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[title] **Should Health Care Providers Be Forced to Apologise After Things Go Wrong?**

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Abstract The issue of apologising to patients harmed by adverse events has been a subject of interest and debate within medicine, politics, and the law since the early 1980s. Although apology serves several important social roles, including recognising the victims of harm, providing an opportunity for redress, and repairing relationships, compelled apologies ring hollow and ultimately undermine these goals. Apologies that stem from external authorities' edicts rather than an offender's own self-criticism and moral reflection are inauthentic and contribute to a "moral flabbiness" that stunts the moral development of both individual providers and the medical profession. Following a discussion of a recent case from New Zealand in which a midwife was required to apologise not only to the parents but also to the baby, it is argued that rather than requiring health care providers to apologise, authorities should instead train, foster, and support the capacity of providers to apologise voluntarily.

Case Study: Midwife Forced to Apologise to Baby

In a recently published investigation by New Zealand's Health and Disability Commissioner (HDC), a midwife was required to provide a written apology following an error to both the parents and the baby.

The case examined the standard of care provided by a midwife who failed to discuss with the parents vitamin K administration during the antenatal period and also failed to perform a Guthrie test (PKU test) test within an appropriate period after birth. The baby was admitted to hospital with neonatal jaundice and later required an urgent craniotomy and evacuation of a subdural haematoma. The HDC found the midwife in breach of the *Code of Health and Disability Services Consumers' Rights (Code of Rights)*. The Commissioner recommended that the midwife

provide a written apology to Mr and Mrs B and a separate apology to Baby B, suitable for her to read when she is sufficiently mature to do so, apologising for Ms A's breaches of the Code. The apology is to be provided to HDC for forwarding by 24 June 2013 (Health and Disability Commissioner 2013a, 12).

Recommendations to provide an apology to a complainant are common in HDC investigations. For instance, in the 41 investigations published on the HDC's website in 2013, it appears that 38 investigations recommended that an apology be provided (Health and Disability Commissioner 2013b). HDC "recommendations" are more than simple suggestions that health and disability providers can freely choose not to follow. Such recommendations effectively amount to a requirement, given the HDC's policy of publicly naming providers who fail to comply with the Commissioner's recommendations, and in practice 98 percent of

providers comply with HDC recommendations (Health and Disability Commissioner 2008). Indeed, the HDC's naming policy explicitly addresses apologies:

Providers have argued that naming for refusal to comply with minor recommendations, such as an apology, is not warranted. However, complainants and consumers do not consider an apology to be a "minor recommendation". If a provider refuses to apologise, it is generally because he or she is unwilling to accept that the care he or she provided was substandard. Such behaviour is itself evidence of a lack of professionalism (Health and Disability Commissioner 2008, 5).

However, the recommendation in this case to provide an apology to a baby "for her to read when she is sufficiently mature to do so" is rather strange. The midwife had already faced a competence review and an HDC investigation and has been referred by the Commissioner for potential disciplinary proceedings. She also has stopped practising as a self-employed midwife and now only works as a hospital staff midwife. The midwife states that the case has "profoundly" affected her and that she has continued to reflect daily in her practice "on the need for good communication and documentation" (Health and Disability Commissioner 2013a, 7). What words should the midwife find to say sorry in a way that a previously harmed (but now well recovered) child can read at some future date? On top of everything else, the recommended apology to the baby seems excessive and hollow. Even with regard to the recommended apology to the parents, one could question why the midwife was not trusted to make a judgement about the matter.

While this particular case is rather unusual, it raises a general question about the appropriateness of coercing health care providers to apologise. Even though other jurisdictions may not have an authority like the HDC that requires apologies, coercion may be exerted by many parties and it is important to reflect on how apologies can be ethically promoted after things go wrong in health care.

The Role of Apologies

The act of apologising carries great meaning in wider society as a means of "responding to the harmed person's need for recognition, offering the individual or organisation the opportunity to make amends, [and] laying the foundation for a better relationship between both parties" (ACSQHC 2012, 42). While an apology can be defined in various ways, certain key elements have been identified in the literature. These include acknowledging that harm has occurred, accepting responsibility for causing the harm, expressing regret, and taking action to remedy the harm and prevent future occurrences (ACSQHC 2012; Allan and McKillop 2010).

Providing an apology also may bestow a number of positive psycho-physiological effects for those harmed. Alfred Allan and Dianne McKillop (2010) note that those harmed by adverse events can experience a range of psychological and physiological stress responses similar to any other stressor and suggest that a full apology can promote forgiveness and reduce negative effects and assist in recovery by “redressing a power imbalance, restoring dignity, achieving closure and stopping the search for an explanation or information, [and] reducing the impulse for redress by making them feel that they have been treated respectfully and fairly” (ACSQHC 2012, 44).

With the development of open disclosure in health care internationally, the role of apologies to patients harmed by adverse events has become an increasingly important consideration, with research indicating that a full and sincere apology following an adverse event is a key element of successful disclosure practice (ACSQHC 2012). Apologising to harmed patients is now widely endorsed, including in the United States (Massachusetts Coalition for the Prevention of Medical Errors 2006), Canada (Canadian Medical Protective Association 2008), the United Kingdom (National Patient Safety Agency 2009), Australia (ACSQHC 2013), and New Zealand (Health and Disability Commissioner 2009). In Australia, for instance, the Australian Commission on Safety and Quality in Health Care reviewed the *Open Disclosure Standard* in 2011 to consider it in light of current research and evidence and to recommend changes to it (ACSQHC 2012). This resulted in the new *Australian Open Disclosure Framework* that specifies that the words “I am sorry” or “we are sorry” should be included in an apology or expression of regret (ACSQHC 2013).

Unfortunately, there has traditionally been a reluctance to offer apologies in health care after things go wrong. As Marie Bismark has noted:

Health practitioners have high expectations of themselves and, not surprisingly, many find it difficult to discuss adverse events openly with patients. Some are afraid of losing patients’ trust, some shy away from difficult conversations, while for others the fear of medicolegal consequences and professional sanctions is cited as an impediment to apologising (Bismark 2009, 96–97).

Nonetheless, research has found that patients often consider that disclosure “would enhance their trust in their physicians’ honesty and would reassure them that they were receiving complete information about their overall care” (Gallagher et al. 2003, 1003) and that an apology “is the most valued part of open disclosure and fundamental in the post-incident reconciliation process” (ACSQHC 2012, 43). Furthermore, while clinicians’ legal fears have

been identified even in very different legal settings as a key barrier to apologising (Gallagher et al. 2006), it is generally held that expressions of sympathy, and even acknowledgements of responsibility, are not an admission of liability, as this is a matter for a court to decide on the basis of facts and not by what is said (McLennan and Truog 2013). More importantly, “without a meaningful and unequivocal expression of wrongdoing, apology cannot be an authentic moral act” (Taft 2000, 1154; see also Lazare 2004). This applies even in health care where harmful errors have complex causes often not attributable to an individual person or a single action.

Few would quarrel with the notion that an apology is owed to patients who are harmed by substandard care and that the act of apology occurs too infrequently. The fact that an apology in these circumstances is ethically the right thing to do, and may potentially have a number of positive benefits, appears to be what is motivating New Zealand’s HDC to consistently recommend health providers apologise after they have been found in breach of the *Code of Rights*. The problem with this approach, however, is that if an apology is offered primarily from fear of punishment it has little value and is likely to end up doing more harm than good.

The Importance of Agency

Genuine regret, responsibility, and intention to change can only be generated by the person concerned. Like love, courage, or determination, these are virtues of character and as such must arise from the person’s own agency. Such moral reflection cannot be, one might say, “outsourced.” Yet, by disregarding any judgements a health care provider may have about the value of apologising to a particular patient, this appears to be precisely what the HDC is attempting to do in requiring apologies. The consequence can only be a denigration of the underlying moral value. As Jack Simmons and Erik Nordenhaug note, “[t]he institutionalization of ... a kind of artificial conscience” alters how an individual relates to ethics by suggesting that “being moral means following the professionally approved rules” (2012, under “Abstract” for a recent lecture and a paper currently under review).

If an apology is primarily motivated by some kind of threat, it will lack the essential elements and take on the form of a charade, becoming little more than a self-interested performance. Lee Taft (2000, 2005) has passionately argued for more than a decade that apologies need to be authentic, and yet he fears we have slipped into “moral flabbiness,” readily dishing out and accepting pathetic apologies: “Apologies are being conflated. We don’t know the distinction between an apology that seeks to repair and an apology that is just a social grace or damage control” (Hall 2010, ¶5).

In certain circumstances, it may be appropriate to compel a moral action (such as apologising) for the purposes of moral development. In these situations, it is hoped that the individual is changed by performing the activity in a way that he or she develops the relevant virtue. The person comes to understand, for instance, that apologising is good. When this happens, the performance of the mandated apology is an act of positive self-formation, an internalising of a previously external value. However, the coercion involved in these cases is justified only insofar as it serves the desired moral end, namely, the development of a morally mature agent, and is only appropriate in the context of certain relationships, the parent–child being the most obvious. If, in such relationships, the “child” is not allowed to “grow up,” that is, if he or she is not released at some stage to make his or her own decisions, then the purpose of the moral training is negated. Similarly, when adult professionals are ordered to apologise, it seems that they are effectively recast as moral minors and thus not merely humbled but demeaned. This is likely to cause them to resent the regulatory body and to undermine their confidence in their ability to make moral judgements and so perform their professional role.

Forced apologies can be similarly damaging for the patients receiving them. Although an apology is often desired by harmed or otherwise aggrieved patients, the written apologies that are provided to patients to fulfil regulatory bodies’ requirements are all too often full of words but devoid of meaning. Because the moral dimension of the apology is subverted, there is no sense of genuine acknowledgement and, hence, little chance of reconciliation. Like the professional, the patient is left feeling disempowered and disrespected and at odds with the institution upon which he or she is dependent.

This problem is reminiscent of what Nancy Berlinger has called “cheap grace.” Berlinger suggests that too often in the hospital setting forgiveness is assumed to be automatic once an apology is given, which she argues is “a way of formulating forgiveness so that its relational character—the actions that various actors undertake in relation to one another so forgiveness can take place—is forgotten” (Berlinger 2003, 29). Jeffrey Helmreich also has emphasised that “[t]he moral agent’s reasons to be self-critical stem from his own investment in not harming others ... [and] mere apologies, with no self-criticism at all, seem to have a less positive effect on victims than the absence of apology” (Helmreich 2012, 594 and 602). Thus, a full apology, when it is authentic, stems from a self-examination that benefits all: the offender’s own moral development and practice, the original victim, and the anonymous others who come after. Apologies that are institutionalised in health care as means to an end at best only reward the provider (and the provider’s insurer or employer) and at worst stunt the advancement of both the individual and the profession as well as harm the patient. A

recommended apology may be appropriate as a *recommendation*, but not as a masked edict. As Taft argues, “[a]uthentic apology is reserved for the morally courageous who seek for themselves and their patients the deep healing authentic apology inspires” (2005, 79). The HDC should thus reconsider its practice of requiring health and disability providers to apologise. Apologising to harmed patients is important, and it doesn’t happen enough. However, the promotion of apologies after adverse events, in any jurisdiction, would be more appropriately achieved via strategies that nurture the development of the moral maturity required for authentic apology. This is most likely to be accomplished through education and institutional reform, but may also be supported by authorities like the HDC. Indeed, part of the HDC’s role in New Zealand is to educate consumers and providers about their rights and responsibilities. This means that instead of formally recommending apologies in investigations (recommendations that are enforced), the HDC should be trying to educate providers regarding the importance of apologising after things go wrong. A consequence of refraining from coercing apologies will be that in some situations patients who deserve an apology will not receive one because the provider involved lacks the required character. However, in our view, this is preferable to the general erosion of moral integrity that forcing apologies generates.

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