

# APOLOGIES IN THE HEALTHCARE SYSTEM: FROM CLINICAL MEDICINE TO PUBLIC HEALTH

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## I

### INTRODUCTION

In recent years, both formal and informal initiatives have promoted the inclusion of apologies in medical education and clinical practices. Many countries have even regulated medical apologies through law. Although there has been much discussion of the potential for apology to promote efficiency and the conditions for a successful apology, the focus has mainly remained the doctor–patient relationship.<sup>1</sup> The literature and many intervention programs have focused on the interactions between doctors and patients after a medical mistake has occurred or some harm has resulted. These interactions have been conceptualized in individualistic settings, with almost no discussion of the collective and cultural dimensions of apology. Moreover, no reference has been made to cases of apology following collective trauma caused by public health activities. These cases involve state activities such as human experimentation or public health interventions that went wrong and are fundamentally different from the usual doctor–patient interaction.

In this article, we explore the role of apologies in healthcare systems from a broader perspective. The article begins by exploring the current state of apology within the healthcare system and tries to point out the limitations of the current individualistic point of view under which medical apologies are conceptualized. The article offers to overcome these limitations and enrich the existing discourse by referring to the cultural and collective aspects of apology. It addresses the significance of apology in terms of social solidarity and demonstrates the ways in which each apology situation entails a clash between

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1. For a recent review of current literature, see Anna C. Mastroianni et al., *The Flaws in State 'Apology' and 'Disclosures' Laws Dilute Their Intended Impact on Malpractice Suits*, 29 HEALTH AFF. 1611, 1612 (2010).

cultural identities. Next, the main part of the article expands the debate on apology by presenting a public health perspective of apologies following collective traumatic events such as the application of sterilization laws or flawed human experimentations in various settings. The article shows how some public health apologies have failed to address the cultural dimension of a healthcare problem and how an emphasis on this dimension can help the public health practice of apology. Finally, the article returns to apologies in the clinical setting and shows the relevance of culture and identity concerns in this more common context. We claim that the public health perspective of apologies should enrich discussion of the more individualistic-oriented clinical medical apologies. Our analysis also has implications for introducing health-related apologies into medical and legal education and everyday practices.

## II

### APOLOGIES IN THE HEALTHCARE SYSTEM: CONDITIONS AND LIMITATIONS

#### A. Apologies and the Law

Apology is traditionally considered as a private act and usually not encouraged or enforced by legal institutions.<sup>2</sup> Apology is considered an aspect of interpersonal relationships, while the role of modern law is to externalize broken interpersonal relationships when individuals are unable to settle disputes on their own.<sup>3</sup> The notion of the rule of law is based on alienated relationships between separate individuals who are governed by law and possess legal rights.<sup>4</sup> Apology, under a classic formal perception of law, is unnecessary since the legal determination of rights is supposed to balance the wrong by giving a remedy and officially regulating the relationship between the parties. Apology is usually presented as a speech act—an act that a speaker performs by uttering words that produce a particular effect in the addressee.<sup>5</sup> Yet apology can fail or succeed depending on whether basic conditions are met.

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2. One exception, however, is in the area of defamation suits. See Hiroshi Wagatsuma & Arthur Rosett, *The Implications of Apology: Law and Culture in Japan and the United States*, 20 LAW & SOC'Y REV. 461, 478–79 (1986).

3. For a famous definition of the rule of law emphasizing this notion of formal legality, see FRIEDRICH A. HAYEK, *THE ROAD TO SERFDOM* 72 (1944) (“Stripped of all technicalities, this means that government in all its actions is bound by rules fixed and announced beforehand—rules which make it possible to foresee with fair certainty how the authority will use its coercive powers in given circumstances and to plan one’s individual affairs on the basis of this knowledge.”).

4. See BRIAN Z. TAMANAHA, *ON THE RULE OF LAW: HISTORY, POLITICS, THEORY* (2004); JOSEPH RAZ, *THE AUTHORITY OF LAW: ESSAYS ON LAW AND MORALITY* 210–31 (1979). See also THANE ROSENBAUM, *THE MYTH OF MORAL JUSTICE* 191–92 (2004) (“The law is about the adjudication of rights, the assignment of liability, the determination of guilt and innocence, the serving of jail time, the payment of compensation. This is what the law means by a legal resolution. Law is not about the repair of relationships, the moral duties owed to and shared by our fellow human beings.”).

5. Summer Inst. Of Linguistics, Inc. Int’l, *What Is a Speech Act?*, LINGUALINKS, <http://www.sil.org/LINGUISTICS/GlossaryOfLinguisticTerms/WhatIsASpeechAct.htm> (last visited Dec. 28, 2009).

Apology as a speech act in modern culture<sup>6</sup> requires a few conditions<sup>7</sup> in order to be authentic and achieve full expression. The conditions of apology are usually stipulated as follows:<sup>8</sup>

1. Acknowledgement that a legitimate rule, moral norm, or social relationship was broken. Proper acknowledgement of the offense includes the identity of the offender and appropriate details of the offense.<sup>9</sup>
2. Acceptance of responsibility for the violation, thereby conveying an understanding of the nature of the wrong done and the impact it had on the receiver. This condition includes an explanation for committing the offense.
3. Expression of regret by communicating guilt, anxiety, shame, remorse, forbearance, or sympathy for having committed the offense.<sup>10</sup>
4. Offer of reparation for the harm caused by the offense.

6. The Greek root of the word apology implied a defense. Although “formal justification” or “excuse” remain definitions for the word apology, “[t]he more generally accepted modern usage of the word . . . is ‘an expression of error or discourtesy accompanied by an expression of regret.’” Max Bolstad, *Learning from Japan: The Case for Increased Use of Apology in Mediation*, 48 CLEV. ST. L. REV. 545, 546 (2000). Our reference to speech acts is based on J.L. AUSTIN, *HOW TO DO THINGS WITH WORDS* (2d ed. 1975).

7. Shoshana Blum-Kulka & Elite Olshtain, *Requests and Apologies: A Cross-Cultural Study of Speech Act Realization Patterns (CCSARP)*, 5 APPLIED LINGUISTICS 196, 207 (1984) (“[T]he apology speech act set includes four potential strategies for performing the act of apologizing: (1) an explanation or account of the cause which brought about the offen[s]e; (2) an expression of the [Speaker]’s responsibility for the offen[s]e; (3) an offer of repair; (4) a promise of forbearance.”).

8. For examples of such formulations, see ERVING GOFFMAN, *RELATIONS IN PUBLIC* 113 (1971); NICHOLAS TAVUCHIS, *MEA CULPA: A SOCIOLOGY OF APOLOGY AND RECONCILIATION* 19–20 (1991); Alfred Allan, *Apology in Civil Law: A Psycho-Legal Perspective*, 14 PSYCHIATRY PSYCHOL. & L. 5, 7–8 (2007); Deborah L. Levi, Note, *The Role of Apology in Mediation*, 72 N.Y.U. L. REV. 1165, 1172–75 (1997); Donna L. Pavlick, *Apology and Mediation: The Horse and Carriage of the Twenty-First Century*, 18 OHIO ST. J. ON DISP. RESOL. 829, 835–36 (2003).

9. Aaron Lazare, *Apology in Medical Practice: An Emerging Clinical Skill*, 296 J. AM. MED. ASS’N 1401, 1402 (2006).

10. Jennifer K. Robbennolt, *Apologies and Legal Settlement: An Empirical Examination*, 102 MICH. L. REV. 460, 468 (2003) (“In its fullest form, the apology has several elements: expression of embarrassment and chagrin; clarification that one knows what conduct had been expected and sympathizes with the application of negative sanction; verbal rejection, repudiation, and disavowal of the wrong way of behaving along with vilification of the self that so behaved; espousal of the right way and an avowal henceforth to pursue that course; performance of penance and the volunteering of restitution.”). See also AARON LAZARE, *ON APOLOGY* 23 (2004) (“‘Apology’ refers to an encounter between two parties in which one party, the offender, acknowledges responsibility for an offense or grievance and expresses regret or remorse to a second party, the aggrieved. Each party may be a person or a larger group such as a family, a business, an ethnic group, a race, or a nation. The apology may be private or public, written or verbal, and even, at times, nonverbal.”); Lazare, *supra* note 9, at 1402 (“The third part of an apology is the expression of remorse, shame, forbearance, and humility.”); Levi, *supra* note 8, at 1177 (noting apology may be viewed “as a corrective ritual performed by two subjects in order to redress a moral power imbalance between them”).

As the conditions above suggest, apology in western thought is both individualistic and moralistic. It includes acknowledgment of a wrong and transformation of the interpersonal relationship through a sequence of acts. It might occur between parties on the private level, but is not susceptible to genuine enforcement or regulation by law. Law begins when the dynamic of private relationship ends and parties pursue their rights in courts. The courts determine their rights and, traditionally, will not enforce interpersonal reconciliation through apology. Apologizing signifies a human gesture beyond the structural relationships created by law.

## B. Apologies in the Healthcare System

Medical malpractice lawyers usually recommend silence when their physician clients are sued for a medical error, especially one leading to serious injury or death. This approach is based on the common assumption that admitting responsibility for any error simply sets the stage for a prolonged lawsuit and massive settlement.<sup>11</sup> Behind this assumption lies the dichotomy presented above, whereby apology is relegated to private interactions while law is the primary tool for handling institutional and professional interactions. A healthcare provider is not supposed to apologize even if she feels the need to do so, since the legal consequences of such an act will be liability and high damages for the hospital. Such costs, according to traditional legal thinking, should only be the product of due process of law through presentation of evidence and application of strict legal procedures.

Recently, more and more voices are trying to change the incentive not to apologize by promoting disclosure of medical errors and presenting apology as both an ethically and professionally responsible act. Apology under this perception is presented as a reasonable choice stemming from utilitarian motives and a crucial way to improve patient safety and quality of care.<sup>12</sup> In order to encourage medical apologies, several countries have introduced apology laws to reduce the concerns regarding the legal implications of disclosure and apology.<sup>13</sup> In the American context, these laws have been in place since the 1990s, mainly as a part of efforts to enhance medical error reporting and patient safety. An important document representing the change in medical

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11. Noni MacDonald & Amir Attaran, *Medical Errors, Apologies and Apology Laws*, 180 CAN. MED. ASS'N J. 11, 11 (2009).

12. Ashley A. Davenport, *Forgive and Forget: Recognition of Error and Use of Apology as Preemptive Steps to ADR or Litigation in Medical Malpractices Cases*, 6 PEPP. DISP. RESOL. L.J. 81, 107 (2006) (concluding that a practice of apologizing effectively may result in "a team-based atmosphere that ultimately reduces errors and protects patients"). See also Lauris C. Kaldjian et al., *An Empirically Derived Taxonomy of Factors Affecting Physicians' Willingness to Disclose Medical Errors*, 21 J. GEN. INTERNAL MED. 942, 943 (2006) (finding ninety-one factors recognized in existing literature that impede or facilitate physicians' willingness to disclose errors); Lee Taft, *Apology and Medical Mistake: Opportunity or Foil?*, 14 ANNALS HEALTH L. 55, 85 (2005) ("Discussing errors openly creates educational opportunities that help others avoid similar mistakes in the future.").

13. Some countries, such as New Zealand, Finland, Denmark, and Sweden, have no-fault compensation systems.

culture with respect to medical errors and the proper response to such errors was the Institute of Medicine's (IOM) report, *To Err is Human: Building a Safer Health System*.<sup>14</sup> This document broke the silence that has surrounded medical errors and their consequences by recognizing that "to err is human" and refusing to blame well-intentioned healthcare professionals for making honest mistakes.<sup>15</sup> Instead, the committee aimed to promote an agenda for reducing medical errors and improving patient safety through the design of a safer health system. Although the report prominently notes the rough legal atmosphere surrounding medical errors, it does not seriously question the current legal framework; rather, the report perceives the framework more as a constraint within which the design of more efficient workplaces and encouragement of disclosure for future preventions of mistakes must operate. The report considers the problem in the context of (1) rising numbers of medical errors, with more people dying in a given year in the United States as a result of medical errors than from motor vehicle accidents, breast cancer, or AIDS; (2) rising costs of medical care, including litigation costs; (3) increasingly technology-oriented hospitals and healthcare interactions; and (4) growing alienation between patients and physicians. While this context invites the idea of reducing these rising tensions, the term apology cannot be found in the IOM report; instead, the main framework is patient safety.

Apology within the healthcare system is unique in that situations which call for apology constantly occur within public institutional settings such as hospitals or community healthcare services. Thus, apology in the context of healthcare services transcends its interpersonal quality and becomes a target for regulation and careful design. Another important characteristic of apology within the healthcare system is the inherent structural imbalance between patients and healthcare providers. Patients are, by definition, less powerful, unfamiliar with the system, less knowledgeable, and less able to control the interaction with healthcare providers.

It can be argued that apology regulation aims to encourage doctors and healthcare providers to develop more sincere human interaction with their patients without fear of sanction by law for such efforts. In other words, legal regulations may provide a safe area where sincere human gestures will not have legal consequences. Healthcare apologies are designed in ways that neutralize the legal consequences—as expected in private apologies—and still enable the advantages of amicable dispute resolution without legal litigation. Although there is an acknowledgement of the importance of apology in transforming relationships and improving healthcare services,<sup>16</sup> many of the current legal

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14. TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (Linda T. Kohn et al. eds., 2000).

15. *Id.* at 5.

16. Lazare describes ten healing mechanisms effected by apology: restoration of self respect and dignity; feeling cared for; restoration of power; suffering in the offender; validation that the offense occurred; designation of fault; assurance of shared values; entering into a dialogue with the offender; reparations; and a promise for the future. Lazare, *supra* note 9, at 1402. For an additional discussion of

arrangements fail to construct circumstances permitting apologies to follow all of the conditions above and, thus, do not produce effective apologies.<sup>17</sup> Regarding *acknowledgement of the wrong*, many countries only exempt benevolent expressions. Thus, physicians and hospitals may fear liability depending on the type of apology they offer.<sup>18</sup> When the law enables only an expression of sympathy and does not include acknowledgement of wrongdoing, an apology might lead to worse outcomes than the expected legal dispute.<sup>19</sup> The condition of *acceptance of responsibility* is also not covered by apology law: even when apology regulation exempts the acknowledgment of a wrong, it will rarely encourage acceptance of responsibility for that wrong.<sup>20</sup> An apologetic act might also fail when *remorse* is expressed in reserved, legal language and *reparation* is offered, not as full compensation, but only as a symbolic act.

The difficulties of regulating apology through special exemption clauses and the imposition of duties to report on medical errors are related to the over-emphasized contrast between apology and law nurtured by mainstream legal culture. In contrast to this gap, an alternative legal culture presenting mediation as the primary legal method to deal with healthcare disputes has the potential of transforming relationships without falling into individualistic assumptions of apology and law.<sup>21</sup> The most effective healthcare apology might be possible within a mediation process due to its confidentiality.<sup>22</sup> When statements made in the course of mediation are privileged under state law, they can be excluded

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the healing aspects of apology, see generally Lee Taft, *Apology Subverted: The Commodification of Apology*, 109 YALE L.J. 1135 (2000); Lee Taft, *On Bended Knee (With Fingers Crossed)*, 55 DEPAUL L. REV. 601 (2006).

17. See Lazare, *supra* note 9, at 1402 (“All [four] parts are not necessarily present in every effective apology, but when an apology is ineffective, one can invariably locate the defect in [one] or more of these [four] parts.”).

18. These fears are reflected in state legislation impacting the legal effect of apologies. For example, in 1986, Massachusetts enacted a rule of evidence that rendered inadmissible “[s]tatements, writings, or benevolent gestures expressing sympathy or a general sense of benevolence” as evidence of an admission of liability in a civil action. Davenport, *supra* note 12, at 98. Other states have equivalent rules.

19. Mastroianni, *supra* note 1, at 1614 (“Our analysis reveals that most [state disclosure] laws have structural weaknesses that may discourage comprehensive disclosures and apologies and weaken the laws’ impact on malpractice suits.”).

20. Jennifer K. Robbennolt, *What We Know and Don’t Know About the Role of Apologies in Resolving Health Care Disputes*, 21 GA. ST. U. L. REV. 1009, 1013 (2005) (referring to an Oregon statute’s provision that “any expression of regret or apology made by or on behalf of [a licensed medical provider] . . . does not constitute an admission of liability for any purpose”).

21. For a presentation of mediation as transcending individualism with a basis in a relational worldview, see generally ROBERT A. BARUCH BUSH & JOSEPH P. FOLGER, *THE PROMISE OF MEDIATION: THE TRANSFORMATIVE APPROACH TO CONFLICT* (1st ed. 2004). For a discussion of the importance of a relational worldview in mediation, see Michal Alberstein, *Forms of Mediation and Law: Cultures of Dispute Resolution*, 22 OHIO ST. J. ON DISP. RESOL. 321, 365–66 (2007); Ran Kuttner, *Human, Not Too Human: Why Is Mediation a Profound Alternative to the Legal Proceedings?*, in 50 STUDIES IN LAW, POLITICS AND SOCIETY 139, 156–59 (Austin Sarat ed., 2009).

22. Bolstad, *supra* note 6, at 574. See also Deborah Levi, *Why Not Just Apologize? How to Say You’re Sorry in ADR*, 18 ALTERNATIVES TO HIGH COST LITIG. 147, 163, 165–68 (2000) (noting the potential for benefit from apologies in mediation settings and factors maximizing that potential).

from admissibility. Many states have such exclusionary provisions, since mediation fundamentally seeks to overcome the rigidity and alienation of the law by encouraging enclaves of private interactions protected by law. Indeed, mediation is probably the preferred forum to encourage an apology<sup>23</sup> within the healthcare system, but since entrance into, and participation in, the process require informed consent, not all healthcare apologies can be handled by this process.

To summarize, other than mediation, which is, in fact, a return to the private, individualistic notion of apology as unregulated by law, healthcare regulations usually fail to enable a full transformative apology when no mediation is conducted.<sup>24</sup> The examples in this section show how, under an individualistic perspective of apology, where assumption of the speech act is supposed to transform interpersonal relationships, restrained apology fails to meet the necessary conditions for transformation and sometimes can become an insufficient act which may produce further dispute and misunderstanding.<sup>25</sup> In the following part, we will show how a more collective notion of apology and healthcare practice can help improve this situation.

### III

#### BEYOND INDIVIDUALISTIC APOLOGY: THE RELEVANCE OF IDENTITY AND CULTURE

##### A. Collectivist Apology

The conditions of apology stipulated in the previous section do not apply universally, and in some cultures, which are usually characterized as collectivist, apology does not focus on the interpersonal private transformation between two individuals. The collectivist notion of apology will be posited here in order to develop the notion of apology as an act of restoring social solidarity, which has importance even in cases when some formal conditions of apology have not been met.<sup>26</sup>

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23. Pavlick, *supra* note 8, at 857.

24. Note, however, the exception of Hawaii, where the statement of the purpose of the apology bill explicitly references the limitations of an individualistic perception: "Particularly in our State, The Aloha State, it is regrettable that members of our statewide community cannot reach out to others in a human way without fear of having such a communication used subsequently as an admission of liability." S. Res. 1339, 24th Leg. (Haw. 2007). The final legislation enacted provides that "[e]vidence of statements or gestures that express sympathy, commiseration, or condolence concerning the consequences of an event in which the declarant was a participant is not admissible to prove liability for any claim growing out of the event." HAW. REV. STAT. § 626-1 (2007) [hereinafter Apology Statute].

25. *But see* Elizabeth Latif, Note, *Apologetic Justice: Evaluating Apologies Tailored Toward Legal Solutions*, 81 B.U. L. REV. 289, 311–20 (2001) (describing the potential beneficial effects of even the potentially imperfect apologies observed in legal settings).

26. In Japan, for example, "apologizing is a sign of an individual's desire to restore or maintain a positive relationship with the other party despite the temporarily disruptive harmful act." Bolstad, *supra* note 6, at 553. For a comparative analysis of apologies in South Korea, Japan, and the United

In contrast to the first condition of apology posited in the previous section, there is no strict emphasis on wrongdoing under the collectivist notion: a person can apologize without necessarily pointing to a breached norm or an excuse for the breach. In eastern thought, “reasoning embraces contradictions among objects in a yin[–]yang field of constant change.”<sup>27</sup> It is a more holistic mode of causation. While westerners base responsibility on culpability, easterners “highlight consequences.”<sup>28</sup> When something bad occurs, both parties apologize, one before the other. These are, of course, only rough characterizations that do not imply rigid dichotomies, as a range of possible reactions exists in various cultures.

Referring to the second condition of apology, the sincerity of the apology is less important than its offering in accordance with prescribed social interaction.<sup>29</sup> The apology, sincere or not, signifies an acceptance of the rules of social behavior and a willingness to conform to those rules in the future. The two parties to the apologetic act take part in this affirmation. There is greater homogeneity and emphasis on maintaining social order. A collectivist apology emphasizes amendment of the social order and harmony as its central values. The Japanese, for example, use a wide range of apology words to suit the social status of the offender and the offended. They discourage explanations and excuses for behaviors. The Japanese apology communicates “submissiveness, humility and meekness.”<sup>30</sup>

It is easier to understand the counter-individualistic notion of apology by examining collectivist societies. In such societies, apologies serve as a primary method to transform disputes in the public sphere and are an important ritual which may happen in court. Some such societies may utilize mediation and other alternative methods as primary dispute resolution mechanisms. In these societies, we would expect apologies to be a central tool for transforming disputes.

As a society places more emphasis on collectivist values, its inclination to regulate apology might avoid its specific individualistic conditions while supporting its social value as a tool for solidarity promotion and amendment of

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States, see generally Ilhyung Lee, *The Law and Culture of the Apology in Korean Dispute Settlement (With Japan and the United States in Mind)*, 27 MICH. J. INT'L L. 1 (2005).

27. Peter Hays Gries & Kaiping Peng, *Culture Clash? Apologies East and West*, 11 J. CONTEMP. CHINA 173, 175 (2002).

28. *Id.* See also LAZARE, *supra* note 10, at 32 (“Japanese apologies are focused primarily on restoring the relationship with the offended party, rather than on relieving an internal state of mind, such as guilt, which is more characteristic of person-to-person American apologies.”).

29. LAZARE, *supra* note 10, at 32–33 (“The Japanese are also more likely to offer and receive apologies than Americans and will often apologize even when the other is at fault.”).

30. *Id.* at 33. See also Wagatsuma & Rosett, *supra* note 2, at 466–67 (“In a society that emphasizes group membership as a basis for personal identity, it is important to maintain the sense of ‘insideness’ after a rupturing conflict. There must be a ceremony of restoration to mark the reestablishment of harmony. . . . [A]n apology, and best of all[,] a mutual apology, are even better as the explicit acknowledgement of commitment to future behavior consonant with group values.”).



social fractures.<sup>31</sup> On the other hand, supporting a full apology that fulfills all the formal conditions but exempts any legal consequence might undermine its social value and make it an empty gesture. Thus, cultural change can be encouraged largely through educational acts and active consciousness-raising and not necessarily through legal regulation. The shift beyond individualism in this context does not have to be extreme and assume a collectivist framework as a new setting. A more dialectic perception of self and other within a relational setting might be more appropriate for encouraging new forms of apology.

## B. Organizational Concerns and Apology Training

Some problems with the infiltration of apology into the healthcare arena relate to a lack of training of healthcare professionals to conduct apology in a proper way. Even deeper difficulties emerge from the common construction of the medical professional identity nourished by medical education, which does not support disclosure and apologies. According to a recent study, medical trainees frequently do not disclose mistakes, and faculty physicians are underprepared to teach communication skills related to disclosure and apology. This fact was reflected in a survey that found that nearly two-thirds of medical trainees and more than two-thirds of faculty physicians who reported making medical mistakes did not apologize.<sup>32</sup> The authors concluded that, “[a]t a time of increased attention to disclosure, actual faculty and trainee practices suggest that role models, support systems, and education strategies are lacking.”<sup>33</sup> Hence, the authors developed an interactive educational program for trainees and faculty physicians that (1) assesses experiences, attitudes, and perceptions about error; (2) explores the human impact of error through filmed patient and family narratives; (3) develops communication skills; and (4) offers a strategy to facilitate bedside disclosures.

Since everyday medical practice involves multiple individualistic, alienated interactions, legal regulation of the doctor–patient relationship seeking to encourage apology might fail to achieve its goals due to a lack of appropriate cultural change encouraged by appropriate training. Such training can begin with more relational education, which emphasizes care and solidarity. It can

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31. See, e.g., Apology Statute, *supra* note 24. For a discussion of the problems created by incomplete exemption of apologies as evidence in legal proceedings, see Jonathan R. Cohen, *Legislating Apology: The Pros and Cons*, 70 U. CIN. L. REV. 819, 842–44, 850–51 (2002).

32. Sigall K. Bell et al., *Improving the Patient, Family, and Clinician Experience After Harmful Events: The “When Things Go Wrong” Curriculum*, 85 ACAD. MED. 1010, 1012 (2010). See also Thomas H. Gallagher et al., *Disclosing Harmful Medical Errors to Patients*, 356 NEW ENG. J. MED. 2713, 2716 (2007) (claiming that “top-down regulation” will likely be less successful than disclosure programs that “emerge locally, are driven by an institutional leadership and a workforce committed to transparency, and focus on providing health care workers with the skills needed to conduct these difficult conversations well”).

33. Bell, *supra* note 32, at 1010 (noting summary of findings in abstract).

continue with workshops and concrete training programs for various healthcare providers.<sup>34</sup>

Furthermore, apologies are usually presented from the doctors' point of view—how difficult it is for doctors to say “I am sorry,” how the current medical competitive and stressful environment impedes an open disclosure of medical errors. This depiction is limited due to the exclusion of other professionals within the systems, such as nurses,<sup>35</sup> health managers, and, most importantly, the patients themselves.

In some cases, organizational and policy considerations result in a cultural change which encourages an enriched notion of apology.<sup>36</sup> As discussed above, it seems that, in most cases, a requirement that hospitals or physicians disclose medical errors is not enough for the development of a significant apology practice. Even if the initial motivations for the apology practice are efficiency and cost cutting, it is clear that these reforms also aim to promote an organizational change in the long run. With time, we will have a better perspective to consider if this move proves to encourage the desired cultural organizational change.<sup>37</sup>

### C. Cultural Dimensions and Public Apologies

Apology is not a universally neutral interaction. Any healthcare interaction—even one performed in a relatively individualistic setting such as that of one doctor to one patient—has its specific context. The patient's own context, stemming from her identification with a specific community, her previous interaction with the medical system, and her current perspective on the events, must be taken into consideration. Is she really interested in an apology and its construction? Is the patient coming from a community that has suffered past medical injustices? What are the gender inequalities that might exist for this specific patient? These questions are of course context-specific, and the answers can and should be very different in any case after careful, sensitive analysis of the cultural context. Apology training should not merely focus on imposing a universal manual which follows the basic abstract conditions for apology, accompanied by legal considerations. Instead, some

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34. One example of such programming is this symposium and its participants. See also Charity Scott, *Foreword: Therapeutic Approaches to Conflict Resolution in Health Care Settings*, 21 GA. ST. U. L. REV. 797, 814–15 (2005) (describing new initiatives for professional education).

35. Dale M. Pfrimmer, *Nursing's Role in Disclosure and Apology*, 41 J. CONTINUING EDUC. NURSING 342, 343 (2010) (calling for the inclusion of nurses in disclosure training).

36. For example, Cohen describes a successful healthcare reform attributable to several organizational differences. He refers to a case where the hospital was able to transform its approach to medical mistakes and their disclosure to patients and family members due to the reduced liability exposure for the hospital, the lack of personal liability for physicians, and the hospital's self-insurance, among other factors. Jonathan R. Cohen, *Apology and Organizations: Exploring an Example from Medical Practice*, 27 FORDHAM URB. L.J. 1447, 1469–73 (2000).

37. Bolstad, *supra* note 6, at 560. See also Davenport, *supra* note 12, at 90–92, 96, 106 (providing an overview of the current systems in practice and possible suggestions for improvement). See generally Gallagher, *supra* note 32.

initial inquiry should be devoted to the construction of the process itself after interviewing the parties involved. In the United States, for example, a long history of suspicion exists between the African-American community and the medical system that must be taken into consideration.<sup>38</sup> Similar issues exist in other countries with respect to other minorities.<sup>39</sup>

These considerations bring forward the questions of identity and its construction within the apology process. Public apologies of governments and political leaders regarding wrongs done to groups belong to a particular category of cases.<sup>40</sup> The apology in these cases does not aim to primarily emphasize individual rights, although there might be an element of admitting fault. Instead, the emphasis is on the group rather than the individual, and the ultimate goal is to strengthen the community. “Race apologies” are paradigmatic illustrations of collectivist goals.<sup>41</sup> As medicine and public health have had a crucial role in the history of race construction throughout history, the collective dimension of apology is possibly an integral part of the process, depending on the issue discussed.

#### IV

#### A CASE STUDY OF PUBLIC HEALTH APOLOGIES

##### A. Public Health Principles and Apologies

Although many definitions exist for public health, a recent report submitted to the U.K. Prime Minister defined public health as “the science and art of preventing disease, prolonging life and promoting health through the organi[z]ed efforts and informed choices of society, organi[z]ations, public and private, communities[,] and individuals.”<sup>42</sup>

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38. See generally Vanessa Northington Gamble, *Under the Shadow of Tuskegee: African Americans and Health Care*, 87 AM. J. PUB. HEALTH 1773 (1997).

39. See, e.g., Nadav Davidovitch & Avital Margalit, *Public Health, Racial Tensions, and Body Politic: Mass Ringworm Irradiation in Israel, 1949–1960*, 36 J.L. MED. & ETHICS 522 (2008) (utilizing case study of Israeli experience with ringworm).

40. For a discussion of public apologies and their relation to reconciliation and justice, see ELAZAR BARKAN, *THE GUILT OF NATIONS: RESTITUTION AND NEGOTIATING HISTORICAL INJUSTICE* (2000); MARTHA MINOW, *BETWEEN VENGEANCE AND FORGIVENESS: FACING HISTORY AFTER GENOCIDE AND MASS VIOLENCE* 91–117 (1998); ERIC K. YAMAMOTO, *INTERRACIAL JUSTICE: CONFLICT AND RECONCILIATION IN POST-CIVIL RIGHTS AMERICA*, 51–52, 192–96 (1999); *THE AGE OF APOLOGY: FACING UP TO THE PAST* 13–255 (Mark Gibney et al. eds., 2008); *WHEN SORRY ISN’T ENOUGH: THE CONTROVERSY OVER APOLOGIES AND REPARATIONS FOR HUMAN INJUSTICE* (Roy L. Brooks ed., 1999); Richard B. Bilder, *The Role of Apology in International Law and Diplomacy*, 46 VA. J. INT’L L. 433, 449–63 (2006); Kathleen A. Gill, *The Moral Functions of an Apology*, in *INJUSTICE AND RECTIFICATION* 111, 120–22 (Rodney C. Roberts ed., 2002); Trudy Govier & Wilhelm Verwoerd, *Taking Wrongs Seriously: A Qualified Defence of Public Apologies*, 65 SASK. L. REV. 139, 140–44 (2002).

41. Eric K. Yamamoto, *Race Apologies*, 1 J. GENDER RACE & JUST. 47, 53 (1997).

42. DEREK WANLESS, *SECURING GOOD HEALTH FOR THE WHOLE POPULATION* 3 (2004).

The principles of public health, as distinct from those of clinical medicine, are based on a population approach.<sup>43</sup> Additional important components include the following: (1) an upstream focus (primary prevention and health promotion); (2) the targeting of a broad range of forces (physical, biological, social, economic, political, and environmental) that affect populations and cause diseases; and (3) the strategic modification of social and environmental variables and the promotion of public health through active social and political involvement.<sup>44</sup> This strategy contrasts sharply with that of “traditional” modern medicine, especially as practiced in hospitals.<sup>45</sup>

Public health maintenance is a function of the complex relationship between the social actions of the state, various institutions, and groups of citizens. Dorothy Porter, a historian of medicine and public health, wrote, “In the modern period, the study of the operation of power in relation to population health necessarily involves an examination of the rise of the modern state as an autonomous political sphere.”<sup>46</sup> This involves understanding the “different interpretations, made in different periods, of the rights and obligations of citizens within the ‘social contract’ of health between the state and civil society in modern democracies.”<sup>47</sup> Therefore, the analysis of public health policies and practices “is concerned largely with social, economic, and political relations of health between classes, social structures and organizations, pressure groups, politics and state.”<sup>48</sup>

As can be inferred from these descriptions of the public health approach, the approach already contains the cultural and collective concerns which we determined are missing from the clinical discourse. Public health thinking addresses the group rather than the individual. It is also aware of the ideological and cultural background that exists in any case where assumingly neutral healthcare policies are applied. More than that, public health concerns focus very much on prevention and upstream thinking; in the context of apologies, such an approach would strive primarily to prevent the offensive conduct or the medical error altogether or make sure it will never recur. A unique application of the public health approach in cases of apology that captures the potential and limitations of apology from a cultural perspective is the study of public

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43. Cf. Nadav Davidovitch & Michal Alberstein, *Therapeutic Jurisprudence and Public Health: A Broad Perspective on Dialogue*, 30 T. JEFFERSON L. REV. 507 (2008) (discussing these principles with respect to another alternative movement, the Therapeutic Jurisprudence Approach).

44. INST. OF MED., THE FUTURE OF THE PUBLIC'S HEALTH IN THE 21ST CENTURY 52–53 (2003). This publication also provides a general overview of public health characteristics.

45. For a discussion of the tensions between public health and clinical medicine, see Allan M. Brandt & Martha Gardner, *Antagonism and Accommodation: Interpreting the Relationship Between Public Health and Medicine in the United States During the 20th Century*, 90 AM. J. PUB. HEALTH 707, 708, 711 (2000).

46. DOROTHY PORTER, *HEALTH, CIVILIZATION AND THE STATE: A HISTORY OF PUBLIC HEALTH FROM ANCIENT TO MODERN TIMES* 5 (1999).

47. *Id.*

48. *Id.* at 4.

apologies following collective trauma caused by mass application of public health policies.

#### B. Public Apologies in Response to Collective Trauma Caused by Public Health Activities

Declared symbolic acts, such as a public apology, are deemed to be part of the social construction and implementation of social healing and rehabilitation mechanisms. The past few decades have witnessed a wave of apologies and requests for forgiveness by states, both at international and domestic policy levels.<sup>49</sup> The primary functions of an apology of this type are (1) restoration of human dignity that has been damaged, (2) reestablishing social relations that have been damaged as a result of the dispute, and (3) rehabilitation of the community. The apology enables renewed thinking about the system of relationships, the common past, and the good that has been put at risk as a consequence of the dispute. A public apology by the state that caused the injury is not directed solely toward the victims, but also toward the ruling bodies and society as a whole, and it bears a message of commitment to change and the strengthening of a system of common values. In the eyes of those who believe in the possible existence of a social healing process, this healing is the core of the primary value of an apology.

A public apology operates in the symbolic dimension. In certain instances, it is possible that an apology alone will be sufficient to permit healing and the mending of rifts. The receipt of compensation without an apology may be perceived as an additional injury by the victims. However, an apology without compensation or other actions testifying to a change in social attitude and structure may be considered a gesture empty of content—a cynical act that attempts to evade the payment of material compensation or “mere words.” Such an empty apology may, under certain circumstances, constitute an even greater injury to the victims than an absence of apology altogether.

Trust in the healthcare system can be broken when medical errors occur and healthcare providers do not openly acknowledge their responsibility for the resulting harm to patients. As discussed above, an appropriate apology can be a first step in the reconciliation process between a harmed patient and a healthcare provider. Similarly, confidence in the public health system may be eroded when legally sanctioned medical initiatives—undertaken in the name of the public’s health—result in harm to their intended targets but are not officially acknowledged. Such an act might produce a collective trauma—a psychic wound spread among an entire community—which affects the identity construction and self-esteem of the individuals within the affected group.<sup>50</sup>

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49. For an overview of state apologies, see generally JENNIFER LIND, *SORRY STATES: APOLOGIES IN INTERNATIONAL POLITICS* (2008).

50. For an elaboration of the notion of collective trauma and its various manifestations, see Austin Sarat et al., *Trauma and Memory: Between Individual and Collective Experiences*, in *TRAUMA AND MEMORY: READING, HEALING, AND MAKING LAW* 3, 3–20 (Austin Sarat et al. eds., 2007).

Healing collective trauma requires restorative processes that help the group to overcome the horrific experience through a variety of reconstructive acts.<sup>51</sup>

The best-known recent public health apology, introduced here as a paradigm for an enriched notion of apology, was given by President Bill Clinton on May 16, 1997, for the Tuskegee Syphilis study, the forty-year government study (1932 through 1972) in which 399 African-Americans from Macon County, Alabama, were deliberately denied effective treatment for syphilis in order to document the natural history of the disease.<sup>52</sup> The infamous Tuskegee Syphilis study became one of the cornerstones of modern bioethics, a symbol for the deception of a disempowered community, as African-Americans who contracted syphilis were not informed of their disease and were denied treatment while participating in an observational study.

An important impetus for Clinton's apology was the continuing shadow cast by the study on African-Americans' relationship with the healthcare system, including the impediment of efforts to improve the health of the African-American community, African-Americans' distrust of the medical system as expressed in low participations in clinical trials and organ donation, and, more importantly, interference with public health campaigns such as HIV and AIDS prevention and treatment programs. The shadow of Tuskegee was invoked to explain why many African-Americans oppose, for example, needle exchange programs. These programs provoked the image of the syphilis study and sparked African-Americans' fears about genocide, leading to perception of these programs, not as efforts to stop the spread of HIV and AIDS, but rather, as a plot to intentionally spread the drug epidemic within the African-American community. This mistrust predates public exposure of the trial: fears of exploitation by the medical profession date back to the context of slavery and

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51. Nadav Davidovitch & Avital Margalit, *Public Health, Law and Traumatic Collective Experiences: The Case of Mass Ringworm Irradiations*, in TRAUMA AND MEMORY: READING, HEALING, AND MAKING LAW 119, 134-35 (Austin Sarat et al. eds., 2007). A recent apology that includes many necessary components presented in this part but will not be discussed in this article is the Canadian Red Cross apology for the blood tragedy during the 1980s that disastrously resulted in AIDS epidemics among hemophiliacs and blood transfusion recipients. Pierre Duplessis, Sec'y Gen. & Chief Exec. Officer, Canadian Red Cross, Public Statement (May 30, 2005) (transcript available at <http://www.redcross.ca/main.asp?id=013578>). The scandal had a profound impact on public trust in the Canadian blood system. Following the tragedy, a commission was established, and, in 2005, the Canadian Red Cross pleaded guilty in Ontario Superior Court. See also BLOOD FEUDS: AIDS, BLOOD, AND THE POLITICS OF MEDICAL DISASTER (Eric A. Feldman & Ronald Bayer eds., 1999).

52. Many books and articles have been published on the Tuskegee Syphilis Study. See, e.g., TUSKEGEE'S TRUTHS: RETHINKING THE TUSKEGEE SYPHILIS STUDY (Susan M. Reverby ed., 2000) (providing a detailed history of these events, from the inception of the study to the apology of Clinton and incorporating many primary sources and reflections on the events). In his formal apology at the White House Ceremony, President Clinton said, "The legacy of the study at Tuskegee has reached far and deep, in ways that hurt our progress and divide our nation. We cannot be one America when a whole segment of our nation has no trust in America." Press Release, The White House, Office of the Press Secretary, Remarks by the President in Apology for Study Done in Tuskegee (May 16, 1997). See also *Tuskegee Public Health Study Apology*, C-SPAN VIDEO LIBRARY (May 16, 1997), <http://www.c-spanvideo.org/program/81273-1> (providing videorecording of President Clinton's apology).

African-American collective memories.<sup>53</sup> Yet the Tuskegee Syphilis trial became a symbol for the mistreatment of the African-American community, and more generally, of ethical misconduct by medical researchers and public health practitioners.<sup>54</sup>

Despite the impressive symbolic appearance of this apology, it is important to note that it took place twenty-five years after the public disclosure of the Tuskegee study and was predated by a lawsuit, denial of material allegations of the complaint by the government, meticulous data gathering about the misconduct of health professionals within the study, and a final settlement. As in other, similar cases of public health misconduct, the government's initial reaction was not apology but rather rejection and denial: the government first claimed that the action was barred due to the statute of limitations and next claimed that the injuries and damages were caused without fault, carelessness, or negligence.<sup>55</sup> The government did not deny the study itself, but its initial position in the years following the public disclosure was that of acute denial: denial of injuries, damages, and fault. About eighteen months after submission of the initial class action lawsuit, a settlement was reached, and the government agreed to pay approximately \$10 million to living participants in the study and heirs of those deceased. The study was also an important impetus leading to the 1974 federal law protecting human research subjects.<sup>56</sup>

Despite the legal settlement and enactment of new legislation regarding human experimentation, the shadow of Tuskegee continued to grow, as expressed in the African-American community's distrust of healthcare professionals as well as continuous debate among researchers, writers, ethicists, and activists. The apology described above arrived only years later in response to demands of the victims and their families and after acknowledgement that not enough had been done to overcome this collective trauma. In 1995, a legacy committee was formed to demand a formal apology from the federal government. Interestingly, their demand for apology was accompanied by a request for funding for a bioethics center at Tuskegee University. The legacy committee pointed to the continuous distrust between the African-American and medical communities, saying that "[i]n the almost twenty-five years since its disclosure, the [s]tudy has moved from a singular historical event to a powerful metaphor. It has come to symbolize racism in medicine, ethical misconduct in human research, paternalism by physicians and government abuse of vulnerable people."<sup>57</sup> In their demand, the committee pointed to two then-recent apologies: the U.S. government's apology for its role in human radiation experiments

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53. Gamble, *supra* note 38, at 1773–76.

54. *Id.* at 1773.

55. Fred Gray, *The Lawsuit*, in *TUSKEGEE'S TRUTHS: RETHINKING THE TUSKEGEE SYPHILIS STUDY* 473, 480 (Susan M. Reverby ed., 2000).

56. Gamble, *supra* note 38, at 1776.

57. Legacy Committee Request, *reprinted in* *TUSKEGEE'S TRUTHS: RETHINKING THE TUSKEGEE SYPHILIS STUDY* 559 (Susan M. Reverby ed., 2000).

(1944 through 1974) and the Southern Baptist Church's apology to all African-Americans for its stand on slavery during the Civil War.<sup>58</sup> The committee stressed (1) the moral and physical harms done to the community of Macon County, where the study was conducted; (2) the fact that, although an economic settlement was reached, no public apology had been made; and (3) the fact that no public official had ever stated clearly that the study was morally wrong.<sup>59</sup> Finally, the committee urged Clinton to apologize on behalf of the American government for the harms inflicted at Tuskegee and direct the apology to the elderly survivors of the trial, their families and the wider community of Tuskegee, and more broadly, to "all people of color whose lives reverberate with the consequence of the [s]tudy."<sup>60</sup> The committee noted that "this apology provide[d] the opportunity to begin to heal the racial wounds that persist in the county."<sup>61</sup> The suggestion was to issue an apology from Tuskegee University linked with a meeting of the National Bioethics Advisory Commission.<sup>62</sup> The committee stressed:

Although a public apology is necessary to heal the wounds . . . , it alone w[ill] not be sufficient to assure the nation that research like the Tuskegee Syphilis Study will not be duplicated. Despite the significance of a Presidential apology, it must not be an isolated event. Consequently, the Committee also recommends the development of a mechanism to move beyond Tuskegee and to address the effects of its legacy. The Committee strongly urges the development of a professionally-staffed Center at Tuskegee University, focused on preserving the national memory of the Study and transforming its legacy.<sup>63</sup>

The center, which just celebrated its tenth anniversary, aimed to change the negative legacy of Tuskegee into a positive symbol demonstrating the importance of acknowledging past wrongs, rebuilding trust, and practicing ethical research. In the ceremony at the White House, which hosted the remaining survivors, Herman Shaw, who was about to celebrate his ninety-fifth birthday, spoke of the trauma and its healing potential as expressed both in the formal apology and the equally important creation of the memorial in Tuskegee, thus "clos[ing] this very tragic and painful chapter in [their] lives."<sup>64</sup> Clinton's speech following Shaw's statement acknowledged responsibility and the importance of moving from apology to the next step of rebuilding trust by (1) building a memorial at Tuskegee, including a center for bioethics; (2) calling on the Secretary of Health and Human Services to issue a report on how the government could best involve communities in research and healthcare, with an

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58. *Id.* at 560.

59. *Id.* at 560–61.

60. *Id.* at 562.

61. *Id.*

62. *Id.*

63. Legacy Committee Request, *supra* note 57.

64. Herman Shaw, Living Participant in Tuskegee Syphilis Study, Remarks (May 16, 1997) (transcript available in TUSKEGEE'S TRUTHS: RETHINKING THE TUSKEGEE SYPHILIS STUDY 572 (Susan M. Reverby ed., 2000)).



emphasis on minority communities; and (3) strengthening researchers' training in bioethics.<sup>65</sup>

When analyzing the Tuskegee apology and comparing it to other apologies in the healthcare system, a few lessons emerge: first, *a legal resolution is not enough*. In contrast to the common clinical setting of apologies—which assumes apologies are used in order to avoid legal procedures and that legal action, especially resolution in favor of the plaintiff, is a sufficient substitute for apology<sup>66</sup>—the Tuskegee case proves that legal settlement of the dispute is not enough to resolve the conflict and heal the trauma. In this case, although the government initially denied responsibility in the class action suits by claiming a statutory bar and lack of fault, damages were finally paid to the survivors and their families. Still, the monetary reparation was not enough: apology was required after the dispute was both considered and settled. The apology in the Tuskegee case effected what formal legal management could not and enabled real transformation and social healing.

Second, there was significant cultural sensitivity and community involvement in framing the apology in the Tuskegee case. The demand for apology came from the legacy committee, which represented the victims, and the committee framed the content and process according to their own sensitivities, including the requirement to establish a bioethics center. When the victims take part in constructing and conducting the apology ceremony and it answers their cultural sensitivities, there is a real chance for transformation and reconciliation.

Third, apology in the Tuskegee case was given only as one step among multiple combined efforts to restore trust, bring conciliation, and prevent future harms of this kind. The response included reparation, establishment of the bioethics center, active dialogue between communities, and the construction of educational programs and memorial sites. Such hybridization of intervening mechanisms is typical of a discourse of alternative dispute resolution (ADR)<sup>67</sup> and helps to enhance a complex transformation of structural conflicts.

Fourth, in the Tuskegee case, there was a sensitive contextualization of the concrete apology within the historical and sociological aspects of race relations in the United States and the role of the medical establishment. Apology was perceived as addressing the collective trauma and not only as answering the individual victims' harm.

Finally, as in many other ADR areas today, the Tuskegee case challenges the usual private–public divide, which depicts ADR as private ordering in the shadow of the public law. Indeed, a closer look at this case reveals a pattern of

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65. William J. Clinton, President of the United States, Remarks by the President in Apology for Study Done in Tuskegee (May 16, 1997) (transcript available in *TUSKEGEE'S TRUTHS: RETHINKING THE TUSKEGEE SYPHILIS STUDY* 576 (Susan M. Reverby ed., 2000)).

66. See *supra* Part I.

67. See, e.g., Michal Alberstein, *ADR and Transitional Justice as Reconstructing the Rule of Law*, J. DISP. RESOL. (forthcoming 2011) (manuscript at 6).

what is defined today in the international sphere as “transitional justice.” The concept of transitional justice represents a systematic response to widespread human rights violations and is usually used in relation to democracies in transition striving to implement the rule of law.<sup>68</sup> The restorative process described above was not only a mediation between the Tuskegee victims and the state as offender, but should instead be viewed as an effort to promote transformations of legal regimes and cultural divides through establishment of hybrid mechanisms. It strives for care and justice within a constructivist future-oriented intervention. When developed and brought into the clinical sphere, such a perspective might be capable of answering some of the challenges and problems that the clinical practice of apology faces today.

More recent public health apologies in the United States were much less successful. The case of sterilization, for example, was traumatic and well-known, but not enough restorative acts were done to overcome it. For several decades up until the 1970s, tens of thousands of people were sterilized according to the law in the United States and other countries. This practice was perceived as beneficial under the eugenic theories prevalent in the medical community at the time. The U.S. Supreme Court decision of *Buck v. Bell* affirmed the practice of sterilization under a public health justification, comparing forced sterilization to the logic of compulsory vaccination.<sup>69</sup>

During the last decade, seven U.S. states conducted ceremonies of apologies connected to historical events such as anniversaries of sterilization laws. In some cases, the ceremonies included people who were sterilized as part of those traumatic events, thus giving a symbolic meaning to the formal apology. Yet despite extensive recent media coverage, no U.S. state has ever paid reparation to the victims of sterilization laws. Not all of the apologies included acknowledgement of full responsibility, and some state representatives were ready to express only regret while justifying the harmful conduct as done in accordance with public health measures as practiced at the time.<sup>70</sup>

Just recently, another public apology was made for U.S. syphilis experiments conducted in Guatemala. From 1946 through 1948, American public health doctors deliberately infected about 700 Guatemalans—prison inmates, mental patients, and soldiers—with venereal diseases in order to test the effectiveness of penicillin. On October 1, 2010, U.S. Secretary of State, Hillary Rodham Clinton, and Health and Human Services Secretary, Kathleen Sebelius, apologized to the government of Guatemala and the survivors and

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68. *Id.* at 4, 14. See generally 1 TRANSITIONAL JUSTICE: HOW EMERGING DEMOCRACIES RECKON WITH FORMER REGIMES 3–41 (Neil J. Kritz ed., 1995).

69. *Buck v. Bell*, 274 U.S. 200, 207 (1927).

70. PAUL A. LOMBARDO, THREE GENERATIONS, NO IMBECILES: EUGENICS, THE SUPREME COURT AND *BUCK V. BELL* 259–60, 264–65 (2008). Other countries such as Sweden and Canada have legislated compensation laws. *Id.* at 265–66.

descendants of those infected.<sup>71</sup> While official Guatemalan representatives thanked the United States for its transparency in telling the facts, material consequences of the apology's declaration, such as reparations for survivors or descendants, are still unclear.

Some cases of public health collective trauma are treated by the state only through reparations, without proper apology. This was the case with the Israeli case of compensation for mass ringworm irradiation.<sup>72</sup> A reconciliation of Israeli medical and non-medical establishments and former Jewish immigrants mainly from North Africa and other Arab states resulted, among other things, in a legal apparatus established for compensation which failed to deliver the original healing intentions. Between 1949 and 1960, the newly established state of Israel instituted a public health program of ringworm treatment of immigrants. The treatment involved irradiating the scalp of all persons suspected of having ringworm. At the time, this treatment was recognized by mainstream medicine; however, it had physical and social consequences. While ringworm cases in the immigrant population decreased as a result of the treatment, the harsh treatment involved stigma and separation from the family and school for some weeks. Further, it was discovered that the treated immigrants had a higher risk of developing head and neck cancers as a result of the irradiation.

The individuals who began tort litigation against the government encountered procedural and substantive barriers such as the statute of limitations and the inability to prove negligence on the part of the government necessary for compensation. The burden of proof for negligence was high since irradiation of the scalp was accepted as common medical practice at the time. As a result, many immigrants who pursued compensation on an individual tort claim basis were denied. The Ringworm Victims Association, a group established to lead a militant campaign for compensation, forced the state to reevaluate the law and enter into active discussions with the victims. In 1994, Israel passed compensation laws to evaluate and compensate remaining survivors of the irradiation by evaluating damages and claims.<sup>73</sup> This law, while a step toward reconciliation, was individualistic and not collectivist in approach and did not address the social and historical context that led to the legislation. Although the legislation addressed the shortcomings of tort claims, it did not

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71. Donald G. McNeil, Jr., *U.S. Apologizes for Syphilis Tests in Guatemala*, N.Y. TIMES, Oct. 1, 2010, available at [http://www.nytimes.com/2010/10/02/health/research/02infect.html?\\_r=1](http://www.nytimes.com/2010/10/02/health/research/02infect.html?_r=1). The secretaries' official statement stated, "Although these events occurred more than 64 years ago, we are outraged that such reprehensible research could have occurred under the guise of public health. . . . We deeply regret that it happened, and we apologize to all the individuals who were affected by such abhorrent research practices." *Id.* The public health doctor who led this experiment, John C. Cutler, played an important role also in the Tuskegee study. See Susan M. Reverby, "Normal Exposure" and *Inoculation Syphilis: A PHS "Tuskegee" Doctor in Guatemala, 1946-1948*, 23 J. POL'Y HIST. 6-28 (2011).

72. For a discussion of this case from historical, medical, and legal perspectives, see Davidovitch & Margalit, *supra* note 51, at 119-65.

73. *Id.* at 120.

include words acknowledging a wrongdoing. From the government's perspective, the law was a gracious offering to remedy harm.

However, what would happen if the government took a collectivist approach and apologized to the groups? What if a museum or some sort of public memorial was built to atone for the harm? These questions remain unanswered as debates continue. It is clear that, for a public health apparatus to maintain its viability and integrity, confidence must be restored in the public health system. An apology can be a crucial step in restoring this public trust.

Nevertheless, the success of an apology for public health collective trauma can never be guaranteed, even when its conditions are fully observed. This was the case with the apologies given by the Max Planck Society (MPS) to a group of holocaust survivors that took part in Nazi medical experiments. The event was preceded by a formal announcement in 2001 by Hubert Markl, president of MPS, in which MPS acknowledged that the management and staff of its predecessor society, Kaiser Wilhelm Society, were involved in Nazi war atrocities and apologized to their victims. The apology was issued "in response to the findings of a group of science historians commissioned in 1999 to investigate the role played by basic researchers of the Kaiser Wilhelm Society during the Second World War."<sup>74</sup> Kaiser Wilhelm scientists joined with the Nazi regime in their eugenic and racial purification program. As physician and medical historian William Seidelman wrote, "The resulting collaboration between science and the Nazi state not only legitimized the policies and programs of the Hitler regime[,] it resulted in the exploitation and mutilation and murder of untold thousands of innocent victims by physicians and scientists associated with some of the world's leading universities and research institutes."<sup>75</sup>

MPS invited the living survivors of Nazi experiments for a ceremony in June 2001, but most of the survivors could not accept the apology,<sup>76</sup> either because of doubt as to whether they were entitled to represent the other victims or because the trauma was so severe as to be incapable of reconstruction through apology.

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74. Alison Abbott, *Max Planck Society Admits to Its Predecessor's Nazi Links*, 411 NATURE 726, 726 (2001). See also Robert Koenig, *Max Planck Offers Historic Apology*, 292 SCIENCE 1979, 1979-80 (2001).

75. William E. Seidelman, *Science and Inhumanity: The Kaiser-Wilhelm/Max Planck Society*, 2 IF NOT NOW E-JOURNAL (Winter 2001), [http://www.baycrest.org/If\\_Not\\_Now/Volume\\_2\\_Winter\\_2001/default\\_7356.asp#](http://www.baycrest.org/If_Not_Now/Volume_2_Winter_2001/default_7356.asp#).

76. As documented in the film *Forgiving Dr. Mengele* (First Run Features 2006). The movie tells the story of Eva Mozes Kor, a survivor of Josef Mengele's cruel twin experiments in the Auschwitz concentration camp, who unlike most other survivors decided to forgive the perpetrators as a method of self-healing. In 1993, Kor met with Doctor Hans Munch, a Nazi doctor at Auschwitz who was acquitted at the Krakow War Crimes trial in 1947. After this meeting, which she recorded on video and showed in the documentary, she wrote Dr. Munch a letter of forgiveness. They met again in 1995 at Auschwitz, where Dr. Munch signed a documentation of the gas chambers, and Kor issued a declaration of amnesty and forgiveness to all Nazis. See also Kevin Thomas, Movie Review, *'Forgiving Dr. Mengele'*, L.A. TIMES, Nov. 17, 2006, available at <http://www.calendarlive.com/printedition/calendar/cl-et-mengele17nov17,0,6043445.story>.

Later compensation schemes established for victims of medical experiments could not add the needed dimension for collective healing.

As these various examples of public health apologies indicate, apologies in public health cannot be a panacea for regaining social trust. Apologies must be perceived in a much broader context, and reframing the previously stipulated conditions for individualistic apology might help in furthering understanding of their operation. Eric Yamamoto, who deals with the processes of social mending and healing in the context of interracial relationships in the United States, proposes an approach of conceptualization that can help us think about the appropriate conception of apology as mediation between cultures.<sup>77</sup> He suggests four concepts that, taken together, permit construction of a process for collective restorative justice.<sup>78</sup>

The first concept, recognition, signifies recognition that injustice and injury have occurred, as well as acknowledging the pain and suffering of the victims with empathy. This concept is an extension of the first condition for apology described *supra* Part I, which deals with acknowledgment of the infringement of the rule or moral duty.<sup>79</sup> Recognition consists of identifying and critically examining the various positions of the parties, both individually and as a group.

The second concept, responsibility, indicates an assessment of group agency and acceptance of responsibility for the injustices and injury. It goes together with the second condition within interpersonal relationships of accepting responsibility when wrongs occur.

The third concept is reconstruction, which requires taking substantial steps toward healing the social wounds. An apology by the party who caused the injury is the major tool for reconstruction, and, in appropriate cases, forgiveness is received from the injured party. The purpose of these steps is to establish a renewed understanding of the past by society. This relates to expressing remorse in individual apologies and accepting forgiveness, in some cases.<sup>80</sup> In collective apologies, such a stage can look like an official declaration in an authoritative location such as a parliament or the site of the trauma.<sup>81</sup> It can involve local public hearings where offenders apologize and receive amnesty and victims forgive, such as the Truth and Reconciliation Commission in South Africa.<sup>82</sup>

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77. YAMAMOTO, *supra* note 40, at 10–11, 174–209.

78. *Id.* The notion of restorative justice, which is usually used in the criminal context, “emphasizes repairing the harm caused by crime. When victims, offenders, and community members meet to decide how to do that, the results can be transformational.” RESTORATIVE JUSTICE ONLINE, <http://www.restorativejustice.org> (last visited Jan. 27, 2011). For a review of the process and its stages, see HOWARD ZEHR, *THE LITTLE BOOK OF RESTORATIVE JUSTICE* (2002).

79. *See supra* notes 8–9 and accompanying text.

80. *See supra* note 10 and accompanying text.

81. *See supra* notes 52–65 and accompanying text (referring to the Tuskegee apology conducted at the White House).

82. *Justice in Transition Booklet Explaining the Role of the TRC*, OFFICIAL TRUTH AND RECONCILIATION WEBSITE, <http://www.justice.gov.za/trc/legal/justice.htm> (last visited Jan. 29, 2011).

The fourth entails the concept of reparation, which parallels the fourth condition for apology,<sup>83</sup> and is closely connected to the concept of reconstruction and deals with the attempt to heal the material injury caused to the victims.

Through these four concepts, it is possible to examine proposals for methods of social healing and resolution in order to understand whether, and to what extent, these apologies may be able to address the cultural contexts underlying them. Such an examination requires consideration of two central questions. The first is a question of the relationship between the symbolic dimensions of the process and its material dimensions. The second is a question as to the nature of legal means for realizing the various dimensions of the process.

Under this approach, law is considered a proper mechanism for mending the social fabric, and emphasis on community and healing gives less importance to the articulation of blame and the existence of malice or clear negligence. Accordingly, although state actions through routine public health activities are supposed to be performed with cultural blindness and with due care, the injurious and harmful effects of these practices are sometimes perceived as racist and biased. Addressing these perceptions in a constructive, healing manner requires a “culturally sensitive apology” approach which serves as a primary—not alternative—method for legal intervention. The four concepts presented above create a framework for discourse regarding the important question concerning the relationship between the symbolic dimension in the process of healing and its material dimension.

All of the concepts require the existence of a symbolic dimension, whereas the material dimension is to be found only in the concept of reparations. These concepts also assist in understanding the tension between the personal dimensions and the collective and social dimensions of the social healing process. As the Tuskegee case shows, it took twenty-five years to add symbolic dimensions, as expressed in the formal apology and construction of a memorial to the victims, based on a strong foundation of understanding of the historical and sociological aspects of the traumatic events for the African-American community.

The symbolic dimension may be declared—explicit or inferred—implicit. A declared symbolic aspect may be represented, for example, by an explicit admission of responsibility by an official entity on behalf of the State for the injustice or an apology by the one who caused the injury. An additional method includes holding an open dialogue between the injured and injuring parties. Within the course of such a dialogue, symbolic gestures are made through discourse: these gestures grant recognition of the injury, deal with the question of responsibility, and send clear messages of the injuring party’s feelings of regret and remorse. Community involvement in the construction of the apology

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83. *See supra* Part II.A.

is crucial to achieving a better understanding of how people construct their own traumatic events and how they perceive the proper means to heal them.

The material dimension is, in principal, concrete (returning property that has been stolen, payment of monetary compensation, and so on, although the repair of material damages may be performed in other ways as well, such as through reverse discrimination). Nonetheless, each material act conceals a symbolic dimension as well. Mere performance of the action itself constitutes a message. This message is not openly declared, but it comprises a constitutive element of the act's meaning. The symbolic message is inferred—implied from the transmission itself. For example, granting compensation may signify a message of recognition of the injury, an admission of responsibility, and even an implied request for forgiveness.

The realization of symbolic and material dimensions through specific actions raises complex questions that cannot be easily answered. For example, there is the question of whether it is just to demand an apology to the victims from one who had no personal part in committing the past injustice, or whether it is just for such a person to bear the burden of material repair. Is it sufficient merely to belong to a group that, in the past, benefited from the consequences of the injustice, or should we condition requirement of these specific actions upon the group members' continued benefit in the present? Another question focuses on identifying those toward whom the apology should be directed and those who are entitled to receive reparations—should they go to the victims as individuals or as a group? In cases in which the State is the perpetrator of the injury, the force of some of these questions is diluted by the fact that the State is an entity whose existence is ongoing. Additionally, the force of the questions is diluted under circumstances in which the victims are still alive or the memory of the injury among the victims' social group is fresh. Under such circumstances, it is not difficult to locate those who committed the injustices as well as the victims.

It follows from this brief review of the types of issues confronting efforts at social healing that processes must be designed with great sensitivity to the factual entirety of traumatic incidents and the complexity of the cultural context of those affected. Only in this way is it possible—and even then, only in a relatively limited fashion—to determine a sufficient measure, in terms of both material and symbolic dimensions, capable of healing and mending social rifts.

The meaning of an apology and its healing power are socially constructed. However, culture is dynamic. Accordingly, it is possible that, if wide use is made of the apology and other alternative practices for settling disputes, concepts of restorative justice will be absorbed into the legal system, the legal culture, and, if not yet already present, the cultures of the various social groups comprising society. In any case, new meaning will be assigned to the act of apology and its relationship to awards of compensation.

## V

APOLOGIES BETWEEN PUBLIC AND PRIVATE: A BROADER ADR  
PERSPECTIVE

When reflecting on the argument developed in this article, it becomes clear that it deals with a divide we tend to find in some other areas of ADR today: a private alternative practice is developed and nourished within a specific context of legal disputes. At first, it is suggested as an innovation and an exceptional treatment of conflicts. Then, it is translated into concrete manuals and actual practice. Later, it is institutionalized and frequently becomes the norm rather than the exception. At that stage, some deep problems of cooptation and loss of faith might develop. On a parallel reality, which may be defined as a public form of justice, the same exceptional idea which has developed in the private sphere has already long been familiar. It is the foundation of a legal regime or a political practice that is mainstreamed and gains popularity.<sup>84</sup> Still, since the idea is practiced only in a symbolic way or without professional training, it sometimes lacks the sophistication and skill already developed in private practice. This is actually the case with apologies as described here.

We examine an ongoing clinical practice of apologies which has evolved from an innovative, pioneering idea into an ongoing practice. This practice involves training programs and requires concrete legal regulations in order to increase effectiveness. At times, a practice may become institutionalized; sometimes, it is co-opted and thus might lose its innovative quality. We find that, during the last few decades, the idea of apology has inspired states and public health promoters to use apology within broader healthcare interactions. Public health apologies are usually given to large populations: they address the collective and cultural aspect of the healthcare dispute, involve various ceremonies and considerations, and sometimes fail due to lack of training and professional knowledge about apologies. In this article, we have tried to put together these two universes of apology and enrich the discourse of clinical apologies through discussion of public health apologies. Our main claim is that the collective, cultural, and organizational aspects of apologies are often neglected within the clinical discourse and, by addressing them through a more “public” eye inspired by public health, the current operation of apologies within clinical practice can improve. Such a sequence can combine with many other contemporary contributions to ADR scholarship,<sup>85</sup> and can contribute to public

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84. See, e.g., Carrie Menkel-Meadow, *Deliberative Democracy and Conflict Resolution: Two Theories and Practices of Participation in the Polity*, DISP. RESOL. MAG., Winter 2006, at 18, 18–20.

85. See, e.g., Amy J. Cohen, *Revisiting Against Settlement: Some Reflections on Dispute Resolution and Public Values*, 78 FORDHAM L. REV. 1143 (2009) (reevaluating the 1984 critique of ADR in light of visions of public values); Richard C. Reuben, *Public Justice: Toward a State Action Theory of Alternative Dispute Resolution*, 85 CALIF. L. REV. 577 (1997) (considering whether ADR could constitute state action).



health studies by offering the practical tools and training for apology as guiding methods for the issuance of public apologies.<sup>86</sup>

## VI

### APOLOGIES IN THE CLINICAL SETTING: SOME CONCLUDING PUBLIC HEALTH LESSONS

Coming back to the clinical setting, the discussions above can contribute to an enriched perception of apologies in the healthcare system and may contribute to a better practice which goes beyond concerns of efficiency and dispute settlement. First, an increase in *cultural sensitivity* is important both in public and private apologies and will help to develop a practice of apology that is much more case-sensitive and rejects adoption of a uniform manual of apology making. There is significant value in considering the different professional and cultural identities involved in the healthcare dispute and constructing an apology that fills the expectations of all parties involved while also considering imbalances and cultural differences.

Second, the purpose of apology should be as much *the promotion of solidarity and harmony* as saving money or avoiding litigation. This is an emphasis that should be developed in medical and legal education in general and apology training in particular. This message fits nicely with organizational needs to improve equality at the workplace and satisfaction of workers and patients.

Third, when considering a case of medical error, public health principles of *prevention and policymaking* should be part of the apology process. Apologizing in a full sense includes, as in the Tuskegee case, more constructive acts of teaching and memorializing, which can assure the patient that his case has sparked the development of new practices and enhanced ethical thinking. It also includes the active participation of the affected parties in constructing a meaningful apology together.

Finally, the more humanistic notions of reconstruction and symbolic acknowledgment should accompany and supplement the notions of efficiency and resolution which prevail today within the “apology market.” Apology is productive, efficient, and definitely improves medical services, but its operation cannot be fully understood without addressing its non-material dimension—the aspect which makes hearts turn and transforms perceptions, without reduction to any manual or calculation.

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86. See an equivalent suggestion of Menkel-Meadow regarding deliberative democracy and the health reform negotiation by Obama in this issue. Carrie Menkel-Meadow, *Scaling Up Deliberative Democracy as Dispute Resolution in Healthcare Reform: A Work in Progress*, 74 LAW & CONTEMP. PROBS. 1 (Summer 2011).