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THE APOLOGY: HEALING WORDS

The notion of apology in medicine and the surrounding debate over its place in clinical practice followed on the heels of great revelations: Medicine is practiced and delivered by humans, and humans make mistakes. Therefore there are mistakes in medicine. This new dialogue began with Lucian Leape’s (1994) groundbreaking article “Error in Medicine.” On its tail came the Institute of Medicine’s books and a different kind of vision for healthcare.

In his book Healing Words: The Power of Apology in Medicine, Michael Woods (2007) suggests that when something unexpected or untoward occurs in medicine, the act of apology is sentinel for providers, patients, and family. The phrase “I’m sorry” is one of the most commonly used in any language, and people reflexively speak it throughout the day.
The power of an apology is enormous if sincerely done in any context. An apology has the power to heal humiliations, free the mind from deep-seated guilt, remove the desire for vengeance, and ultimately restore broken relationships (Lazare 2004). Leape (2005) has applied the characterization of the therapeutic power of an apology to medical errors:

- Apology begins to restore the patient’s dignity and respect. Injury is humiliating and unfair. An apology can mitigate the humiliation: “You respect me enough to acknowledge my hurt.”
- Apology provides an assurance of shared values, reaffirming the patient’s and doctor’s mutual commitment to the rules of the relationship and re-establishing trust. “I really am the person you thought I was.”
- Apology assures patients that they are not at fault—a common and often unappreciated response to mishaps.
- 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 patient’s self-respect.
- By making amends, such as providing extra attention or attending to the patient’s immediate needs, apology demonstrates that the doctor understands the impact of the patient’s suffering and loss of trust.

For reasons that we explore in the next section, practitioners and workers in healthcare have been effectively gagged by the culture of healthcare and kept from speaking these healing words. “I’m sorry” can express respect, regret, compassion, and caring, yet we have disallowed such expressions in healthcare when patients and providers need to exchange them most.

**Constraints to “I’m Sorry”**

- Physician culture
- Legal advice
- Risk management
- The culture of the organization

The biggest constraint to apology is cultural and begins with the physician. The “deny and defend” approach to bad outcomes was created by attorneys and the
malpractice insurance industry. Lawyers are prone to warning doctors that patients and families may see an apology as an admission of guilt. It becomes hard to show that apology may reduce risk: How do you measure lawsuits that do not occur? Of course an apology in no way guarantees avoidance of a lawsuit (Croskerry et al. 2009). In an effort to defuse potential liability for an apology, 29 states have adopted “apology laws” (Exhibit 11.1). These statutes make an apology or statement of sympathy expressed by a physician in the setting of medical error inadmissible as evidence to prove negligence.

The taboo on apologizing is not driven by data but by fear and anecdote. Though apologizing and admitting mistakes are becoming more culturally accepted, behind

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**Exhibit 11.1 States with Apology Laws**

17. North Carolina: General Stat. § 8C-1, Rule 413
closed doors the old dialogues continue. Insurers tell their physician clients, “Never use the words ‘I’m sorry.’”

Risk management has also contributed to the constraints to apology. Most risk managers have subscribed to the notion that it isn’t appropriate to apologize unless something bad has happened that could have been prevented and that the organization is responsible for. Risk managers are less supportive of providing a full apology than physicians are willing to offer one (Loren et al. 2010). But, as Woods (2007) points out, we say “I am so sorry” when we learn of a death in the family or other bad news even though we have no connection to it or liability for it. Apology has nothing to do with causation.

Remember, apology is most effective at the front lines and in the clinical trenches. In fact, the likelihood of being sued falls by 50 percent when an apology is offered immediately (Pelt and Faldmo 2008). More than 70 percent of malpractice claims are due to poor patient–provider relationships (Beckman et al. 1994). Providers who have good communication skills and talk to their patients in an authentic way are sued less often (Vincent, Young, and Phillips 1994). Risk has everything to do with the interpersonal relationships between patients and providers and relatively little to do with the quality of the care that was rendered.

**APOLOGY AND DISCLOSURE**

Healthcare organizations are increasingly moving toward early disclosure of a medical adverse event or error with full disclosure of the facts. Patients and their families want information, particularly reassurance that they will recover and that efforts are being made to prevent the problem from occurring again. Patients want an apology as part of the disclosure of a harmful medical error (Gallagher and Lucas 2005). Organizations that have processes in place outlining how such episodes should be managed are helping patients and their families cope and helping staff recover as well.

Provider training and leadership in how to apologize and disclose have been successful at both the University of Michigan Health System (Boothman 2006) and the VA Hospital in Lexington, Kentucky (Woods 2007) (see the case study on page 104). Although the organization and insurers can’t micromanage the interpersonal relationship between provider and patient, they can get out of the way and provide basic principles and approaches.
THE FIVE Rs OF APOLOGY

According to Beverly Engel’s (2001) book *The Power of Apology*, an authentic apology has three elements: regret, responsibility, and remedy. Woods (2007) feels that in healthcare there are two added critical elements: recognition and remaining engaged. The five Rs are:

1. Regret. An expression of regret tells the patient you recognize her fear, anxiety, and pain. It should go something like this: “I am sorry this happened. It is not what either of us wanted or expected, and I need to tell you how sorry I am.”

2. Responsibility. This is the step that your insurer and your organization are most worried about. You need to convey that you are responsible for your patient’s care, you will get to the bottom of how this error happened, and you will work to ensure it doesn’t happen again. This is surprisingly important to patients and their families. Woods (2007) recommends first-person singular, not plural, for these expressions (see the scripting section on page 102 for more examples).

3. Remedy. This element includes discussing both medical and financial remedies. Risk management should help you assure the patient that if a longer stay or another surgery is required, your organization will provide aid. For example, “Please do not worry about your condition or the expenses associated with whatever care you need. The hospital will take care of you and any consequences of this event.” Evidence is mounting that when the patient does not face a financial burden after a medical error, he is less likely to seek compensation in the courts (Woods 2007).

4. Recognition. Caregivers must understand when an apology is needed and not become defensive, withdrawn, or evasive. Providers must learn to recognize early when the patient’s or family’s expectations have not been met.

5. Remaining engaged. Too often after an adverse event, complication, or medical error the providers want to disengage from the patient and the family. Yet this is the time when the patient needs to feel the physician or provider is there to help her deal with the looming consequences. The patient must not feel abandoned by the provider. This can be particularly difficult for the emergency physician whose scope of care ends at the ED doors. Phone calls to the family or patient to check on progress are important.
APOLOGIES AND RISK MANAGEMENT

There are now growing examples of the effectiveness of incorporating apology into a risk management strategy, effectively reducing risk and the costs incurred after adverse events (Peto et al. 2009; Cox 2007; Wojcieszak, Banja, and Houk 2006). The University of Michigan Health System crafted a policy in 2001 that incorporated apology into its risk management strategy. The core of this program was to enhance patient safety and provider–patient communication. The policy had three basic tenets:

1. Compensating patients quickly and fairly when unreasonable medical care caused a bad outcome
2. Rigorous defense of the staff and hospital when treatment and management met the standard of care or did not cause an injury
3. A focus on learning from mistakes and the patient experience

In the first year of the program dramatic improvement could be seen. Of the seven cases that went to trial, all but one case was won. The lost case was ultimately settled for a smaller sum than was anticipated. The system saved $2.2 million in the first year.

<table>
<thead>
<tr>
<th>Communication During the Apology</th>
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<tr>
<td>• Make full eye contact.</td>
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<tr>
<td>• Place hands relaxed at the sides (do not cross arms across the chest).</td>
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<tr>
<td>• Sit down and consider sitting on the edge of the bed after asking the patient’s permission.</td>
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<tr>
<td>• Use open hand gestures.</td>
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<tr>
<td>• Give the patient and family ample time to ask questions.</td>
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SCRIPTING FOR ADVERSE EVENTS AND MEDICAL ERROR

Scripting, in which staff are provided with positive dialogue for specific situations in the ED, shows promise in improving the communication and interpersonal interaction of the physician–patient encounter (Handel et al. 2010; Robert Wood Johnson Foundation 2006; Mustard 2003). The following examples are taken directly from Woods (2007) and illustrate the language and dialogue that should
take place when adverse events occur. Your organization’s risk management department could develop and teach similar scripts. Some providers will also need coaching in the delivery of the script.

### Examples of Scripting

- “I’m sorry this has happened to you, and I want to assure you I’ll do everything possible to get at how this happened.” (Recognition)
- “I’m sorry you are upset—I am upset about this, too. I am doing everything I can to understand how and why this happened.” (Recognition)
- “I really regret this happened. I know it is not what either of us wanted or expected, and I want you to know how sorry I am for what you are going through.” (Regret)
- “I am responsible for your care, and I will find out what happened and if possible why it happened. I will keep you posted of what I learn and how it can be used to prevent this from happening again. At this point I am not sure if I would have done anything differently, but I intend to explore this thoroughly.” (Responsibility)
- “I am responsible for your care and for this regrettable outcome. The drug reaction you experienced has been reported, but it is very uncommon. I’m looking into matters to see if your reaction could have been anticipated. I will keep you posted of what I have learned.” (Responsibility)
- “While it is still early to tell, I don’t think you will have any long-term health problems, but I will verify this over time. I want you to know the problem occurred because of a communication error, and I am looking into changes that will keep it from happening again.” (Remedy)
- “I am responsible for your care and will be completely available to you. Here is my card. Please call me directly if you have any problems.” (Remaining engaged)

### THE ROLE OF EXECUTIVE LEADERSHIP

Incorporating apology and disclosure into the culture of the organization is the responsibility of executive leadership. Both the risk management department and the legal department will have to align with the goals and culture change expressed by the executive leadership. This will take finesse at best and high-level staff changes.
at worst if these individuals resist these changes. As long as there is one attorney or one risk management professional promoting fear over apology, the program will not be allowed to grow.

**Case Study**

The VA Medical Center in Lexington, Kentucky, had one of the worst records for malpractice claims in the system. In 1987, after losing two large lawsuits totaling more than $1.5 million, the risk management committee decided that a new approach was needed. The goal was to change the culture to foster a more empathetic attitude among clinicians, particularly after a patient had been harmed. Rather than respond with a defensive or adversarial approach, the committee wanted caregivers to respond in a caregiving way.

As the new policies and program were implemented the risk management committee mapped out the details of timing and disclosure at the organizational level. They opted for a rapid full disclosure of adverse events and ramped up their patient safety efforts. All employees were now expected to report not only errors but near misses to the hospital risk management committee. The committee acts promptly to determine the root cause, and if a patient is harmed it makes quick recommendations for remedy, including financial compensation. At a face-to-face meeting representatives of the hospital apologize for the event and explain what is being done to correct the system that allowed the error, and the chief of staff answers all questions from the patient and his or her family. The hospital attorney offers a fair settlement.

The VA Medical Center in Lexington found that this approach helped diffuse the anger of the patient and family members and effectively curbed the motivation for litigation. Legal fees decreased. Following implementation of this program the VA Medical Center in Lexington reported 88 malpractice claims in seven years, but the average cost of each claim was one-twentieth of the average cost reported by the National Practitioner Data Bank.

**Results:**

VA Lexington average cost of claim: $15,622  
National Practitioner Data Bank average: $270,854

**SOURCE:** Woods (2007).
**Strategies for Healthcare Executives**

- Support training for staff at all levels that includes apology as part of a response to medical error.
- With the legal and risk management departments, develop and train staff using scripts for major adverse events.
- Integrate this program with a robust patient safety program that seeks to get upstream of latent errors and patient safety issues.
- Demand that your risk management and legal departments have 24/7 on-call capability to quickly address ED adverse events and make rapid offers of compensation when needed.
- Cultivate a culture of apology and disclosure that is timely and patient-centered, and iterate these goals often and at all levels of leadership.

**Recommended Readings**


