Apologies - A Necessary Soft Skill or Something to Avoid?

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Abstract

An apology can be thought of as a sincere expression of regret and emotional support, but can at times be interpreted as an admission of guilt. While countries have different laws relating to the topic of apologies in medical practice, the duty for open disclosure is being increasingly stressed upon medical practitioners. This narrative review seeks to discuss the definition, structure, role, effectiveness, and laws governing apologies in medical practice. It also aims to discuss if and how a physician should apologise and the practicality of apology laws in disclosing information to patients. Research highlights that fewer lawsuits result when apologies are issued by medical practitioners. The two main types of laws governing medical apologies are the tort system and the no fault system. Political lobbying and media emotionalization of certain cases influence lawmakers' decisions and so the implementation of these systems. While issuing an apology is effective, apology laws do not provide a definite positive impact in this regard. When a medic feels that an apology is warranted, they should discuss the full issue with a superior and peer, and take into consideration the local jurisprudence governing their profession. It can be displayed that successful training and teaching in the correct use and delivery of an apology increases the effectiveness of an apology when one is justified. This is many times lacking in undergraduate medical education.

Introduction

In a world where compassion is increasingly encouraged in healthcare, and where medical students are taught to empathise with patients, should a medical practitioner or a medical student apologise? How should one do this in terms of the healing process? What are the legal implications of doing so? Is there a different way of expressing regret, while not legally implying that one is at fault?

Although students are equipped with all the necessary medical knowledge to effectively treat diseases after finishing medical school, non-technical skills such as situational awareness and effective team communication are barely touched upon. Among these skills is the ability to address medical errors and give an appropriate apology (1).

In the original "apology," Plato provides a defence of his actions rather than expressing regret (2). Over the centuries, the definition of an apology has changed to an expression of

regret for causing trouble or hurting someone (3).

Due to the above definition, an apology is sometimes, and in some jurisdictions, taken as an admission of guilt, and thus carries a legal liability for the action by which a patient suffers harm (4). Yet, in most cases when a patient is harmed, both the patient and the physician desire an apology to express sympathy or to help in the therapeutic process. Thus the worry of creating a legal liability through an apology creates a feeling of a general lack of emotional support on both sides (5). This fear is not unfounded, as in the United States of America doctors on average face at least one malpractice lawsuit throughout their professional careers (6).

Due to this fear, so-called "apology laws" have been adopted by numerous nations and states to make physicians' expressions of regret inadmissible in the eyes of the law when disclosing medical errors and complications (7).

What constitutes an apology?

The Role of Apologies in Healthcare

During the medical care of patients, especially during medical error disclosure, malpractice, and issues of patient safety, apologies may be critical in supporting patients and their relatives. Giving a sincere apology is one of the most effective tools in doctor-patient communication and an important component of the patient-centred approach in healthcare (8).

An apology should be offered when an error has been made and harm has occurred, or there is potential for harm to occur. Yet, not all errors merit an apology. Misspelling a word in a doctor's note may not merit an apology, but misspelling similarly sounding medications might merit one. Similarly, the extent and severity of the error might merit a more profound apology, from several people or administrators representing the institution (9).

A Duty For Open Disclosure

Patients are owed the truth from their physicians. The process of disclosure of information on medical errors should be transparent, open, and honest (10). Many times patients express anger about the treatment after the error rather than because of the error itself. The patients and their relatives should get to know of the errors in a timely manner, and from the medical practitioners themselves, rather than an error known to the physicians being highlighted by the patients or relatives. As such an open, honest, and timely disclosure of the events leading up to, and following the error should be the only approach in cases of medical error (11).

How to Apologise

A good and effective apology is done at the right place, and at the right time (Figure 1). When one becomes aware of an error, the error should be reported immediately to the caring consultant. Breaking this information to the patient or family might be an emotional time, so this process should be slightly delayed until most facts are clear, to

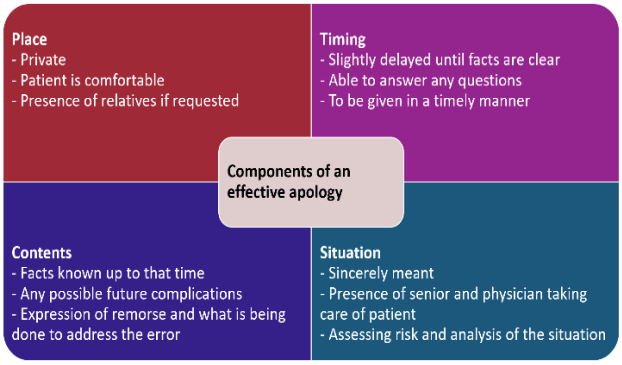

Figure 1: Illustrative Representation of What Makes an Effective Apology

avoid not being able to answer questions which might be asked. On the other hand, waiting too long might lead to the relatives or patients finding out through other means, and being accused of deception and disregard (9,12).

The place where this apology is issued should be somewhere private, and it should be made sure that the patient is comfortable. If support to break the news to relatives is requested by the patient, this should be adequately prepared in an environment of privacy (9,13).

The apology should be sincerely meant, and be tailored to the patient's situation. It should contain the facts known so far, possible complications, and what further studies one will make to assess the error. This should be done in the presence of the physician in charge of the patient, a charge nurse or peer, and in some cases a hospital administrator. The patient should also be informed of any support available to them and their relatives (13). Furthermore, this should not be a forced apology in which the institution obliges the responsible person to give an apology (14).

The formulation and structure of an apology differ according to the situation. The clinician should keep in mind the outcome of the error in choosing the way in which one expresses the apology. If the outcome is a development of an underlying medical condition, it is a good idea to offer an expression of concern and sympathy, albeit not an apology. If there is a risk of investigation or further treatment in the outcome itself, an expression of regret should be provided, but admittance of responsibility should not be provided in the form of an apology. If, after careful analysis of the situation, the outcome is determined to be related to a system or healthcare provider failure, an apology should be considered by the organisation or provider, as it is appropriate and expected to acknowledge responsibility for any outcome in such situations (15,16).

Apology - A Definition

The structure and definition of an apology, as well as considerations to give an apology, vary according to the circumstance faced by the clinician. Yet, the four basic components of an effective apology remain the same (16,17) :

1. Acknowledgement - explaining to the patient that you are aware of the situation.
2. Explanation - sharing the facts one knows about what has happened and reporting more to the patient as it becomes known.
3. Expression of remorse and humility - showing regret about what happened and reassuring the patient to uphold the best possible standard of care, whether or not one admits or implies an admission of fault.

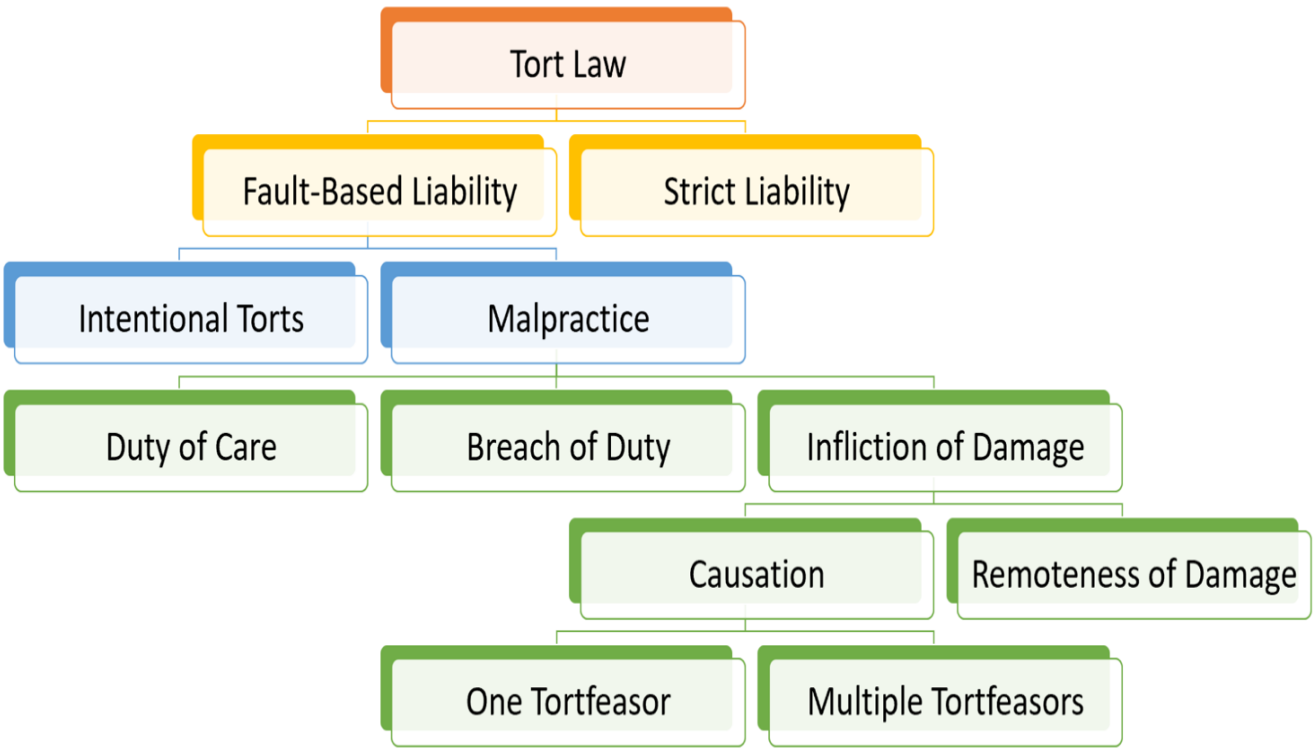

Figure 2: A Hierarchical Breakdown of Tort Law.

4. Reparation - explaining what was learnt from the outcome of the error and how one will make sure that the situation will not be repeated again.

Apology Laws and Legal Liability

The Tort System

The *tort* system is a system by which one is liable for damage which occurs through one's own fault, as explained in Figure 2 (18). This is the system currently enforced on Maltese medical practices by the Maltese Civil Code (19). While this system is important in maintaining accountability for one's actions toward another, it paves the way for potentially dangerous defensive medicine. Defensive medicine is the process of ordering additional tests or procedures primarily to avoid malpractice liability or avoiding patients or treatments out of concern for malpractice liability. Tort law implies that a physician is admitting to wrongdoing and fault by giving an apology. In this case, it is legally advised not to issue apologies to patients or their relatives in cases of medical error (20).

The No Fault System

The *no fault* system has become widely adopted in issues of liability and medical negligence. This is the case in Denmark, Finland, Sweden, Norway, Canada, New Zealand, some states in the United States of America, and some Australian provinces (7,20). The UK adopted what is considered to be legislation which is similar to the *no fault* system, as part of an act providing compensation for workers affected by asbestos exposure (21).

In this system accidents and injuries are regarded as inevitable. Proof of causation, rather than proof of fault, needs to be offered to uphold the claim. Therefore in this system, apologising for an error does not incriminate, as it may be an inevitable error. The claimant must show that the medical error was thus the causative factor in the injury sustained, irrespective of who is to blame, as explained in Figure 3 (22).

Effectiveness of Apology Laws

In a recent study, empirical evidence was used to observe the impact of apology laws with regard to settlements and lawsuits. This study concluded that for minor injuries, the law did not significantly impact the settlement payment of cases, but reduced the total number of such cases. On the other hand, cases involving significant and permanent injuries increased the number of resolved cases, while giving a decrease in the average settlement payment in these cases. The increase in the number of resolved cases is believed to be due to a reduction in the time to reach a settlement due to more protracted lawsuits. The research paper also concluded that in the long run, there could be fewer lawsuits overall (23).

In other studies, it is argued that apology laws are a form of tort law reform, and are in essence not enough. A study observing American heart attack patients concluded that apology laws do not deter defensive medicine, and increase the patient's length of stay in hospital (24). In a separate study, it was found that neurosurgeons face increased numbers of lawsuits and increased settlement payments when apology laws are in force (25).

Yet, literature suggests that while apologies themselves do make a positive impact, apology laws fail to do so. The reason behind this is that there is a lack of training of physicians and other healthcare providers in the manner and frequency that these apologies are given. Development of educational programs specific to apologies and medical error disclosure, as well as coaching and emotional support for healthcare workers, administrators, patients, and relatives promotes better use of apologies and so more effective apologies. As such, apology laws in the absence of physician and healthcare worker education are simply not enough (16,24).

Alternatives to Apology Laws

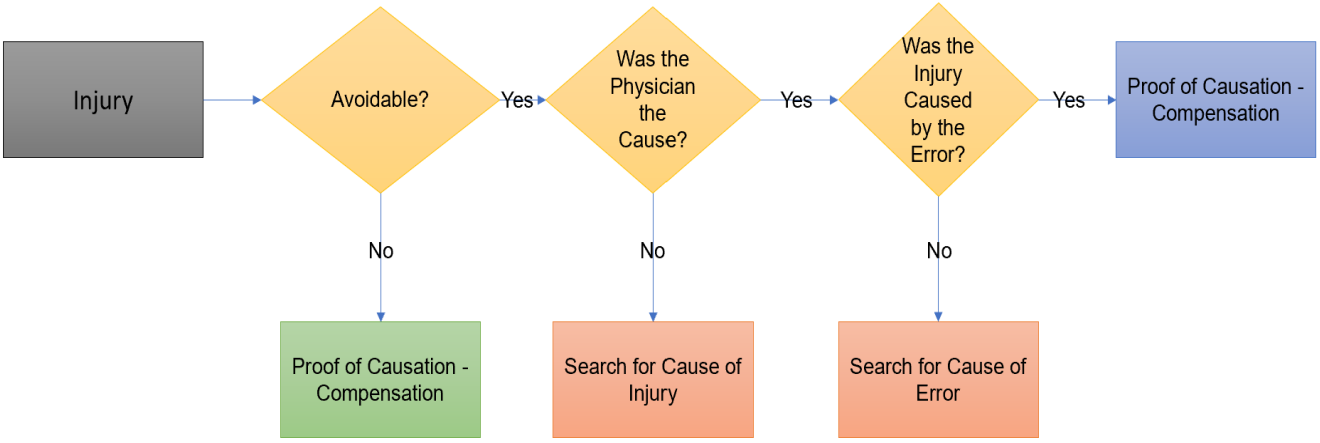

Figure 3: A Flowchart Showing the Process of Determining Proof of Causation.

Stemming from the present system, alternative dispute resolution is a method through which a claim of medical malpractice is settled between parties without involving the courts (20).

The most common practice related to this is mediation. Mediation involves the appointment of a third party, with agreement from both sides, to assist them in resolving the dispute. The mediator would then be able to identify the issues and generate and explore potential solutions. A process of mediation and communication would then be started and mediated until the two parties reach an agreement about all or part of the dispute. This would thus need the mediator to be autonomous from both parties, for the mediator to be sufficiently informed to be able to make decisions, and for the mediator to treat the dispute with absolute confidentiality. While this might be a faster and less costly option compared to litigation, the mediator does not have the authority to impose a legally-binding decision on the parties, and so the resolution of the dispute ultimately lies in the disputed parties' hands (26).

Similar to mediation, arbitration involves the use of non-judicial third parties to resolve disputes between parties. This is many times done to minimise the expenses and formality of a lawsuit. The medical system might apply this practice by requiring patients to sign a terms of service contract before undergoing certain procedures, in which the patients agree to solve any disputes which might arise out of court, in the hands of a tribunal (27). In Malta, a decision taken by a tribunal is legally binding, as long as a Notice of Arbitration is sent to the relevant authorities. Arbitration would require competency and informed consent, which some critics argue are not correctly ensured (20).

Another mechanism is pre-hearing screening. This involves the patient's lawyer submitting a request for a review of a case of malpractice to a medico-legal committee appointed jointly by a bar association and a medical association. This request would include preliminary information on the case and authorise the panel to deliberate in confidentiality on the merits of the case. The panel does not settle or compromise the claim, it only judges whether there is substantial evidence to support the claimant's allegations. The panel then delivers its judgement in a report addressed to the lawyer and the physician or physicians concerned. The deliberations and any votes taken by the panel remain secret. In cases where the panel deems that there is or might be reasonable enough evidence for professional negligence through which the claimant was harmed, it cooperates fully with the claimant to move the dispute to a court of law. In cases where the panel finds that there is no reasonable possibility of professional negligence, or harm arising from such negligence, the lawyer would refrain from filing court action unless personally certain that there are overriding reasons in the interest of the client. This system would thus weed out unreasonable claims, thus lessening the burden placed on the courts. While this is advantageous, in jurisdictions where this method is accepted, the submission of these claims is voluntary, and the decision of the panel is not binding, thus placing additional financial and time burdens on the claimant (28).

Discussions and Conclusion

It becomes apparent that there is no one perfect solution to the issue of apologies in medical practice. Yet, steps should be taken to have a universal stance on the topic, especially when considering the implications of the right to cross-border medical care within the European Union.

While there is empirical research highlighting the benefits and drawbacks of different systems through which this issue is tackled by various countries, it is many times political lobbying, rather than impartial research, which drives lawmakers to choose one over another.

Media also plays an important role in lobbying for a different legal system. In recent times, there has been an increase in media reporting and emotionalising cases, generating an infallible view of medics and the law as well as a sense of crisis. As such, both locally and internationally, there has been a recent drive to change laws, and hold physicians accountable, even when there is the shared burden of system errors.

As Alexander Pope writes in his poem *An Essay on Criticism*, "To err is human, to forgive divine." It should therefore be accepted that physicians are prone to error, as any other mortal being. Indeed, critical thinking skills and training in medical error disclosure are skills which are not emphasised in medical school but are very much needed during one's professional life in the medical sector. Consequently, these soft skills should be taught, adequately explained, and trained within medical school and also during post-graduate training (29).

Moreover, although human fallibility cannot be changed, the conditions under which one works can. Shorter hours, aid by electronic systems, and laws which protect physicians' fallibility can all be piloted and introduced to minimise medical errors. While one can try to discuss and try to eliminate errors one by one, it is more efficient to look into the actual cause and eliminate it.

In closing, apologies, when merited, result in fewer overall lawsuits, while there is conflicting evidence of the effectiveness of apology laws. When patient harm has occurred, or has the potential to occur, an apology should be offered. This is an important part of the healing process and can help to build trust between the patient and the practitioner. A doctor should discuss the complete situation with a superior or legal counsel and take into account the local jurisdiction and clinical guidelines set by their respective medical associations when they believe an apology is necessary. It is only after this consultation that a decision should be taken whether to issue an apology for each specific situation.

In situations where an apology may not be appropriate or legally advisable, there are other ways to express regret and demonstrate a commitment to addressing any issues that may have arisen. For example, practitioners can express sympathy for the patient's experience, offer to investigate the situation further and take steps to prevent similar incidents from occurring in the future.

Ultimately, the most important thing is to prioritize the patient's well-being and to take appropriate steps to address any issues that may have arisen. Whether through an apology or other means, practitioners, and students should be proactive in taking responsibility for their actions and working to ensure that patients receive the highest quality care possible.

Declarations

Conflict of interest: N.A.

Ethical statement: N.A.

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