologically assimilate what has happened. The health practitioner and patient may need to meet on several occasions to talk things through, and understand the implications for the healthcare relationship. Remember this wisdom from Shakespeare: *"How poor are they that have not patience! What wound did ever heal but by degrees."*⁴²

Conclusions

For many health practitioners, talking about apologies still feels uncomfortable. It can be helpful to remember that, years ago, health practitioners were similarly uncomfortable talking about informed consent. Now it has become a standard part of the healthcare relationship. As the "wall of silence" continues to crumble, we can expect to hear much more discussion about the importance of saying "sorry" in the health sector. We can all support the work that needs to be done to improve health practitioners' literacy in the language of apology, and to address the fears and misperceptions that prevent health practitioners from expressing sympathy and, where appropriate, apologising in the aftermath of an adverse event. We can hope for an increasing recognition that saying *"I'm sorry"* can be a sign of strength, rather than weakness. It is an act which requires honesty, generosity, humility, commitment, and courage.⁴³

⁴¹ Phipps, G. Complaints need systemic response. New Zealand Doctor November 2006.

⁴² Shakespeare, W, Othello the Moor of Venice.

⁴³ Lazare, A. On Apology. 2004. Oxford University Press: New York.

While an empty or insincere pseudo-apology can do more harm than good, a heartfelt expression of sympathy or sincere apology can have profound healing effects for all parties. *"Apologies are some of the most profound interchanges between people because they touch us at what can be our most vulnerable moments."*⁴⁴ They can bring comfort to the patient, forgiveness to the healthcare provider, and restore trust to their relationship.

This paper finishes where it began, with the story of Justin Micalizzi. Years have now passed since Justin's death, and still his mother Dale has not received an apology, or even an expression of sympathy, from some of the health practitioners with whom she entrusted her son's life. Over that time Justin's mother has become a powerful advocate for safe, compassionate, patient-centred care. It seems appropriate to conclude this paper with the quote that appears on the back of the bookmarks that Justin's mother, Dale, distributes in her son's memory:

Integrity: "The highest courage is to dare to be yourself in the face of adversity. Choosing right over wrong, ethics over convenience, and truth over popularity...these are the choices that measure your life. Travel the path of integrity without looking back, for there is never a wrong time to do the right thing."

⁴⁴ Lazare, A. On Apology. 2004. Oxford University Press: New York.