Apology for Errors: Whose Responsibility?

Lucian L. Leape, HFACHE

Summary • When things go wrong during a medical procedure, patients’ expectations are fairly straightforward: They expect an explanation of what happened, an apology if an error was made, and assurance that something will be done to prevent it from happening to another patient. Patients have a right to full disclosure; it is also therapeutic in relieving their anxiety. But if they have been harmed by our mistake, they also need an apology to maintain trust.

Apology conveys respect, mutual suffering, and responsibility. Meaningful apology requires that the patient’s physician and the institution both take responsibility, show remorse, and make amends. As the patient’s advocate, the physician must play the lead role. However, as custodian of the systems, the hospital has primary responsibility for the mishap, for preventing that error in the future, and for compensation.

The responsibility for making all this happen rests with the CEO. The hospital must have policies and practices that ensure that every injured patient is treated the way we would want to be treated ourselves—openly, honestly, with compassion, and, when indicated, with an apology and compensation. To make that happen, hospitals need to greatly expand training of physicians and others, and develop support programs for patients and caregivers.

Lucian L. Leape, MD, HFACHE, is adjunct professor of health policy in the department of health policy and management at Harvard School of Public Health.
In the move toward increasing transparency and patient-centeredness in healthcare, few aspects have proven more difficult than ensuring that patients injured by our mistakes are fully informed and receive a prompt and meaningful apology.

Yet, in these situations patients’ expectations are clear and simple (Full Disclosure Working Group 2006). First, they expect an acknowledgment that something has gone wrong and an explanation of what happened. Second, they want their caregiver to take responsibility for the event. Patients don’t expect perfect care, and they understand that everything that occurs in the hospital is not under the control of their physician, but they look to their physician to oversee their care and be their advocate and protector. Even when someone else, such as a nurse, resident, or radiologist, made the mistake that caused the injury, patients look to their primary caregiver to take responsibility and to protect them from further harm.

Third, injured patients expect the hospital to undertake a serious effort to find out why the incident happened and make changes if possible to ensure that it does not happen again—and to share with the injured parties what is being done. This step is more important to patients than many physicians and executives realize. Knowing that another person is less likely to suffer in the same way gives positive meaning to an otherwise bad experience.

The ethical argument for full disclosure is straightforward: All patients have the right to know everything about their care. Hospitals have neither a legal nor a moral right to withhold this information. When this right is denied, patients often feel it rather keenly. Few things are more infuriating than the caregivers’ unwillingness to admit when someone is harmed and take responsibility.

Disclosure is also therapeutic. When things go wrong, patients may experience a host of emotions: fear, confusion, uncertainty, anxiety. If the injury is not acknowledged or their concerns are dismissed, patients feel devalued, humiliated, and disrespected (Vincent and Coulter 2002; Vincent, Young, and Phillips 1994). Anxiety turns to anger, and the relationship begins to deteriorate. Prompt, open explanation and acceptance of responsibility is the most effective way to prevent these feelings from developing, or at least to moderate them.

But disclosure alone is not sufficient. Whenever the injury is caused by an error or other failure, disclosure must be followed by an apology. The patient has been harmed by the individuals and institution they came to for help. Thus, an injury caused by an error or breakdown in the system is a threat to trust. Trust is the cornerstone of the doctor–patient relationship—and the core of the patient’s perception of the institution.

Apology is the way to restore trust. If we rapidly admit and take responsibility for our failure, express remorse, and attempt to make amends, trust can be maintained or rebuilt. If we do not, the threat turns to reality and is replaced by suspicion, fear, anger, and disappointment. Even if these feelings do not lead to a malpractice suit, they far outweigh all of the positive experiences that may have occurred during the hospitalization in determining the patient’s feelings toward the physician and the hospital. Patients deserve disclosure because it’s a right, but they need an apology to heal.
**How Apology Works**

Lazare (2004) has taught us that apology is therapeutic in many ways:

- Apology begins to restore the patient’s dignity and self-respect. Injury is humiliating and unfair. Lack of apology intensifies this humiliation: “You don’t respect me enough to acknowledge my pain.”
- Apology provides assurance of shared values, reaffirming the patient’s and doctor’s mutual commitment to the rules and values of the relationship. Each confirms for the other, “I really am the person you thought I was.” Trust is re-established.
- Apology assures patients that they are not at fault. Self-blame is a common patient response to injury, but most physicians are unaware of this phenomenon. Apology shows that self-blame is unwarranted.
- Apology assures patients that they are now safe and that the caregiver recognizes the hurt and is committed to taking every possible measure to prevent further injury.
- Apology shows the patient that the doctor is also suffering. In this sense, it levels the playing field, helping to restore the victim’s self-respect.
- By making amends, such as by providing extra attention or attending to immediate financial needs, apology demonstrates that the doctor understands the impact of the victim’s suffering and loss of trust.

Caregivers need healing, too. Apology is also the first step in healing for the provider. It helps doctors deal with the normal shame and guilt they feel and provides a means for expression of empathic concern for those they have harmed. Restoring the balance—acknowledging “we’re both hurting”—begins to restore the relationship, which is important to both parties.

**How to Apologize**

You have to apologize correctly. Saying “I’m sorry” is not apology. It is an expression of regret, of empathy. And it is appropriate in the immediate aftermath of an injury—when it may not be clear whether there has been an error. Caregivers are genuinely sorry that the event happened, and they should express those feelings promptly and sincerely.

True apology is much more than regret. It is taking responsibility, saying, in essence, “I’m sorry we did this to you.” Therefore, it is only indicated when the patient has in fact been hurt by the healthcare organization’s mistake—whether on a personal or system level. Often whether the mistake caused harm is not clear immediately following an event. Thus, it is wise to not apologize until after a full investigation has taken place. When an unpreventable complication of disease occurs, empathy is indicated—“I’m sorry this happened to you”—but not true apology.

As Lazare (2004) has taught, true apology has three essential components: taking responsibility, showing remorse, and making amends. All three are essential. Taking responsibility starts in the disclosure process by conveying, “This shouldn’t have happened.” But apology is taking responsibility for the mistake, owning it. Remorse must also be shown for apology to be genuine. Caregivers usually feel remorse—and should. Expressing it is therapeutic for the patient. Finally, making amends, doing what you can to “make it up to” the patient, is an essential part of apology.
All three components are essential. None can be faked. An insincere, incomplete, or qualified apology is probably worse than no apology. It is disrespectful and insulting. But a true apology, given from the heart, is powerful—for both patient and doctor.

Apology is an individual act but an institutional responsibility. Whether it is done, when it is done, and how it is done determine, perhaps more than anything else, how an injured patient will feel about the doctor and the hospital. It defines in a very real sense for the hospital whether its mission is truly healing—or whether it is something else, such as service, prestige, or business success. Thus ensuring that apology occurs when it is indicated and that it is done properly must be a major concern for institutional leaders as well as physicians. Unfortunately, the evidence is that we often don’t do it very well. Why?

Why Is Apology So Difficult?
Regardless of the situation, apologizing is always difficult. In healthcare it is especially difficult, for several reasons. Unlike the usual nonmedical situation, in which the harm one is apologizing for is social or psychological—a slight, or hurt feelings—in the healthcare setting, doctors and hospitals must apologize for causing physical harm and pain that is sometimes quite severe.

Second, the consequences of the injury can be substantial. The patient may die or have lifelong disability. The more severe the injury, the more difficult the apology. Third, the injury occurs as part of medical treatment that is intended to help the patient. Thus the injury lends a sense of betrayal, threatening trust. That makes it even more difficult for the physician.

Fourth, physicians often lack sufficient skills for apologizing. Until very recently, they got little or no instruction about apology in medical school, and during residency training most did not have the opportunity to witness a senior physician apologizing as an example. Because serious errors are, fortunately, rare, few physicians have had opportunities to learn in practice. So they are being asked to do something that is difficult and for which they feel unprepared and inexperienced. No wonder they feel uncomfortable.

But the main reason physicians find apologizing so difficult is the feelings of shame and guilt that come when they have made a mistake that hurts someone (Leape 2002; Davidoff 2002; Newman 1996; Hilfiker 1984). Doctors have very high standards and strive hard to provide the highest-quality care. Most believe they can do it if they try hard enough. When they fail, they take it personally. Their self-image is threatened. They have failed not only the patient but also themselves.

This distinction is an important point. Physicians view error not as a failure of a process but as a failure of themselves as people. When these kinds of emotions are in control, it is difficult to focus on the needs of the patient. We are asking physicians to perform an extremely difficult and sensitive human interaction at the time when they feel most vulnerable and inadequate. They need help, and too often the institution and their colleagues do not provide it.

If we are to make progress in preventing errors, it is essential that we learn from our mistakes, analyze the failures, and identify the systems changes that will prevent them in the future.
Whose Responsibility Is Apology?

The fundamental tenet of the safety movement is that errors are caused by systems failures, not by bad people (Kohn, Corrigan, and Donaldson 1999). The corollary of this concept is that errors can be prevented by redesigning systems. A large amount of recent experience in healthcare validates this concept. Good systems do in fact prevent errors (Leape and Berwick 2005; Pryor et al. 2006; Pryor et al. 2004; Haynes et al. 2009; Berenholtz et al. 2004; Pronovost et al. 2006). Who controls the systems? Not the physician, the institution. The logical implication, therefore, is that the institution bears responsibility for the apology.

However, neither patients nor hospitals understand it that way. For the patient, the injury is very personal: It was caused by a specific error made by a specific person. That a faulty system led to the error seems a bit theoretical. They look to the doctor or nurse who hurt them to apologize (Full Disclosure Working Group 2006). Hospital leaders often tend to agree, particularly if they really aren’t convinced about systems theory.

But if we are to make progress in preventing errors, it is essential that we learn from our mistakes, analyze the failures, and identify the systems changes that will prevent them in the future. That is an institutional responsibility. Doctors and nurses can’t do it by themselves. The hospital has to take responsibility for the systems failures and correct them. If it does not, the errors will recur. Responsibility for the failure also means responsibility for its consequences—physical, psychological, and financial.

Therefore, disclosure and apology in the systems era requires a combined approach. As the patient’s advocate and guardian, it is important for the patient’s physician to take primary responsibility for the explanation and apology. But a senior hospital executive should also participate, explain and apologize for the systems failure, and take institutional responsibility for corrective action. If the harm is serious, such as the death of the patient, the hospital spokesperson should be the chief executive officer. While explaining how the system failed may sound self-serving coming from the physician, it has credence when the message is delivered by an executive leader.

Physicians are sometimes reluctant to take responsibility for an error made by someone else, such as a resident, nurse, technician, or other medical specialist. However, it is important that they do so. The patient looks to the responsible attending as their guardian and leader of the team. At the same time, it is important for the person who made the mistake to also take responsibility and apologize. Thus, in this situation, both parties need to disclose and apologize, along with the senior executive, who speaks for the institution and shows support for both professionals.

Full transparency, taking responsibility, and apologizing are therapeutic for caregivers as well. Making a mistake that hurts someone is traumatic for the person responsible. Therefore, being open and apologizing begins the healing process for patient and doctor. Both need support. The hospital and colleagues need to provide support to both the caregiver and the patient for some time after the event.

One of the great tragedies of our long-standing obsession with liability has been that it has led institutions whose primary mission is healing to overlook the crucial role of apology in the healing process—for both the patient and the caregiver. That has to change.
IMPLEMENTING AND SUPPORTING DISCLOSURE AND APOLOGY

Many hospitals have made great strides in recent years in increasing transparency, taking responsibility for adverse events, and providing training and support for professionals to apologize. Some have worked in collaboration with national advocacy groups such as Medically Induced Trauma Support Services (MITSS) to develop formal programs that provide support to patients and caregivers following mishaps. Increasing numbers of hospitals are developing their own full disclosure, apology, support, and early compensation policies and programs.

Why haven’t all hospitals done it? The most obvious reason executives have been reluctant to enter this arena is that until recently there has been very little pressure from any source—peers, the government, or the public—for hospitals to function in a more supportive role. Another reason is that some executives, fortunately a shrinking number, don’t accept the concept that errors and accidents result from systems failures—or if they do, they fail to make the obvious connection that therefore the primary responsibility for the failures is theirs.

But a more important reason many hospital executives shy away from taking responsibility for medical errors and systems failures is that they genuinely believe it is inappropriate for them to interfere with or promote any part of professional practice. For all of recorded memory, and in many different venues, from small community hospitals to major academic medical centers, doctors have vigorously espoused that approach. Hospital leaders are also aware that apology is a sensitive subject for physicians. On top of all this, for years hospital lawyers have counseled against honest, full disclosure and apology, claiming that they increase the likelihood of being sued, and of losing in court. Financial considerations have trumped morality.

All of these reasons are crumbling. The legal argument has essentially dissolved. There has never been any evidence that disclosure or apology increases the chance of being sued—not a single documented case. In fact, experienced trial lawyers have long told us just the opposite: that the major reason patients sue—some estimate two-thirds of their cases—is that the patient is angry because the doctor won’t tell them what happened, take responsibility, and apologize. Recently, evidence has accumulated from multiple sources, including the Veterans Administration Health Service (Kraman and Hamm 1999), the Universities of Michigan (Boothman et al. 2009; Boothman 2006) and Illinois, and others, that when hospitals and physicians have provided full disclosure, apologized, and made often modest financial settlements, the rate of malpractice suits drops substantially and total payouts drop even more dramatically. At the University of Michigan, a full disclosure, apology, and compensation system was instituted in 2000. From 2001 to 2005 malpractice claims decreased by 57 percent and total litigation costs decreased by two-thirds (Clinton and Obama 2006; Boothman 2009).

External pressure for change has also increased a great deal in the past few years, as the public and third parties have become better informed about quality and safety. Led by patient advocacy groups, government agencies and payers have dramatically increased the pressure
on hospitals to measure and report their results and measures of quality. Hospitals, more than physicians, are being held accountable for providing safe and effective care and for treating patients the way they should be treated.

In this environment of increasing accountability, all parties look to the hospital leader to ensure that the hospital’s systems are effective and safe. The executive’s responsibility may not be to tell physicians how to practice, but it is their responsibility to set standards, and to facilitate, support, and insist that all personnel, including physicians, meet standards of quality, honesty, and openness. Full disclosure and apology are essential components of this new standard of care, and it is the hospital leader who is responsible for making it happen.

**What Needs to Be Done?**

Making the transformation from a culture of secrecy and denial to one of openness, responsibility, and restitution is a major challenge for institutional leadership. Experience from hospitals that have pioneered in disclosure and apology demonstrates that close collaboration of hospital and physician leaders is essential for success (Boothman et al. 2009). The hospital needs to develop a policy, a process, training, and support mechanisms.

First, the CEO must take responsibility for leading the institution to establish a clear and unambiguous policy that when things go wrong communication with the patient will be prompt, open, and honest and that the hospital will take responsibility and apologize for errors and other systems failures. Developing such a policy is the first step toward necessary culture change and is a major test of leadership. Full participation of all stakeholders, particularly the clinical leaders, is essential.

Following policy development, doctors, nurses, risk managers, and administrators must collaborate to develop a clear, detailed, and workable process for responding to events. Physicians need to know whom to call when things go wrong. The support mechanisms, including just-in-time coaching in disclosure, must be well-understood and easily, even automatically, activated. This requires an extensive educational effort ahead of time to inform all who may be involved at some time in the future, particularly physicians (Gallagher, Studdert, and Levinson 2007; Gallagher et al. 2003). Part of the process should be establishing clear criteria for immediate identification of patients for whom the disclosure and support process needs to be initiated. The moment of the event is not the time to be confused about whether disclosure is indicated.

Training is essential. Most doctors and nurses lack the skills and know-how to communicate appropriately with patients in these situations. They need to learn what information to share when, how to provide support to the patient, and how to apologize. A cadre of expert coaches needs to be developed to provide just-in-time help for the difficult disclosures and apologies (Truog et al. 2011).

Support programs need to be developed for both the patients and the caregivers. Even if communication is flawless and apologies are forthcoming when indicated, patients often require a long time to recover, lose their fear, and re-establish trust. Psychological support may be needed for months. The hospital has a responsibility to provide that support even after the patient has been discharged. Caregivers also need support. Their psychological wounds may be profound. Peer support programs need to be developed to help them recover.
Finally, patients should receive financial compensation for their losses, both immediate and long term.

**Compensation**

Apology without compensation is a sham. As Lazare (2004) has taught, the essential components of meaningful apology are taking responsibility, showing remorse, and making restitution. The last is curiously absent from many otherwise excellent apologies. But the most expertly delivered, heartfelt apology is hollow if nothing is done to try to make the patient whole. This has to change. Patients need and deserve restitution. The hospital has the responsibility to provide it. However, developing mechanisms to do that has proved difficult.

For many years, the discussion of patient injury in the United States has been dominated by malpractice concerns. As a result, we have failed to address the problem of the costs of the much larger number of treatment-induced injuries that are caused by non-negligent errors. Unlike other countries in the Western world, our social safety-net mechanisms (e.g., unemployment compensation, disability payments, home care) are poorly developed. Thus, when Americans are injured they often have significant out-of-pocket financial costs. For some, malpractice litigation is the only way to receive compensation to meet these expenses.

This is immoral. Patients should not have to pay for our mistakes. It is also inefficient. As the experience with progressive programs has demonstrated, prompt and fair compensation dramatically reduces liability payments (Clinton and Obama 2006; Boothman 2009). It pays for itself. It truly is a win–win situation. Many years ago, the Medical Practice Study demonstrated that all of the downstream lifelong costs of significant adverse events, regardless of whether they were caused by errors or not, were less than the amount spent annually by doctors and hospitals on liability insurance (Johnson et al. 1992). However, moving insurance dollars from liability to disability has proved challenging.

The change starts with the hospital accepting responsibility for the costs—short-term and long-term—of treatment-induced injuries. As curator of the systems, it is the hospital, not the physicians and nurses, that is responsible for ensuring that those systems are working safely. Accordingly, it is the hospital, not the physician, that should be responsible for compensating patients who are injured when the systems fail. Because the malpractice system focuses primarily on the physician and is restricted to negligent injuries, it is incapable of meeting this need. A new insurance product is needed: medical treatment disability insurance. The more efficient alternative is a state-based no-fault compensation plan, such as those used in New Zealand and Sweden, but that seems unlikely to occur in the United States in the foreseeable future. A more realistic alternative is to change the insurance.

Large institutions that are self-insured, such as academic medical centers, clinics, and university healthcare systems, are well-equipped to make this transition. Experience shows that as such institutions implement policies of prompt compensation, their liability claims decrease more than enough to make up for the increased number of payouts. The challenge isn't finding the money,
it is convincing people to make the change and developing fair and efficient mechanisms to make it happen. There will be resistance from all quarters: the lawyers, the risk managers, the accountants, and physician skeptics. Leaders must persevere.

Smaller independent institutions and their physicians have a much greater challenge. They are dependent on commercial insurance products, which are traditionally limited to liability insurance. However, insurance companies will produce virtually any product if there is a market for it. Some creative thinking is needed to address this problem. One way to create that market would be for the hospitals to agree through their state hospital association to purchase patient disability insurance. Such a joint purchasing association can also negotiate with the liability carriers—who might well be the developers of the new disability product—to reduce premiums promptly as the payouts decline when full compensation is implemented.

The difficulties in making this kind of transition are many. The upfront costs can be substantial. Some of these can be met through substantial savings that result from aggressive safety programs to implement new safe practices, particularly in prevention of hospital-acquired infections. However, smaller independent hospitals may need help from their state legislatures. If large systems demonstrate feasibility and savings from full compensation plans, enlightened state legislatures might be able to help with transition funding once they recover from the current recession. We need multiple experiments to find the most efficient mechanism.

**The Time Is Now**

Ensuring that patients receive a prompt and meaningful apology when they have been injured by our mistakes is a joint responsibility. As the patient’s advocate, the physician must continue to play the lead role. However, as custodian of the systems, the hospital has primary responsibility both for the mishap and for preventing it in the future. Hospital leaders must step up and take that responsibility. They need to participate in the apology and in the solution.

All hospitals need to have policies and practices that ensure that every injured patient is treated the way we would want to be treated ourselves—openly, honestly, with compassion, and, when indicated, with an apology and compensation. The time has come for hospital leaders to make it happen.

**References**


