

# Opinion

## Too Err Is Human: To Apologize Divine?

Since the Institute of Medicine's report on the staggering burden of iatrogenic illness was released in 1999, hospital medical staffs, multispecialty clinics and ambulatory surgical centers have implemented programs to reduce medical errors. In surgery, ophthalmologists have begun taking "time-outs" so that the correct operation on the correct eye is confirmed by all those present in the operating room.

**But what about the patient who is the victim of a medical error?** Most risk management experts, including those at OMIC (Ophthalmic Mutual Insurance Company), recommend immediate and full disclosure of the error, as soon as the patient is able to understand.<sup>1</sup> What is not as widely practiced is a heartfelt personal apology to the patient by the physician. An editorial by the chancellor of the University of Massachusetts Medical School, Aaron Lazare, MD, is well worth reading.<sup>2</sup> Considerable literature has now accumulated showing that, where it is practiced, disclosure of errors and an apology to the patient has actually reduced the number and cost of malpractice claims. According to Dr. Lazare, there are four parts to an effective apology: acknowledgement of the offense (who, what, where); an explanation of the circumstances bearing on the offense (why); an expression of remorse, shame, humility and a commitment not to repeat the offense; and finally reparation (which could include early scheduling for next appointment, cancellation of

the bill, etc.). Not all four parts need be present in every case for an apology to be effective, but an ineffective apology can usually be traced to omission of at least one part.

**How do apologies heal?** To understand this, it is helpful to examine how a patient feels when he or she learns of a medical error. They often express humiliation, "I was treated like I was on an assembly line," powerlessness, lack of validation of emotions, the feeling that they were somehow at fault, and, not surprisingly, concern that the same thing could happen to someone else. The longer those feelings fester, the more difficult they are to mitigate through apology. But a prompt and proper apology can make the patient feel cared about by the physician, whose self-humbling has leveled the emotional field between them. Showing a patient how their experience will lead to changes in procedure to avoid recurrence restores their sense of power. Validation of the reasonableness of the patient's feelings about the error is also helpful in reducing their amplitude.

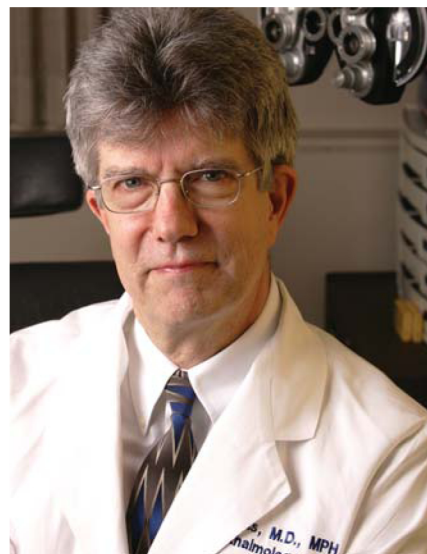
**Apologies need not be limited to medical error.** Patients feel better about having waited an excessive time for their appointment if a sincere apology is extended. And there are other circumstances with bad outcomes but no errors in which disclosure and empathy are called for—not an apology. Consoling comments, such as "I am so sorry for what happened" are usually appro-

priate but are not apologies, because there is neither an offense nor acknowledgement of one.

But, if apology is attempted, it must be done without fraudulence, insincerity or disingenuousness. If the patient detects any of those qualities, the healing effect of the apology is lost. Being a physician is all about healing, so apology as a clinical skill ought to be part of our therapeutic armamentarium. Most of us could use some practice at it. Maybe I'll start my practicing at home.

1 [www.omic.com/resources/risk\\_man/forms/medical\\_office/UnanticipatedOutcomes.rtf](http://www.omic.com/resources/risk_man/forms/medical_office/UnanticipatedOutcomes.rtf)

2 JAMA 2006;296:1401-1404.



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