The Art of Apology: When and How to Seek Forgiveness

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Introduction

Mistakes happen. What happens after a mistake can be as, or even more, important to a patient's ultimate outcome and satisfaction with care. This article discusses how to decide if an error has been made in your practice and how to offer an apology when one is warranted. It also recommends strategies to avoid future errors.

What is an Error?

Not everyone defines error the same way. An often-cited 1999 Institute of Medicine (IOM) report defined error as a "failure of a planned action … or the use of a wrong plan."[1] Some patients include rudeness or prolonged waiting time when describing medical error.[2] With the literature offering at least 25 definitions of error,[3] how do you decide whether an occurrence rises to the level of an error and whether it should be disclosed to the patient?

Whatever definition you use, it is clear that health care professionals have frequent opportunities to learn from, and answer for, their mistakes. The IOM report estimated that between 44,000 and 98,000 Americans die annually in hospitals because of errors.[1] A review of 11 studies found between five and 80 errors per 100,000 primary care visits.[4] Another study asked family physicians to identify errors in their practice; they disclosed errors in 24 percent of their office visits, with 24 percent of those errors causing (usually minor) harm.[5]

From a systems perspective, every error - large or small - offers an opportunity for improvement and may be worth identifying, correcting and tracking. Yet, disclosing every error, no matter how trivial or benign, chips away at patient confidence, while failure to disclose erodes patient trust. From a patient perspective, there is a preference for full disclosure, although patients appear to agree with professionals when deciding if an error was committed - they tend to rely on whether professional standards were breached and whether harm occurred.[6]

Even when the care is blameless, a caring professional will show empathy when a patient has an undesired or unanticipated result, or appears unhappy or offended. (Here are some examples: "I am sorry things turned out this way." "How are you holding up?" "This must be difficult for you." "Thank you for waiting.")

Empathy, however, is not an apology.

When to Apologize

An apology acknowledges responsibility and reflects remorse. It should be offered when an error has occurred and harm or potential harm has resulted. (For more on this, see "The apology zone" in the sidebar.)

As with most judgment calls, determining whether the error's magnitude and harm, real or potential, merit an apology will depend on the circumstances. For example, a misspelled word in a progress note would not usually be cause for an apology. However, if the misspelling was a medication that was similar in name to another drug, and a subsequent prescriber refilled the misspelled medication, which in turn caused harm to the patient, then an apology would be in order.

When the outcome is unwanted or unexpected, people are unhappy, or errors are suspected, an apology should be considered. Before concluding that an apology is needed, it is first necessary to get the facts: What happened, *exactly*? What are the perspectives of the other members of the care team? What was the proper procedure for the condition in question, and was it followed? Was there an error? If the patient - or very often, a family member - demands an explanation or apology on the spot, before you have a sufficient understanding of what happened, it is appropriate to reply, "I don't know, but I will find out." When things go bad, clinicians may jump to premature conclusions about whether an error occurred, perhaps feeling a need to offer some explanation of what happened or to cope with their own emotions over a bad outcome.

Consider the example of an infant with cerebral palsy who had a worrisome electronic fetal monitor tracing before a difficult vaginal birth. The cord blood gas at delivery showed a pH of 7.34. Feelings of grief, guilt or empathy with the distraught parents may cause the clinician responsible for the delivery to attribute the cerebral palsy to brain damage due to perinatal asphyxia and to consider an apology for not delivering the infant sooner by cesarean section.

Before offering an apology, however, it is important to reflect on the facts of this case and on what is known about cerebral palsy. The infant's cord gas pH was not consistent with the acidemia expected in a newborn diagnosed with perinatal asphyxia. Moreover, electronic fetal monitor tracing has not been shown to improve or predict long-term birth outcomes.[7] Fewer than 10 percent of children with cerebral palsy are thought to have developed the handicapping condition as the result of their birth process. While cerebral palsy may be related to prematurity or perinatal infection, in most cases no one knows why the cerebral palsy developed or whether it could have been prevented.[8]

In the spirit of full disclosure, the clinician might refer back to the worrisome electronic fetal monitor tracing, acknowledge the potential for cerebral palsy to be caused by asphyxia in a small proportion of affected babies and explain that the cord gas results made asphyxia unlikely in this case. While it might not sound as professionally confident or be as satisfying for those desperate for the certainty of definitive answers, the correct explanation to the parents in this case is most likely, "I don't know why your baby has cerebral palsy, but we'll continue to work on trying to find out." At the same time, the clinician should offer more than just science. The emotional aspects of the diagnosis must also be addressed: "How are you coping? Having a child diagnosed with cerebral palsy can be overwhelming for families. I am sorry you and your family have to deal with this difficult time."

How to Apologize

After deciding that an apology should be offered, it is essential to do it well. A badly done apology can make things worse for both the patient and the professional. A well-done apology involves at least four parts: acknowledgement, explanation, expression of remorse and reparation.[9]

The high emotion surrounding an apology warrants that it occur at the right time and place. If you do it too soon, you won't know enough facts. If you wait too long, you might be suspected of deception or disregard. Ensure sufficient time, a comfortable physical layout and adequate privacy so that a meaningful, and likely emotional, conversation can take place. Consider who should be present: Who would the patient like in attendance? Should other members of the care

team attend? Does someone from your organization's patient relations staff need to participate? Having more people participate increases the chance that all relevant concerns will be aired, but it also raises the risk that the moment will be less personal and, perhaps, less effective.

Be aware of your body language as you get ready to begin your apology. First, sit down and maintain an open and receptive posture (no crossed arms or speaking over the shoulder). Maintain eye contact, and speak in a professional and empathic manner. Avoid jargon, defensive statements or angry rebuttals. Facial expressions and body language will likely be remembered as much as words.

Focus on listening. Begin by asking the patient - and, if present, family members - about their understanding of what happened. This will provide insight into their interpretation of the facts and will highlight potential gaps in their knowledge or possible misperceptions. After their explanation, describe in chronologic order what happened when and why various interventions were taken, or not taken, at each step. Explain the error that occurred, let them know that you share their frustration that the mistake happened, and express your sincere remorse.

It is especially important to patients to find meaning in their experience. To the extent possible, describe what their outcome will mean for them, what can be done to prevent similar errors from occurring and how others may be helped by what was learned. If possible, offer restitution. Obviously, any monetary amounts would need coordination with and possible approval by institutional or insurance carrier representatives, as appropriate, before discussing them in specific terms.

Who Apologizes

The patient's personal physician often is in the best position to explain what happened and to express sorrow over the outcome; a long-trusted relationship goes a long way toward helping the healing. If the personal physician was not responsible for the error, then the person who made the mistake should apologize, perhaps with the personal physician in attendance. When a trainee (e.g., a resident physician or a medical student) has committed the error, that person should be accompanied by the attending physician when making the apology. When the error is due to systems or institutional failure, it might be an administrator who should apologize. Should the responsible person not be identifiable, or able or willing to apologize, then the personal physician or organizational leader should make the apology.

Time for Reflection

Learning to give a skilled apology without improving on patient safety is like perfecting firefighting while ignoring fire prevention. Start by practicing reflective medicine. Think about each hospital admission as a possible failure in outpatient management. This develops the habit of doing root cause analysis of why your patient deteriorated to the point of requiring hospitalization. This, in turn, can lead to changes in practice routines (e.g., arranging for a nurse call the day after an office visit for a chronic obstructive pulmonary disease exacerbation). Many larger groups now have patient safety officers who are responsible for overseeing safety practices. Create an "oops" box - known in hospitals as a repository for incident reports - that allows staff to report events or routines that caused, or could have caused, error.

Beware the handoff. The transfer of responsibility for care from one clinician to another is one of the high-risk moments in health care. Electronic sign-outs or communication through unit clerks or paging services may suffice for stable patients, but a real-time conversation in person or by phone is usually needed for patients who are fragile, critically ill or high risk (e.g., their cases involve social issues, including problems in previous care).

Electronic records offer great potential to improve the safety of care by eliminating illegibility, making more information available more easily, providing warning signals and reminder prompts, and facilitating easier identification of practice patterns and potential problems (e.g., notifying patients on a specific medication of newly released drug alerts or recalls). At the same time, however, poorly designed electronic records may allow clinicians to dump huge volumes of text that obscure the important data, document histories or exams that were less complete than represented, or generate so many warning messages that they become an ignored blur.

Perfect care is an ideal that can only be pursued, not achieved. Individual effort can assist in that pursuit, but the most substantial improvements will occur through system redesign, which requires a reflective approach to care and the commitment of all members of the care team. In the journey to better care, missteps and trips will occur. Meanwhile, skill in the art of apology will be needed.

The Aftermath

One potentially vexing decision for a family physician who commits an error and apologizes is whether to continue as the patient's personal physician. Like most difficult questions, the answer will depend on the circumstances and the people involved. Continuing the professional relationship may be too emotionally difficult for the patient or the doctor. Yet, terminating the relationship, if not handled properly, may leave the physician vulnerable to allegations of abandonment. If the patient or family is unable to forgive the doctor, then they will likely answer the question themselves by seeking care from another physician. Even when there seems to be genuine forgiveness, it may not be appropriate for the doctor to continue as the patient's physician if the doctor cannot maintain the necessary professional objectivity in future stressful situations involving the patient. Doctors who have erred in the care of a patient may attempt to compensate by overresponding when the patient develops subsequent problems.

Should the relationship continue, the patient will expect, and deserve, extra-attentive care in order to validate the essence of an apology ("I am sorry for what I did, and I will do my best to avoid future mistakes."). Giving the patient special attention is also the right thing to do; when someone has been injured by another's error, there is a duty to prevent further harm from happening.

An apology puts the health care professional in the unfamiliar and vulnerable position of being dependent on the patient for something that only the patient can provide: forgiveness. Thus, it represents a shift in power and a kind of role reversal. A sincere apology cannot heal all wounds - it will not immunize the professional against litigation or other retribution.[13] It is, however, the right thing to do and is considered an ethical duty for the professional. For the patient, it begins the healing. For the professional, it allows forgiveness.

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Sidebar:

How to Apologize

1. Get the facts.
2. Get the right people to attend.
3. Find the right time and place.
4. Ask what they understand.
5. Describe what happened.
6. Show empathy.
7. Offer an apology.
8. Make things right.

The Apology Zone

An error is defined as the failure of a planned action to be completed as intended (i.e., error of execution) or the use of a wrong plan to achieve an aim (i.e., error of planning).

An adverse event is an injury caused by medical management rather than the underlying condition of the patient. An adverse event attributable to error is a "preventable adverse event."

When errors and adverse events intersect, you have entered an "apology zone" and an apology might be appropriate.

Negligent adverse events represent a subset of preventable adverse events that satisfy legal criteria used in determining negligence (i.e., whether the care provided failed to meet the standard of care reasonably expected of an average physician in the same or similar circumstance).

SOURCE: Kohn LT, Corrigan JM, Donaldson MS, eds, for the Committee on Quality of Health Care in America, Institute of Medicine. *To Err Is Human: Building a Safer Health System.*Washington, DC: National Academy Press; 1999.

The Risk of an Apology

An understandable concern of many health care professionals is that apologizing may increase the likelihood of disciplinary action, loss of license or a malpractice claim. Sorry Works (http://www.sorryworks.net) is a coalition that advocates the more frequent use of apology through approaches such as first apology laws, which would prevent the introduction of an apology as incriminating evidence at a malpractice trial if the health care professional offered the apology before any demands were made by the injured patient. Several states have enacted, and Congress has considered, such legislation.[10] It should be noted, however, that while first apology legislation might foster apologies, such laws are unlikely to reduce the current risk of litigation because most plaintiffs do not rely on an apology as evidence of negligence, but instead establish negligence through the medical record and expert-witness testimony.

It is too early to tell what impact these first apology statutes have had on patients, physicians, lawsuit frequency or litigation outcomes. Some malpractice carriers, such as the Colorado Physicians Insurance Company (COPIC), have formalized the apology process and empower the physicians they insure to offer up to $30,000 in restitution. Under the 3R program (Recognize, Respond and Resolve), which was started in 2000, COPIC physicians must go through a training process and follow certain steps and criteria when making an offer. While it is too soon to know the full impact of the 3R program, COPIC reports a reduction in expected suits and payments.[11] The Veterans Affairs Medical Center in Lexington, Ky., adopted a policy of "extreme honesty" and found that it had a higher number of claims but lower payouts than expected.[12] It is not known whether the Veterans Affairs experience can be generalized to all patient settings.

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