


Eliciting the Functional Processes of Apologizing for Errors in Health Care: Developing an Explanatory Model of Apology

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Abstract

The purpose of this article was to analyze the concept development of apology in the context of errors in health care, the administrative response, policy and format/process of the subsequent apology. Using pragmatic utility and a systematic review of the literature, 29 articles and one book provided attributes involved in apologizing. Analytic questions were developed to guide the data synthesis and types of apologies used in different circumstances identified. The antecedents of apologizing, and the attributes and outcomes were identified. A model was constructed illustrating the components of a complete apology, other types of apologies, and ramifications/outcomes of each. Clinical implications of developing formal policies for correcting medical errors through apologies are recommended. Defining the essential elements of apology is the first step in establishing a just culture in health care. Respect for patient-centered care reduces the retaliate consequences following an error, and may even restore the physician patient relationship.

Keywords

concept development, pragmatic utility, apology, health care, qualitative research, reconciliation, medical error

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Despite the significance and copious literature on the disclosure and reporting of errors, and the epidemic of errors in hospitals, the corollary, the role of apology and the correct procedure for apologizing, is not linked to this literature. Rectifying serious problems in the United States is delegated to the courts in the form of financial settlements (Murtagh, Gallagher, Andrew, & Mello, 2012). Yet, little is known about the procedures and role of apologizing, how apologies may mitigate legal settlements, and restore the patient–provider relationship.

Here, an apology is defined as “a regretful acknowledgment of an offense of failure; a formal, public statement of regret, such as one issued by a newspaper, government, or other organization” (Oxford English Dictionary [OED], 2014). Apologizing shows respect and dignity for the other, reduces the incidences of malpractice litigation, and allows the provider to save face (Kraman & Hamm, 1999; Woods, 2004). There are two main types of apology: (a) the almost reflexive, “I’m sorry,” “Pardon me,” or “Excuse me” that allows one to acknowledge minor social refractions in everyday discourse and re-stabilizes relationships, and (b) the more formal, planned apologies used for more serious incidents (or even courtroom). In this review, we address the second type, formal apologies as used in health care. Despite

their use, little is known about the structure, components, and utilization of apologies when a serious error has occurred in health care.

Background: Why Is This Important?

The 1999, Institute of Medicine report, “To Err is Human” determined that health care was not as safe as previously believed, and became the tipping point for transparency and full disclosure in health care (Kohn, Corrigan, & Donaldson, 2000). This ignited the patient safety movement that focused on process and systems rather than the individual practitioner (Kohn et al., 2000). Laws protecting physicians who wish to express regret when an error occurs have now been enacted in 36 states in the United States (Wojcieszak, Banja,

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& Houk, 2006). In 2008, the American Medical Association committed to quality, safety, and science, but guidance on how to apologize to patients for medical errors was not provided (Wilson, 2008). A position statement for nurses to improve patient safety and supporting a “Just Culture” published in 2010 (American Nurse Association [ANA]), and the Code of Ethics for Nurses (ANA, 2015), urged nurses to participate in patient safety initiatives, including policy development and investigation of near misses, and directed nurses to report and investigate any error that occurs. Nonetheless, this document falls short of acknowledging the need for nurses to disclose and apologize errors to the patient (ANA, 2015).

Method

Concept Development Using Pragmatic Utility

“Apology” is considered a partially mature concept (Morse, Hupcey, Mitcham, & Lenz, 1996): Although adequately defined (OED, 2014), the attributes (characteristics/variables) are not clearly delineated. There is disagreement about the use of apology in the health care context, about its role in the institution and health care in general, and who should actually apologize once an error has occurred (Leape, 2012; Taft, 2005). Even the types of apologies, the timing, and who should apologize has not been clarified. The purpose of this article is to develop the concept of apology by identifying the components of the types of apologies and the antecedents and outcomes of apologizing. We use *Pragmatic utility* (Morse, 2000, 2017), a method that bridges methods of concept development and meta-analysis. Pragmatic utility analyzes partially mature lay concepts for which there is a moderate amount of literature available, and develops a theoretical model from this literature.

Partially mature lay concepts are commonly used in everyday discourse, are defined in the dictionary, yet have not been operationally defined for scientific use (Morse, 2000, 2017; Morse et al., 1996). Therefore, by working inductively, a more mature understanding of the concept emerges. First, a literature search was conducted to identify all sources of data in applicable publications. Databases searched included Nursing and Allied Health Literature (CINAHL), PubMed, PsycINFO, and Google Scholar. The years 1985 to 2015 were searched. A method of citation chasing was used to capture additional sources. Key words and medical subject heading phrases were used for searching: apology, apologize, forgiveness, medical/nurse error, and disclosure. The search was limited to accessible full-text articles, review articles, and books in English. A total of 216 abstracts, articles, and books from various disciplines were identified. Titles and abstracts were screened for relevance in health care settings related to medical error and apology (shown in Figure 1). A total of 59 full-text articles and books were assessed for the in-depth analysis. Further screening

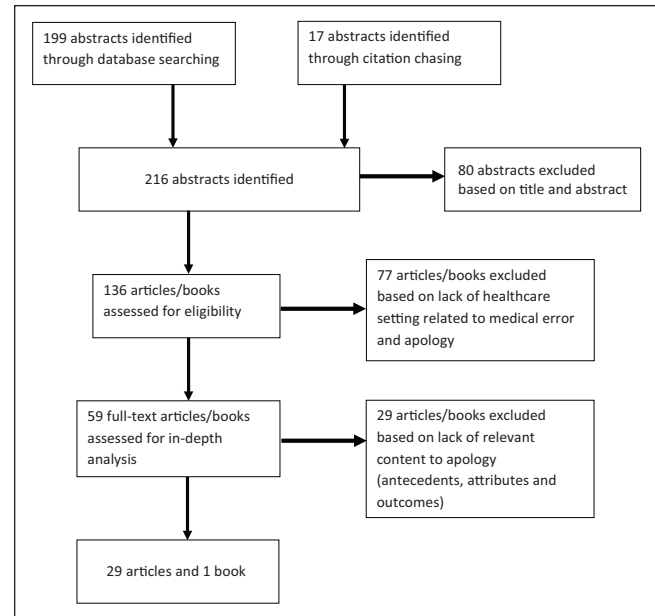


Figure 1. Literature search process (years searched 1985–2015).

based on the content of apology (antecedents, attributes, and outcomes) related to health care settings from the physician, nurse, and patient perspective using “apology following a medical error” resulted in the final analysis of 29 articles and one book. Articles included descriptive studies, reviews, and expert opinions from Australia, Canada, the United Kingdom, and the United States. Exclusion criteria included articles on “error disclosure,” legal and ethical perspectives, and patient recovery process following a medical error.

From these articles, all definitions of apologies, the reasons for apologizing (antecedents), components of apologizing, emotions involved from both victim and institution or personnel involved, the outcomes and process of apology, and any rectification were listed on a large chart. All authors, dates, institutions, and any descriptions were listed on this chart. Categories were created to assist in the analysis of the data and included the following: recognition, regret, guilt, courage, placing blame, helplessness, repentance, timeliness, formality, vulnerable, forgive self, fear, caring and attentive, empathy, compassion, sorrow, trust, forgiveness, accountability, admit fault, statement of error, responsibility, impact of harm, explicit apology, emotional support, honesty, time, dignity, respectful, genuine, explanation, remedy, keeping promises, follow-up, make amends, fix the problem, and offer compensation. Thus, the “anatomy” (i.e., conceptual structure) of all instances of apology could be analyzed. Analytical questions were developed and asked of all inquiries of apology and are shown in Table 1, with the answers from the literature recorded for meanings, clarity, and depth of the concept (Morse, 1995, 2000, 2017; Weaver & Morse, 2006).

Table 1. Analytical Questions, Responses From the Literature, and Attributes of the Concept of Apology.**Antecedents**

1. Why do we apologize?
2. What keeps us from apologizing?
3. What are the consequences of not apologizing?
4. What is there to gain by apologizing?

Attributes

1. What is a full apology?
2. What are the essential components of an apology for it to work?
3. Why do apologies fail?
4. Can you show empathy without apology?
5. Can you apologize without remorse?
6. Can an apology be taught?

Outcomes

1. What comes after the apology?
2. Do apologies need to be documented?
3. Can the patient–provider relationship be repaired?

These results were then inductively synthesized to identify patterns, common attributes, and boundaries of the concept. Comparison enabled the identification of what the concept is and is not (Morse, 2000, 2017; Morse et al., 1996). This process of inquiry enabled us to map the conceptual domain using all available pertinent articles. We were then able to synthesize these data, and evaluate strengths and gaps, the relationship between “types” of apologies, and the outcomes. We then developed a model displaying these relationships, and therefore were able to move inquiry forward in this area.

Conceptual Antecedents

The results from these analytic questions were next explored and summarized to further develop the analysis. At this stage, it was critical to link ideas and content with the contributing authors:

Question 1: Why do we apologize? Errors that occur in medicine are emotional and sometimes very painful experiences for both the provider and the patient. Apologizing allows the provider to express these emotions and relieve guilt, enables emergency treatment to be provided, provides informed consent when additional treatment is needed, and salvages the provider–patient relationship (Kaldjian, Jones, Rosenthal, Tripp-Reimer, & Hillis, 2006; Lazare, 1995; Lazare & Levy, 2011). Apologizing maintains relationships with the victim, restores trust, and reduces anger (Hébert, Levin, & Robertson, 2001; Wu, Huang, Stokes, & Pronovost, 2009). It is an ethical response, a professional standard, and demonstrates respect to the patient (Cornock, 2011; Kaldjian et al., 2006; Pfrimmer, 2010).

Question 2: What keeps us from apologizing? Debilitating feelings of shame, guilt, anger, fear, and humiliation often

keep providers from disclosing and apologizing to the victim. A culture of shame, blame, and secrecy is still prevalent in health care today as well as fears of failure and unknown consequences, including litigation (Bell, Moorman, & Delbanco, 2010; Gallagher, Waterman, Ebers, Fraser, & Levinson, 2003; Lazare, 2006; Wagner, Harkness, Hébert, & Gallagher, 2013). Frequently, providers are unsure of what constitutes a medical error or they believe the error is inconsequential resulting in little or no injury to the patient (Cornock, 2011; Gallagher, Studdert, & Levinson, 2007; Roberts, 2007; Wagner et al., 2013). Lack of experience and training in the process of apology and the fear of making things worse creates a “wall of silence,” and withdrawal from providers (Bell et al., 2010; Jeffs et al., 2011; Leape, 2006; Pfrimmer, 2010). Nurses are concerned with being punished or reprimanded, yet medical mistakes are not deliberate and can be difficult to face. Providers do not know what to say, so they do not say anything at all (Bell et al., 2010; Carmack, 2014; Wagner et al., 2013).

Question 3: What are the consequences of not apologizing? Lack of apology affects our emotional, spiritual, and even physical well-being. When apologies are lacking, there is a lack of validation that someone has been harmed. Absence of apology creates feelings of bitterness and anger, causing a broken provider–patient relationship (Bell et al., 2010; Cornock, 2011; Crigger & Meek, 2007; Hébert et al., 2001; Kooienga & Stewart, 2011; Pfrimmer, 2010), compounding feelings of neglect that increases settlement costs (Gallagher et al., 2003; Keogh, 2014; Kooienga & Stewart, 2011; Roberts, 2007).

Question 4: What is there to gain by apologizing? Apology and full disclosure appears to be enough to restore faith and trust in the physician. To the physician’s surprise, patients sometimes request they remain their provider. However, lack of disclosure and honesty is detrimental in reestablishing the patient–physician relationship. Failure to accept responsibility for the incident increases anger and retaliation (Duclou et al., 2005; Gallagher et al., 2003; Lazare & Levy, 2011; Mazor et al., 2013; Mazor et al., 2004; Micalizzi & Bismark, 2012; Wu et al., 2009); restoring damaged relationships diminishes the providers’ guilt, shame, and fear (Crigger & Meek, 2007; Lazare, 1995, 2006). Patients expressed the need to have closure, and if injuries had occurred, reparation for financial and emotional burden with continued clinical support. “Will you still be my doctor?” (Carmack, 2014; Gallagher et al., 2003; Iedema et al., 2008; Mazor et al., 2013). Patients expect that hospitals will fix or correct what led to the error, which will transform systems, making them safer. Patients feel disrespected and inconsequential with the risk of reoccurrence, while others remain in danger (Jeffs et al., 2011; Lazare & Levy, 2011; Mazor et al., 2013; Mazor et al., 2004).

Attributes

The attributes of the concept may be considered the components. These components must work together “physiologically” in order for the apology to be successful. All components of the concept must be present. Exploration of the concept from this perspective allowed us to determine the types of apologies and why a full apology was successful and other types of apologies failed to satisfy the victim as an apology. Analytic questions asked, and the responses interpreted from the literature, were as follows:

Question 1: What is a full apology? A full apology consists of the following characteristics:

1. Acknowledgment that an error has occurred: This is an expression of regret, an explanation of what happened, remorse, and reparation. An expression of genuine soul-searching regret and sympathy can strengthen the sincerity of the apology (Armstrong, 2009; Cornock, 2011; Gallagher et al., 2007; Keogh, 2014; Lazare, 1995, 2006; Lazare & Levy, 2011; Leape, 2006; Roberts, 2007).
2. An expression of sorrow is an expression of grief, sadness, and disappointment in the occurrence that has transpired, which is different from regret and sympathy (Armstrong, 2009; Hébert et al., 2001; Mazor et al., 2013).
3. The provider himself or herself must accept responsibility: This includes stating that an error occurred (Allan, McKillop, Dooley, Allan, & Preece, 2015; Gallagher et al., 2003; Iedema et al., 2008).

Question 2: What are the essential components of an apology for it to work? Apologies must be a timely acknowledgment of the wrong, hurt, or error. An apology provides *validation* of the impact on the victim (Armstrong, 2009; Lazare, 1995; Lazare & Levy, 2011): an *explanation* of what went wrong, *reason* for the mistake, and responsibility with a *commitment to prevent* recurrence (Armstrong, 2009; Gallagher et al., 2007; Gallagher et al., 2003). The institution must be direct without covering or concealing. The level of formality signifies the importance and impact of the error (Allan et al., 2015; Iedema et al., 2008; Keogh, 2014). These formal expressions of regret, concern, empathy, and caring are essential and may have more importance than receiving a full explanation about what happened (Duclos et al., 2005; Lazare, 1995; Lazare & Levy, 2011; Mazor et al., 2013; Wu et al., 2009).

Question 3: Why do apologies fail? The level of responsibility and sincerity of the apology are directly related (Lazare & Levy, 2011). The majority of physicians simply express regret rather than apologizing. The inability to use the word “error,” and the assurance the error will

not happen again, as well as lacking in sincerity causes additional damage (Chan, Gallagher, Reznick, & Levinson, 2005; Gallagher et al., 2003; Lazare & Levy, 2011; Weiss, 2006).

Question 4: Can you empathize without apologizing? Simply saying “I’m sorry” is not apologizing. Empathy is the act of expressing sorrow for the error that has happened; expressing empathy is not an apology in itself (Armstrong, 2009; Pfrimmer, 2010; Roberts, 2007). However, failure to express empathy gives patients the impression that the physician does not care about what happened, and one is not really sorry (Chan et al., 2005; Iedema et al., 2008).

Question 5: Is an apology effective without remorse? A forced apology or a false apology is easily identified. Patients say, “Don’t insult our intelligence.” Casually informing a patient of an adverse event is inadequate; this is a “failed or pseudo-apology” (Lazare, 2004, pp. 85–106). An apology that minimizes the error is a conditional apology; “I’m sorry if I have hurt anyone by my actions” indicates a lack of remorse (Lazare, 2004).

Question 6: Is apologizing a skill that can be taught? The challenge is for providers to identify the impact of a seemingly trivial error being disclosed (Gallagher et al., 2003). Surgeons are challenged when using “error” when speaking to patients. The majority of physicians reported they had not received any previous training on error disclosure (Chan et al., 2005). Preparing for an apology is essential. Training increases recognition of the error and willingness to disclose and apologize (Armstrong, 2009; Lazare, 2006; Leape, 2006; White et al., 2011).

Conceptual Outcomes

The conceptual outcomes are a description of how “successful” the apology was. Of importance was the type of apology to the outcome and this is discussed further in the development of the apology model. From the literature however, communication, the person making the apology, and the timing of the apology were critical to the victims’ acceptance of the apology:

Question 1: What comes after the apology? Many physicians questioned whether they should continue as the patient’s provider following an error; other physicians were unable to ask for forgiveness due to guilt (Roberts, 2007). Yet patients wanted their provider to remain engaged with them. The apology should never be the only communication with the patient. Lack of communication left patients experiencing fear of the unknown and increased anxiety (Gallagher et al., 2003; Pfrimmer, 2010; Weiss, 2006).

Question 2: Do apologies need to be documented? Providing the apology in writing can convey the seriousness of the apology and provides a written account of

Table 2. Characteristics of Full, Partial, and Failed Apologies.

Type of Apology	Provider Recognizes the Error?	Disclosure? Admit Fault? Statement of Error?	Express Sincere Regret and Mortification by the Practitioner?	Correct the Mistake?	Restore Relationship?
1)A. Full apology	Admit fault	Yes, expression of regret or sorrow	Yes, honest respectful listening	Yes	Restitution
2)B. Token apology					
• By proxy	No	Disclosure, no involvement from provider	No	Yes	No
• With excuse	Yes, no responsibility	No	No	Sometimes	No
• Victim blaming	Yes, no responsibility	Disclosure, but no admission of fault	No	Sometimes	No
• Forced	No	Yes, but forced	No	Yes	No
3)C. Failed apology					
• Expression of regret	Yes	Yes: no fault statement of error	Regret without mortification	Yes	Forced restitution
• Disclosure, no apology	May or may not	Yes	None	Yes	Forced restitution
4)D. No apology	No	No	No	No	No

what happened (Armstrong, 2009). However, written apologies do not replace personal verbal apologies (Weiss, 2006).

Question 3: Can the patient–provider relationship be repaired? Relationships were saved with quick disclosure, responsibility, and genuine apologies (Micalizzi & Bismark, 2012). Communication becomes the crucial step in the continued relationship with follow-up and support as patients come to terms with the outcome of the error (Duclos et al., 2005; Iedema et al., 2008; Micalizzi & Bismark, 2012).

Development of the Apology Model

From the above, the characteristics of a full apology were identified, and when components of the full apology were not present, characteristics of partial and failed apologies were documented. These are shown in Table 2. A flow chart illustrating the pathways for each type of apology and their outcomes as they may occur in the hospital is shown in Figure 2.

Full Apology

A schematic representation of a full apology is shown on the top line of Figure 2 (A). Full apology occurs when the provider recognizes the incident or error and discloses, displaying “disclosure mortification.” The provider then must provide a full apology: (a) accept responsibility for the incident, (b) express sincere regret, and (c) promise to resolve the problem from reoccurring by doing everything to make a permanent change. These three components of an apology are incredibly important, allowing closure and healing to the

patient and family. Full apologies may also consist of reparation in some form to the patient or family. Receiving a full apology allows for a continued relationship between the patient and the provider. In this case, the desire for retaliation by the injured party diminishes, and there are often no legal ramifications. Thus, the institution and care provider have a decreased risk of litigation and can focus on any necessary policy and procedural changes to create a safe patient practice.

Timing is critical to the apology process, particularly when the patient and family are vulnerable and are trying to understand what has gone wrong in their care. There is a golden hour when disclosures should be provided, even though the provider may not have all of the information about the incident; an apology is never a one-time event. Apologies may need to be repeated, as information becomes known during the investigation process by the institution and the provider. This reiteration ensures ongoing communication and repair of the provider–patient relationship.

Token Apologies

Many times institutions find or recognize a medical error through a family complaint or during a routine audit. Yet, although an “apology” is provided to the patient and family, these apologies do not meet the criteria of a full apology:

1. *Apology by proxy* (Figure 2, B1): This is an apology offered by the institution (by, for instance, an administrator, rather than the care provider). This apology contains only some of the characteristics of a full apology: Although the patient may recognize that the error occurred and that the institution regrets the

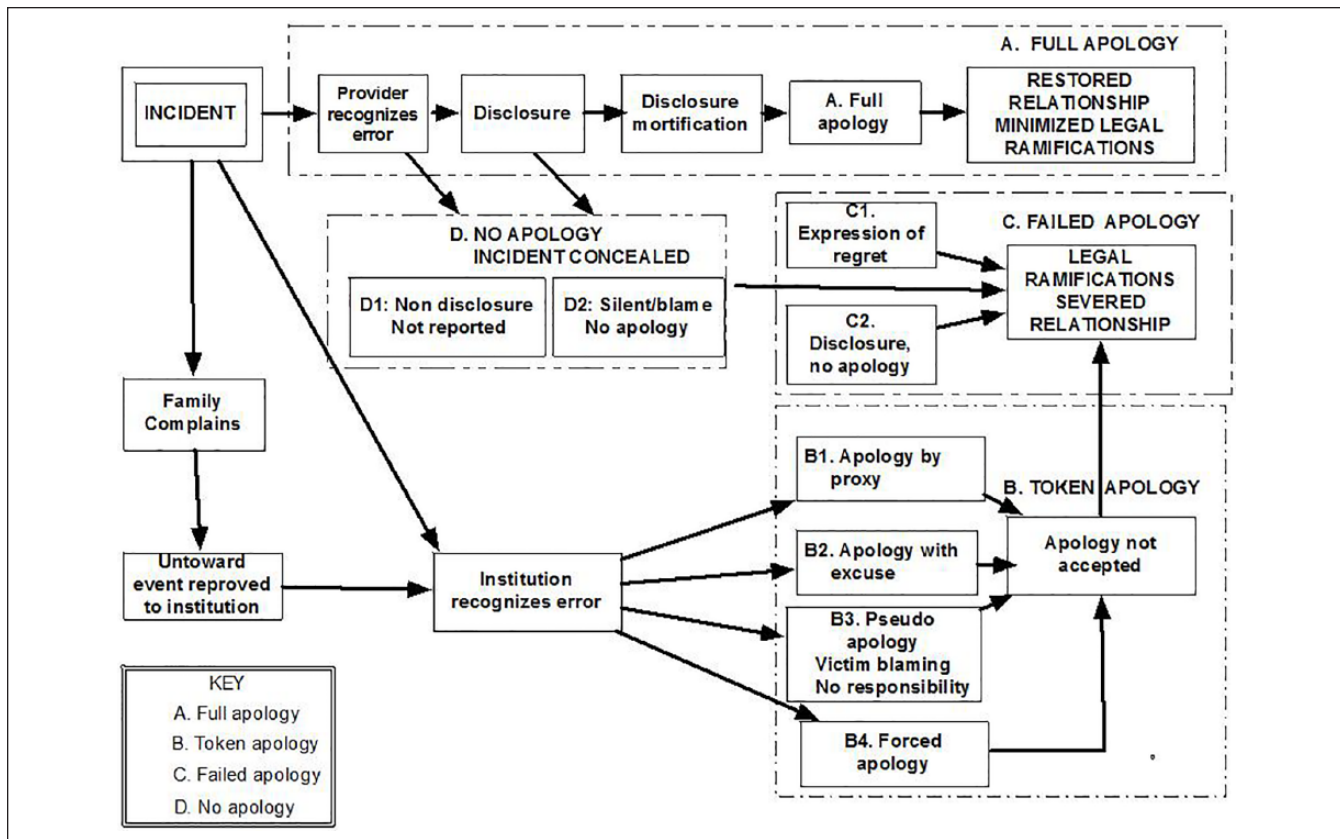


Figure 2. Model showing pathways and types of apologies.

incident, the patient does not “see” the provider’s expression of regret, disclosure of the error, or level of mortification. The injured party cannot be assured that change will occur and result in permanent change. The patient’s distrust and anger is not abated.

2. *Apology with excuse* (Figure 2, B2): In this case, the provider removes himself or herself from the responsibility of the error by blaming outside, untoward influences. An example might be, “I’m sorry a sponge was left inside during surgery. The nurse is responsible to count the sponges and the count wasn’t correct.” Again, the patient’s distrust and anger is not abated.
3. *Pseudo-apology* (Figure 2, B3): Pseudo-apologies lack responsibility for the error. Providers may blame the patient for the incident; for example, the victim may be blamed for being obese, being late for an appointment, or blamed for not seeking immediate medical care. The apology lacks acceptance of responsibility by the provider and deflects the blame onto the victim.
4. *Forced apology* (Figure 2, B4): Forced apologies occur when an institution enforces the responsible provider to offer an apology. The problem with this type of apology is that the provider again takes no

responsibility for the incident and shows no remorse for the incident, so the apology appears (and is) insincere.

All of these token apologies create or accelerate the patient’s feelings of betrayal, loss of trust, and increased anger. Token apologies lack responsibility by the provider, are not accepted by patients or their kin, and they may demand further action from the provider and the institution, thereby increasing legal ramifications.

Failed Apologies

Failed apologies are false apologies. Although the care provider or the institutional representative “goes through the motions” of apologizing, these apologies lack the essential attributes or characteristics of an apology:

1. *Expression of regret* (Figure 2, C1): When disclosure of a medical error is given without an apology, or an expression of regret is provided during disclosure without the full emotional weight of disclosure mortification, the “apology” is not accepted by the patients and their family. The provider may feel that he or she has actually apologized, simply by acknowledging the

incident. Nevertheless, a full apology has not been given, and legal ramifications are likely to follow.

2. *Disclosure with no apology* (Figure 2, C2): Sometimes the provider's error is acknowledged by the provider of the institution, without other components of a full apology. This is incredibly difficult because the victim is not allowed the emotional release of an apology. Anger increases with feelings of betrayal, and patients retaliate with legal ramifications. Relationships are rarely restored between the provider and patient.

Incidents Concealed

When the incident is concealed, the provider does not report the incident to the institution and does not disclose the error to the victim (Figure 2, D1). The provider may choose not to disclose because of feelings of humiliation or failure, and he or she fears legal ramifications. Such disclosure leads to so much guilt and fear should the incident be discovered that the provider is unable to disclose the medical error.

Many times a provider is silent (Figure 2, D2). With feelings of fear or loss of job, licensure, or legal ramifications, the response is silence, with the person justifying the incident to himself or herself and his or her conscience, or silently blaming others, and the event is not disclosed.

In these concealed instances, there is no apology, no revealing of the incident, and the incident is not disclosed beyond the care provider or the institution.

Discussion and Limitations

We found the use of apology in the medical, nursing, psychology, business, and sociology literature wide-ranging in the number of articles and treatment of the concept. This concept development, using pragmatic utility, largely focused on defining apology in the context of health care following a medical error. We recommend further qualitative investigation in defining other clinical providers' role, particularly nursing's role, in apology in health care.

In 2010, Fehr and Gelfand developed a 14-item scale exploring a three-component apology model consisting of items related to empathy, acknowledgment, and compensation, exploring undergraduate students' perceptions of a "good apology" and using college-related scenarios. However, Fehr and Gelfand's model misses some significant components identified here, such as responsibility, regret, and mortification. Although the approach could be used to assess health care providers' views on the identified components of a full apology, a valid questionnaire is yet to be developed.

The "five languages" of apology were identified by Chapman and Thomas (2006); they noted that individuals

have a particular apology language that must be expressed to receive forgiveness. However, the wrongdoer must understand and know the apology language of the individual for this to work. The authors suggest if the offender lacks a personal relationship with the victim, then all five components must be used in the apology. The five languages are to express regret, accept responsibility, make restitution, genuinely repent, and request forgiveness. These components provide a relative comparison with the proposed apology model, but they fail to recognize that levels of injury (hurt) may require various levels of mortification, restitution, and corrective action. Given this model was meant to repair marital relationships, the components have not been fully explored (Chapman & Thomas, 2006).

A conceptual model of medical errors as developed in this article provides uniformity in disclosure and apologies for all health care providers. The literature lacks information on how to disclose hospital-acquired conditions such as infections, and the extent of those incidents that should be disclosed. For instance, it is not discussed if apologies will be necessary in the future when a patient develops a hospital-acquired infection, an injury from a fall, or a pressure ulcer. Inherent in such events is the belief that falls or pressure ulcers, and even perhaps infections, are a "normal" part of illness and aging, and therefore no apology is required (Harris et al., 2015) or the changing opinion in the United States that such incidents are not accidents, but prevention is the responsibility of the caregiver.

Conclusion

It is time for all health care workers to realize our care may be fallible, that errors do occur, and with sincerity, apologize to the victim when an error occurs. Embracing a "Just Culture" by creating safe environments that support health care workers to come forward in a timely manner and report errors is a necessary part of the equation (ANA, 2010).

The importance of a full apology that addresses the characteristics of the incident and components of the concept should be incorporated into all health care provider education. Furthermore, institutions must embody a level of disclosure and full apology in all procedures and policies related to medical error. Staying connected to our patients, having honest discussions, and apologizing when things go wrong is an essential reparative step in providing excellent care.

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