

**IN A “SORRY” STATE: THE ETHICS OF INSTITUTIONAL APOLOGIES IN
RESPONSE TO MEDICAL ERRORS**

by

Autumn R. Boyer

B.A., Speech Communication, California Polytechnic State University, 2003

M.A., Communication & Rhetoric, University of Pittsburgh, 2005

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This thesis was presented

by

Autumn R. Boyer

It was defended on

March 12, 2009

and approved by

John Lyne, Professor of Communication, Center for Bioethics and Health Law

Mark Wicclair, Adjunct Professor of Medicine, Center for Bioethics and Health Law

and Professor of Philosophy, West Virginia University

Thesis Director: Lisa S. Parker, Associate Professor of Human Genetics,

Center for Bioethics and Health Law

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The rise in prominence of public apologies since the mid 1990s and increased awareness of the frequency and severity of medical errors in the United States has led to scholarly and professional interest in doctors’ apologies in response to medical error. Literature targeting health care professionals indicates a growing consensus about the ethical and professional imperatives for apology. However, it also exposes the authors’ difficulty in achieving conceptual clarity about apology and its application to modern clinical practice carried out by multiple providers within complex medical, legal, and insurance systems.

This project articulates the ethical underpinnings of apology and establishes ethically and professionally appropriate responses—both by clinicians and administrators of health care institutions—to medical error. Foundationally, this argument includes clarifying salient distinctions related to medical error and adverse events and conceptualizing apology as it is applicable to health care contexts. In sum, a policy or culture of responsibility—to which apology may instrumentally contribute—is ethically valuable and contributes to overall quality of care in contemporary health care institutions. The roles and responsibilities of clinicians and administrators within a culture of responsibility are discussed, in addition to the structure, applications, limitations, and ethical considerations of policies regarding apology.

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1.0 ERRORS, WRONGS, AND RESPONSIBILITY

It seems that every week another public figure, ranging from professional athletes to heads of state, offers a widely publicized apology. Psychiatrist and former medical school chancellor Aaron Lazare notes that, since the mid 1990s, the public prominence of apologies has been noticeably higher than in past generations.¹ This “apology phenomenon” has been of interest in lay and scholarly circles alike.² One realm where apologies have been widely discussed and remain controversial, despite the proliferation of political and public apologies in other realms, is in health care. The current discussions of apologies in medical literature, however, do not mean that doctors have not always had personal and professional concerns about the ethically and professionally appropriate way to respond to the realization that they have made a mistake. Adding fuel to the proverbial fire of the apology question, the Institute of Medicine’s 1999 report, *To Err is Human*, shocked the nation with its figures about the frequency and severity of medical errors occurring in the United States each year.³

While access to and quality of health care have been perennial issues in public, professional, and academic spheres, the specific focus on the role of apology in health care contexts has sharpened only in the early years of this millennium. There are likely multiple

¹ Aaron Lazare, *On Apology* (New York: Oxford University Press, 2004), 6-7.

² Lazare, *On Apology*, 7.

³ Nancy Berlinger, *After Harm: Medical Error and the Ethics of Forgiveness* (Baltimore: Johns Hopkins University Press, 2005), 11.

reasons for increased concern about professional responses to medical error. First, as Lazare indicates, Americans have become increasingly interested in and attentive to public apologies offered for a wide range of offenses. Second, Americans' attitudes about the relationship between patients and care providers has shifted away from a predominantly paternalistic "doctor knows best" mentality to a more cooperative care team approach in which the patient has the right to (and, prescriptively, should) participate in decisions about her health care. Attention to such rights is incompatible with the traditional "deny and defend" stance of hospitals and doctors toward adverse events, a stance that is falling out of favor with the increased advocacy of an acknowledge and apologize approach. Whereas it was once commonly accepted that disclosing a medical error and apologizing to the patient (or the patient's family) would render well-meaning doctors vulnerable to career-ending malpractice suits, today nearly 30 states have laws protecting physicians' empathic and apologetic expressions to patients, and a handful have passed legislation mandating disclosure of adverse events.⁴ Today, newspaper articles with titles such as "Hospitals Learn to Say Sorry"⁵ or "Doctors Say 'I'm Sorry' Before 'See You in Court,'"⁶ pieces in medical journals that advise physicians how to "Apologize Like a Pro,"⁷ and even a book about "the power of apology in medicine"⁸ are not rarities. While these publications indicate a growing consensus about the ethical and professional imperatives for apology, they also expose the difficulty in the field to achieve and maintain conceptual clarity about apology. Some apology advocates are unclear about how—or if—apology is distinguished from mere

⁴ Stacey Butterfield, "Apologize Like a Pro," *ACPHospitalist* (January 2008): 14.

⁵ Maura Lerner, "Hospitals Learn to Say Sorry," *Star Tribune* [Minneapolis-St. Paul, MN], March 29, 2008.

⁶ Kevin Sack, "Doctors Say 'I'm Sorry' Before 'See You in Court,'" *New York Times*, May 18, 2008.

⁷ Butterfield, "Apologize Like a Pro," 14.

⁸ Michael S. Woods, *Healing Words: The Power of Apology in Medicine* (Oak Park, IL: Doctors in Touch, 2004).

disclosure of errors and the expression of empathy; more ambiguity surrounds the types of circumstances that, according to the medical apology literature, warrant apology.

This thesis contributes to an examination of the apology proliferation in healthcare with the specific goals of articulating the ethical underpinnings of apology and conceptualizing ethically and professionally appropriate responses to instances of error, both by clinicians and administrators of health care institutions. This focus on not only clinicians but also administrators recognizes that modern medical practice does not take place in an isolated bubble inhabited by a lone doctor and her patient. Rather, a nexus of care providers, other professionals, and diverse employees contribute to patient care within complex medical, legal, and insurance systems. If we include apology as a possible ethical response under consideration (or, even, a response that is *preferable* to denial), we may also need to ask the same questions posed by sociologist Nicholas Tavuchis about apologies offered by collectives: “[H]ow is an apology formulated in this context and what does it signify? What does it, or can it, render when essentially inanimate, and therefore mute, social entities require human agents to speak on their behalf? Finally, can we speak of collective sorrow and regret in any sense other than metaphorically?”⁹ Armed with these concerns, I analyze the ethics of institutional apologies offered in response to instances of medical error.

The thesis is organized into four chapters. The first chapter addresses the topic of medical errors and differentiates among bad outcomes, adverse events, iatrogenic illness, mistakes, negligence, and breaches of standard of care. Additionally, this chapter discusses the practical and ethical distinctions between being wronged and being harmed, specifically with regard to health care contexts. The second chapter turns to the topic of apology, conceptualizing it along

⁹ Nicholas Tavuchis, *Mea Culpa: A Sociology of Apology and Reconciliation* (Stanford: Stanford University Press, 1991), 96.

the lines of its core definition, its appropriate contexts and goals, its requisite components, key participants in the social practice of apology, and the differences between apologies offered by individuals and those offered by institutions through a spokesperson. The third chapter lays out the reasons why a policy or culture of responsibility-taking is ethically valuable in contemporary health care institutions. I discuss the roles and responsibilities appropriately assigned to clinicians and administrators within a culture of responsibility and address the structure, applications, limitations, and ethical considerations of policies regarding apology. The concluding chapter addresses additional ethical rationales and considerations for apology within a culture of responsibility. Throughout the thesis, I use the case of the transplantation error at Duke University Medical Center that resulted in the death of Jessica Santillan and the subsequent responses by Duke and its physicians to illustrate and test the proposed theory of apology for medical error.

1.1 UNDERSTANDING MEDICAL ERROR

As a prerequisite to understanding ethical responses to medical error, we must be clear about what constitutes medical error and how to differentiate between such errors and other adverse events and bad outcomes in health care. Key terms defined and discussed in this chapter include the standard of care, bad outcomes, adverse events and adverse drug reactions, iatrogenic illness, medical error, sentinel events, and negligence. These concepts hold ethical as well as legal significance, so we must be clear about what types of events warrant the offering of apology.

In order to have any discussion about error, we must presuppose that a standard exists from which an error is some sort of deviation. The *standard of care* in medicine refers to

“performance expectations, structures, or processes that must be in place for an organization to provide safe and high quality care, treatment, and service.”¹⁰ This standard shifts as the best practices in medicine are continually tested and refined, and it is the physician’s responsibility to keep up with research developments in her field in order to assure that she is meeting the ever evolving standard of care. Care providers are professionally and morally obligated to provide services that meet or exceed the standard of care, which serves as a quality benchmark. However, the therapeutic obligation demands that clinicians adapt standards and guidelines to meet the particular needs of specific patients. With increased latitude for individual judgment comes increased moral and legal responsibility for avoiding errors and harms.¹¹ Additionally, a scarcity of resources—including technology—may confound clinicians’ efforts to perform according to best practices. Diagnostic and therapeutic technologies available in an urban, academic medical center may not be available in more rural or less affluent areas of the country. The abstract ideal of the standard of care must be understood within the context of care to which it is applied; the standard of care reflects the “performance expectations, structures, or processes” to which one has access.

An *adverse event* in medical care can occur whether or not an error has taken place. For example, a medication or treatment may cause an uncomfortable or harmful effect, even when applied correctly. The Institute of Medicine defines an adverse event, in part, as “an injury caused by medical management rather than the underlying condition of the patient.”¹² Adverse events may either be unexpected or may be consistent with known possible side effects or

¹⁰ Joint Commission on Accreditation of Healthcare Organizations, *Comprehensive Accreditation Manual For Hospitals: The Official Handbook* (Oakbrook Terrace, IL: Joint Commission, 2008), GL-22.

¹¹ Virginia A. Sharpe and Alan I. Faden, *Medical Harm: Historical, Conceptual, and Ethical Dimensions of Iatrogenic Illness* (Cambridge: Cambridge University Press, 1998), 106-7.

¹² Institute of Medicine, *To Err is Human: Building a Safer Health System* (Washington, D.C.: National Academy Press, 2000), 28.

reactions. Co-morbidity—known or unknown—may confound or complicate a course of treatment and result in adverse events. An allergic reaction to an unknown trigger, such as medication or latex, is an adverse event, as might be a hospital-acquired infection.

A subset of adverse events is the *adverse drug reaction* (ADR), defined as the “unintended, undesirable, or unexpected effects of prescribed medications or of medication errors” that result in any of the following consequences: the need to discontinue or modify the dose of a medication, the need to treat the patient with additional prescription medication, required hospitalization (or prolonged hospitalization), disability, cognitive deterioration or impairment, congenital anomalies, life-threatening illness, or death.¹³ Like the broader class of adverse events, ADRs are not necessarily the result of an error, though they may occur when insufficient attention is given to a patient’s documented allergies or the interaction of multiple drugs that the patient has been prescribed.

Obviously, adverse events result from less ethically benign incidents, as well. The Institute of Medicine defines “preventable adverse events” as those attributable to error.¹⁴ Bedsores, for example, result from inadequate implementation of known prevention methods like specialized bedding and routine physical movement and adjustment of a sedentary patient. Medical errors—discussed in more detail below—may result in an adverse event such as infection, impaired cognition, or other morbidity, although error may occur without an adverse event resulting.

A key feature of *medical error*, “the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim,”¹⁵ is that it is a deviation from the

¹³ Joint Commission, *Comprehensive Accreditation Manual*, GL-2.

¹⁴ Institute of Medicine, *To Err is Human*, 28.

¹⁵ Institute of Medicine, *To Err is Human*, 4.

standard of care and is, therefore, preventable. The definition given here from the Institute of Medicine accommodates both errors of execution and errors of planning, respectively. Virginia A. Sharpe and Alan I. Faden define a mistake as “an error in action, opinion, or judgment caused by poor reasoning, carelessness, or insufficient knowledge.”¹⁶ To call an action or inaction an “error” or a “mistake” is to maintain that a correct plan would be chosen by almost all others in the same situation (a statistically normal plan, not an idealized or *possible* plan) or that the proper skills and reasoning of execution would have been displayed by almost all others in that situation.¹⁷ Using these norms and standards of professional practice are helpful in thinking through error. In sum, error is a deviation from the processes and practices that constitute the standard of care.

However, the conceptualization of medical error includes several subcategories and definitional refinements. Sociologist Charles L. Bosk describes four categories of preventable individual errors: technical errors, judgmental errors, normative errors, and quasi-normative errors.¹⁸ Technical errors are those that arise from inadequate skill applied to the task at hand and are committed more commonly by inexperienced physicians than by those with more familiarity and practice with particular procedures; increased training and experience lead to a decrease in frequency of the commission of technical errors.¹⁹ Examples of technical errors may include injury caused by a wayward scope, repeated attempts to place an intravenous line, or an inadvertent slip of the scalpel during surgery. Judgmental errors are the incorrect choice of a treatment strategy and are made more often by those with discretionary power over patients’

¹⁶ Sharpe and Faden, *Medical Harm*, 137.

¹⁷ Edmund G. Howe, “How Should Ethics Consultants Respond When Careproviders Have Made or May Have Made a Mistake? Beware of Ethical Flypaper!” in *Margin of Error: The Ethics of Mistakes in the Practice of Medicine*, ed. Susan B. Rubin and Laurie Zoloth (Hagerstown, MD: University Publishing Group, 2000), 165-81.

¹⁸ Charles L. Bosk, *Forgive and Remember: Managing Medical Failure* (Chicago: University of Chicago Press, 1979), 37.

¹⁹ Bosk, *Forgive and Remember*, 37, 45.

care.²⁰ That a judgmental error has occurred tends to be determined in hindsight on the basis of the consequences: “Clinical results, not scientific reasoning, determine how correct judgment is.”²¹ Examples of judgmental error include failing to perform surgery when it is needed and prescribing the wrong medication to treat a specific disease. Like technical errors, judgmental errors can be decreased with additional training and experience and are not necessarily a sign that a physician is irredeemably incompetent. Normative errors and quasi-normative errors are breaches in role responsibilities within the hierarchy of institutionalized medicine and “signal error in assuming a role.”²² Normative errors include a subordinate’s failure to disclose a patient’s condition change to her attending physician or the hospital’s house staff quarreling with nurses and support staff. They are treated as moral and personal shortcomings rather than the inevitable errors of a conscientious physician.²³ Whereas normative errors are breaches in the role expectations that are *generally* held by attending physicians, quasi-normative errors are breaches in the expectations of a particular physician for her particular subordinates. Norms discussed in the language of “what is done on *my* service” or “the way *I* do things” indicate that the supervising physician expects the subordinate to follow specific instructions rather than exercise individual discretion or judgment about the “right” way to treat patients; a failure to abide by these individualized norms constitutes a quasi-normative error. Normative and quasi-normative errors do not necessarily risk harm to patients, but the commission of these errors undermines the reputation of the offender and diminishes the trust afforded to the offender by her superiors.²⁴ They result when clinicians fail to understand their limitations and fail to seek help

²⁰ Bosk, *Forgive and Remember*, 45.

²¹ Bosk, *Forgive and Remember*, 45.

²² Bosk, *Forgive and Remember*, 51, 55.

²³ Bosk, *Forgive and Remember*, 60.

²⁴ Bosk, *Forgive and Remember*, 61.

from others when needed—instead asserting self-sufficiency—at the possible expense of patient safety.²⁵

Physician Lucian L. Leape’s definitions of slips and mistakes map onto the categories of technical and judgmental errors described by Bosk, although the fit between the two sets of distinctions is not tight. “Slips” according to Leape, are skill-based, action errors when one commits a glitch in one’s automatic activity, usually because of distraction, fatigue, or interruption.²⁶ Examples of slips include charting patient notes in the wrong chart (perhaps after being distracted by a conversation about that patient) and ordering a typical or standard dosage of a medication that is an inappropriate dose for this particular patient (following an automatic behavior pattern). While, in effect, these slips share similarities with Bosk’s technical errors, Leape attributes slips to diminished attentiveness to familiar and routine tasks at hand rather than on an actor’s unfamiliarity or lack of experience with those tasks. By contrast, a “mistake” is a rule-based, knowledge error arising from faulty reasoning.²⁷ According to this definition, a mistake is the same as a judgmental error in Bosk’s schema. Mistakes include misinterpreting diagnostic information and misapplying a treatment “rule” to an inappropriate context. To contrast with the dosage slip above, a dosage mistake may be the result of conscious, but incorrect reasoning that the standard dose is the correct dose, as opposed to omitting the reasoning stage entirely.

Medical errors may or may or may not result in harm to the patient but typically have the potential for such harm. A medication dosing error may be caught before delivery to the patient, or the dosing error may not have an appreciable effect on the patient. Patient misidentification,

²⁵ Joel E. Frader, “Mistakes in Medicine: Personal and Moral Responses,” in Rubin and Zoloth, *Margin of Error*, 121.

²⁶ Lucian L. Leape, “Error in Medicine,” in Rubin and Zoloth, *Margin of Error*, 100.

²⁷ Leape, “Error in Medicine,” 100.

wrong site surgery, misdiagnosis (in some cases, according to the diagnostic standard of care and professional practice standards), and administering a documented allergen to a patient are all instances of medical error, even if the error is detected and corrected before harm occurs.

When an adverse event or error is serious enough, it may warrant designation as a *sentinel event*, as defined by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO): a sentinel event is “an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase ‘or the risk thereof’ includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.”²⁸ Sentinel events are not necessarily the result of a medical error, and not all medical errors lead to a sentinel event; still, the term “sentinel” indicates that these types of events are deemed to require immediate attention and response.²⁹ JCAHO asks accredited healthcare organizations to voluntarily report sentinel events so that JCAHO may review them. JCAHO also recommends that the institutional response to sentinel events should include “conducting a timely, thorough, and credible root cause analysis [focusing on systems and processes rather than individuals³⁰]; developing an action plan designed to implement improvements to reduce risk; implementing the improvements; and monitoring the effectiveness of those improvements.”³¹

Adverse events, adverse drug reactions, and medical errors may also be categorized as iatrogenic illness—illness that finds its source in any or “all health care providers who are directly or indirectly responsible for the care of the patient.”³² Iatrogenic illness also includes

²⁸ Joint Commission, *Comprehensive Accreditation Manual*, SE-1, GL-22.

²⁹ Joint Commission, *Comprehensive Accreditation Manual*, SE-1.

³⁰ Joint Commission, *Comprehensive Accreditation Manual*, SE-2.

³¹ Joint Commission, *Comprehensive Accreditation Manual*, SE-1.

³² Sharpe and Faden, *Medical Harm*, 117.

nosocomial infection, which is “one that develops in a patient after admission to a hospital; the infection was neither present nor in the incubation stage at the time of the patient’s admission unless related to a previous hospitalization.”³³ Additionally, some iatrogenic illnesses, including nosocomial infections, may qualify as sentinel events according to the JCAHO standards.

Many adverse events may occur even when health care providers are following the standard of care: hospital-related infections occur even when hygiene and sanitation standards are met, adverse drug reactions sometimes occur because of a previously unknown intolerance for a particular medication, and some surgical interventions will result in heart failure and death. But some result from unintended errors and even from intentional or negligent action. In the medical context, *negligence* is a frequently discussed type of error, one that overlaps with some of the types of error identified by Leape and Bosk. Medical neglect is “the absence of minimal services or resources to meet basic needs” and includes the failure to provide a safe environment, adequate nutrition and hydration or appropriate medical care (except in instances where such interventions are refused), hygiene, or clothing.³⁴ Medical negligence may occur when the physician undertakes an inappropriate procedure, based on the physician’s or team’s skill (a normative error, according to Bosk) and other factors. Sharpe and Faden discuss four criteria that must be met in order for a care team to recommend appropriately a procedure. A failure to meet these criteria indicates the inappropriateness of an intervention: “If an intervention is inconsistent with the patient’s clinical presentation or if the physician or team is insufficiently skilled to carry out the intervention (e.g., has a high complication rate), then the intervention is *de facto* inappropriate and should not be recommended,” regardless of the procedure’s normal

³³ Proceedings of the International Conference on Nosocomial Infections, August 3-6, 1970 (Atlanta: Center for Disease Control, 1971), 42. Qtd in Sharpe and Faden, *Medical Harm*, 158.

³⁴ Joint Commission, *Comprehensive Accreditation Manual*, GL-14.

benefit/harm ratio or the quality of evidence about the efficacy of the procedure.³⁵ In a case where the patient's condition does not indicate a particular treatment or where the physician is unqualified to perform the intervention and does so anyway, there is a clear breach of the standard to provide safe, high quality care to the patient.

Since the standard of care is not met in cases of negligence, health care providers in these cases may be guilty of malpractice and face legal sanctions. Malpractice—legal liability for the harms caused by alleged negligence—can be determined if all of the following criteria are met: (1) the provider has a duty (standard of care) in this particular situation; (2) the provider breaches that duty; (3) the affected party suffers harm (physical and/or “pain and suffering”); and (4) the harm was caused by the breach of standard of care.³⁶ The process of legally finding malpractice and awarding compensation “depends upon the identification of an individual agent who, in failing to abide by established standards, caused harm to a patient.”³⁷ Without the identification of this individual, malpractice cannot be determined.

Commentators have identified several reasons why the medical malpractice system is by itself ineffective for reducing instances of medical error.³⁸ First, medical malpractice is only concerned with instances of demonstrable harm to a patient in which the patient or her surrogates respond with legal action; it does nothing to assess or prevent medical errors that do not directly harm patients. Yet, many scholars claim that most errors do not result in harm to patients, and thus the malpractice system would fail to address the majority of errors.³⁹ Second, the punitive focus of malpractice proceedings serves as a disincentive for health care providers to voluntarily

³⁵ Sharpe and Faden, *Medical Harm*, 215.

³⁶ Frader, “Mistakes in Medicine,” 120.

³⁷ Virginia A. Sharpe, “Taking Responsibility for Medical Mistakes,” in Rubin and Zoloth, *Margin of Error*, 187.

³⁸ Sharpe, “Taking Responsibility,” 187-8.

³⁹ Sharpe, “Taking Responsibility,” 187.

report their own medical errors, near-misses, and adverse events associated with mistakes. Third, malpractice settlements require an identifiable party who is responsible for the error (and who will pay the awarded compensation); this requirement disregards the system-level problems that play a role in many mistakes. Some negligence may indeed be committed by “bad apples” who are incompetent or dismissive of the standard of care, but more often a combination of factors leads to a breach in the standard of care for which the end-point clinician is not solely responsible.⁴⁰

In light of the variety of actions and conditions that have the potential to lead to adverse events, it is critical to determine the conditions under which actions or inaction are truly errors. It bears repeating that not all adverse events are the result of preventable errors and not all errors lead to adverse events. Sharpe notes that designation of an action as a mistake or error depends on how the action squares with the obligation of due care:

Harms associated with recklessness, incompetence, or negligent incapacitation (such as when the practitioner is inebriated) are not genuine ‘mistakes,’ since they do not result from error *per se*, but from a disregard for due care itself. When a mistake in reasoning, judgment, or action does involve erring from standards of due care, however, it is a genuine *error* and, as such, is presumed to have occurred within a context of good faith.⁴¹

According to this rationale, the practitioner may be blameworthy both for actions—or failures to act—in disregard of the (legal) duty to care, and for true errors that occur while attempting to meet the (medical) standard of care within the context of due care. The practitioner is morally blameworthy for harmful actions if she has acted without due regard for the standard of care;

⁴⁰ Sharpe, “Taking Responsibility,” 186.

⁴¹ Sharpe, “Taking Responsibility,” 184-5.

however, adverse events that are not the result of negligence or error are not blameworthy because there has been no breach of the duty to care.

Another factor in determining blameworthiness is the ever-rising standard of care. As medical knowledge deepens and technologies improve, the opportunities for successful medical intervention expand. The standard of care is elevated as medico-scientific progress provides more opportunities to treat more ailments successfully. A failure to implement medically beneficial knowledge and technology becomes a culpable error where previously the intervention may have been unknown, innovative, or experimental rather than standard. These improvements to medical care include preventive practices, such as performing a sponge count before closing a surgical site, which become part of the standard surgical checklist; a failure to perform the obligatory sponge count is now considered an error rather than an omission of a preventive double-check.⁴² Kenneth DeVille and Carl Elliott note that this phenomenon of the failure to implement preventive practices being viewed as error “may help explain why medical error has seemingly increased in the United States in the 20th century at the same time that medical professionals have almost certainly become better educated, more skillful, and more careful than their historical counterparts.”⁴³ The authors conclude that determining error, just like identifying disease, “continues to be an amalgam of physiological explanation and social definition.”⁴⁴ Consistent with this position is the acknowledgement that there are inherent limitations of scientific and clinical knowledge—whether we accept or deny the fact of medical uncertainty

⁴² Kenneth DeVille and Carl Elliott, “To Err Is Human: American Culture, History, and Medical Error,” in Rubin and Zoloth, *Margin of Error*, 32.

⁴³ DeVille and Elliott, “To Err is Human,” 32.

⁴⁴ DeVille and Elliott, “To Err is Human,” 33.

and subjectivity will affect our process of determining when a mistake has been made and whether a cause can be determined, let alone prevented.⁴⁵

1.2 OFFENSES, WRONGS, AND HARMS

In this thesis, the words ‘offense’ and ‘wrong’ are both used to describe instances where one’s rights have been violated by another or where another has neglected her obligations with regard to her treatment of the victim. In a broad sense, the term ‘offense’ can include both trivial and profound cases ranging across affronts to one’s senses, shock to one’s sensibilities, embarrassment, fear, and humiliation, and can also subsume what we would otherwise term ‘wrongs.’⁴⁶ In a narrower sense, an offense is differentiated from a wrong in part because an offense is contingent upon the subjective state of mind of a victim who *feels* wronged by someone else (regardless of whether the action was, in fact, inherently wrong or wrong under the circumstances), whereas a wrong describes a more objective determination of the violation of a right or obligation regardless of the victim’s perception.⁴⁷ I employ the broader sense of offense in this thesis, including wrongs and other minor affronts under the term ‘offense’ and reserving the term ‘wrong’ to account specifically for violations of one’s rights and violations of one’s obligations to meet a particular standard of conduct. A victim may or may not be aware of

⁴⁵ Frader, “Mistakes in Medicine,” 120-1. See, also, the summary of Eric Cassell’s argument laid out by Tod Chambers, “Framing Our Mistakes,” in Rubin and Zoloth, *Margin of Error*, 20-2.

⁴⁶ Joel Feinberg, *The Moral Limits of the Criminal Law*, vol. 2, *Offense to Others* (New York: Oxford University Press, 1985), 14-22.

⁴⁷ Feinberg writes, “Whereas ‘offense’ in the sense of the offense principle specifies an objective condition—the unpleasant mental state must be caused by conduct that really is wrongful—‘offense’ in the strict sense of ordinary language specifies a subjective condition—the offending act must be taken by the offended person to wrong him whether in fact it does or not. In the strict and narrow sense, I am offended (or ‘take offense’) when (a) I suffer a disliked state, and (b) I attribute that state to the wrongful conduct of another, and (c) I *resent* the other for his role in causing me to be in the state.” *Offense to Others*, 2.

having been wronged (e.g. asleep or unconscious while one's privacy is violated), but nonetheless some legal, professional, medical, or ethical principle or standard was violated. The wrongs on which I focus in this thesis are failures to adhere to the standard of care and the failure, therefore, to fulfill therapeutic obligations to patients.

Harm, by contrast, is the "thwarting, setting back, or defeating of an interest" that leaves that interest "in a worse condition than it would otherwise have been in had the invasion not occurred at all."⁴⁸ Harms may be physical, psychological, economic or other injury to one or one's interests, which may or may not result from the breach of a norm. All relevant norms may be met in a particular instance, and harm may still result. For example, a patient may consent to surgery, fully understanding that some of her interests (say, freedom from acute physical pain) will be harmed as a result. In such a case, however, there would be no wrong precisely because all relevant norms, including informed consent, are satisfied. Evidence of harm may be immediately appreciable or latent, meaning the victim herself may not be fully aware of the damage for some period of time. Moreover, one may be harmed without one ever recognizing or appreciating that one is harmed, as in the case where one's interests are harmed without one's knowledge. Harm to one's surviving interests, such as an executor's failure to honor the terms laid forth in another's will, are a clear instance where the victim cannot appreciate the harms suffered to her interests.

Harm may result from a wrong, or it may result from an accident where no one is to blame. I may stub my toe while walking up the stairs and suffer physical harm. I may even be afraid of ascending stairs in the future due to the psychological effects of the incident. However, no wrong was committed against me—I was simply clumsy. Moreover, harm may be the result

⁴⁸ Joel Feinberg, *The Moral Limits of the Criminal Law*, vol. 1, *Harm to Others* (New York: Oxford University Press, 1984), 33-4.

of action that meets all relevant standards. Harm may simply be a bad outcome when everything that should and could be done was done, and was done correctly.

With regard to medical error, as has been discussed, not every error or wrong results in harm to the patient. Some errors are detected and corrected before they reach the patient, or the error may fail to cause the damage it has the potential to. Likewise, not all harm is due to error. There are inherent risks associated with most forms of medical care, including diagnostic procedures, even when the standard of care is met. The standard of care serves as a benchmark for ethical and legal evaluations of medical practice and can help distinguish the occasions where legal and/or moral culpability is appropriately assigned. When a medical team meets or exceeds the standard of care, and yet the patient suffers some harm (e.g., progression of her aggressive cancer despite appropriate interventions), the team is morally and legally blameless for that bad outcome or, in this case, the harm she suffers from the progression of her illness. By contrast, a caregiver could meet the medical standard of care but fail to demonstrate appropriate respect for her patient throughout the course of treatment. Even if no harm is evident, we may still fault the caregiver for breaching her ethical duty—if not her medical duty—to her patient. Given that people have interests in not being wronged and, in this case, being treated respectfully, we can conclude that all instances of wrong at least harm a person in the sense of harming the person's interest in not being wronged, in this case, the patient's interest in being treated with respect. Even if no physical or psychological harm is done by the caregiver's breach of the duty to respect her patient, the patient's interests are harmed.

Consider another example of these interrelated concepts. If a physician breaches her duty to care and fails to meet the standard of care, we can say that she has acted wrongfully and find her blameworthy according to ethical and professional standards. If that failure of her duty also

results in compensable harm to the patient, she would also be liable—by legal standards—for negligence and, thus, malpractice. Ethical culpability and legal culpability do not adhere to all the same criteria, but the standard of care in the medical arena clearly carries implications for both.

1.3 INDIVIDUAL AND INSTITUTIONAL RESPONSIBILITY

DeVille and Elliott write, “How one explains particular instances of misfortune will inevitably be tied to one’s judgment of the socially relevant facts, which are in turn dependent on one’s understanding of the way the universe works. [...] It reveals notions about blame and responsibility, about what might have happened but did not, about the gap between what was expected and what was done.”⁴⁹ Indeed, parsing individual and institutional responsibilities for error—and even the designation of an action or event as an error in the first place—reveals our assumptions of how we think things ought to be.

In contrast to the small-town house-calling doctors of yore, in contemporary medical contexts, myriad individuals, institutions, and systems cooperate and compete to deliver health care. Within this interdependent network of individuals and institutions, assigning responsibility for errors and error prevention becomes a tricky task. In these institutions, no person’s roles and responsibilities are wholly independent of others’. Every member of a health care institution has an effect on others within the institutional structure and culture. Policy decisions made by administrators must be implemented accurately and consistently by others at myriad levels of the

⁴⁹ DeVille and Elliott, “To Err Is Human,” 26.

institutional structure and at multiple points in clinical practice. Likewise, the aggregated actions of individuals can draw attention to the effectiveness or ineffectiveness of the policies of the various systems, to which administrators respond with reinforcement or revision of those policies.

Within healthcare institutions, patient care is affected by individuals at all levels: physicians, nurses, unit secretaries, technicians, pharmacists, orderlies, janitors, and other support staff.⁵⁰ Individuals are responsible to follow protocols and policies applicable to their roles within the institution. Since healthcare is delivered through complicated coordination of dozens of services, vendors, and team members, there exists an interdependency of individuals to each other. As I will argue in the third chapter, institutions that operate with a culture of responsibility would encourage each individual within the system to be alert to prevent or detect their own commission of errors as well as those potentially or actually committed by others. Moreover, I shall argue, they must also be alert to conditions that may make such errors more likely.

Within the context of this interdependency, administrators of medical institutions are responsible for monitoring the internal activities of the institution and for ensuring that the policies and practices of the institution are consistent with the standard of care. Additionally, administrators are responsible for the decisions regarding contracts for products, services, and personnel in order to meet the quality goals and fiscal needs of the institutions. Sharpe and Faden describe institutional responsibility as follows:

An institutional commitment to providing technical and policy support is essential to these efforts [to eliminate system-related sources of risk in the processes of

⁵⁰ Sharpe and Faden, *Medical Harm*, 111.

care]. This will involve sophisticated analyses of the processes of care, mechanisms such as provider benchmarking and feedback on adverse events, computerized surveillance of adverse drug reactions, medication error review, and nosocomial infection control.⁵¹

The institution's responsibility to provide safe, high quality patient care as well as a safe environment for employees, contractors, and visitors means that it must be attentive to the ways in which its initiatives support or stymie the efforts of individual clinicians and support staff to pursue their employment responsibilities in an efficient, effective, and safe manner.

This discussion has already gestured to the argument that common medical errors often occur as a result of both institutional and individual factors. Sharpe and Faden note, "Recent research reveals that system failure and poor system or job design contribute significantly to harmful error by providing the conditions under which error will thrive."⁵² Following a "systems theory of causation," institutions may allow or perpetuate error through the *processes* in place: unnecessary variation or complexity in procedures, flawed and inadequate communication channels and practices, inadequate training, and tasks or work schedules designed without regard for inherent human limitations.⁵³ Medication errors are common in health care; an institution's role in medication error may be its failure to implement a system for recording and tracking patient allergies, as well as each specific dose that is administered to a patient, and requiring physicians and pharmacists to confirm their performance of double-checks. In this, as well as with regard to other aspects of patient care, it is clear that institutional design and leadership shape the work environment of the individuals on the front lines.

⁵¹ Sharpe and Faden, *Medical Harm*, 111.

⁵² Sharpe and Faden, *Medical Harm*, 138.

⁵³ Sharpe and Faden, *Medical Harm*, 188.

At the same time, however, institutions can maintain unenforceable or prohibitively complex policies that, by virtue of their ineffectiveness, jeopardize patient safety and the quality of care at that institution. If the recommended practices are considered too complex or onerous by the individuals who must implement them, it is likely that individuals will find convenient work-arounds (“cutting corners”) in order to accomplish tasks more easily and quickly. Of course, these work-around practices frustrate an institution’s efforts to ensure safety and quality of care at the same time that the policies on the books can frustrate those who are affected by them. Additionally, the administration can foster a climate of defensiveness and secrecy with respect to errors and adverse events, thus decreasing the opportunities for the responsible individuals and those with whom they work to learn from the experience and improve the quality of the care they offer. With regard to medical error, any root cause analysis or ascription of blame needs to look beyond the “end” person to examine how interdependencies and systems features contributed to or failed to prevent human error farther down the line.

1.4 JUSTIFICATION AND EXCUSE

When discussing issues of error and culpability, one must also consider what constitutes a justification or an excuse. Both justifications and excuses are offered in an attempt to establish one’s blamelessness for particular actions, but there are significant distinctions between the two. When one offers a justification for one’s actions, one accepts responsibility for the actions (or failure to act) but claims that those actions (or omissions) “were defensible or permissible on the

basis of some countervailing demand or obligation.”⁵⁴ Moreover, from a legal perspective—or, by analogy, an ethical perspective—a justified act is one where “what is done is regarded as something which the law [or ethics] does not condemn, or even welcomes.”⁵⁵ For example, a full waiting room of patients seeking care in an emergency department will be triaged based on the severity of their condition. Some, whose conditions are not as critical as others’, may endure a longer wait before they are seen by physicians, but this would be justified by the principle of attending to the sickest patients first—a principle that has utility in the face of the limitations of the staff and resources to attend to all those who seek care and that is generally lauded as the appropriate approach to emergency medicine.

By contrast, those who seek to excuse their actions or omissions admit that the behavior was wrong but seek to shift or deny non-causal responsibility (or culpability) for their action or inaction. In other words, to offer an excuse is to admit that the action “wasn’t a good thing to have done, but to argue that it is not quite fair or correct to say *boldly* ‘X did A.’”⁵⁶ The nature of the actor’s behavior may then be explained with some excusing condition. Legal philosopher H. L. A. Hart identifies the psychological state of the accused as the locus of excusing conditions, typically including “those forms of lack of knowledge which make action unintentional: lack of muscular control which makes it involuntary, subjection to gross forms of coercion by threats, and types of mental abnormality, which are believed to render the agent incapable of choice or of carrying out what he has chosen to do.”⁵⁷ The accused may also point to particular features of the action or circumstances surrounding it that serve as mitigating factors that should both excuse

⁵⁴ Sharpe, “Taking Responsibility,” 184.

⁵⁵ H. L. A. Hart, *Punishment and Responsibility: Essays in the Philosophy of Law* (Oxford: Clarendon Press, 1968), 13.

⁵⁶ J. L. Austin, “A Plea for Excuses: The Presidential Address,” *Proceedings of the Aristotelian Society* 57 (1956-1957): 2.

⁵⁷ Hart, *Punishment and Responsibility*, 14.

the act and absolve the agent of responsibility in this situation.⁵⁸ For example, one may claim that one is excused because one was never advised about the proper protocol to follow. In this case, ignorance is proffered as the mitigating circumstance that excuses one's dangerous or dissatisfactory performance.⁵⁹ Similarly, a surgeon's hand may be temporarily unsteady when she unexpectedly hiccups, and we would not find her to blame for negligence or other wrongdoing.

Justifications and excuses are appropriately offered and accepted if—and only if—we accept the underlying reasons given in support of their claim. That is, if the competing principle or demand offered in justification is considered to be relevant and sufficiently weighty to pose a legitimate conflict among putatively right actions, we will accept the justification and consider the agent not to be blameworthy. Similarly, if we accept as legitimate and compelling the reasons offered as an excuse, we may exonerate the agent of any blame for their actions, or alternately, reduce the amount of blame that we attach to the partially excused agent.⁶⁰ By contrast, if the justifying or excusing conditions are not accepted as relevant, legitimate, or compelling, we will still assign responsibility—either partial or full—for the action or failure to act to the agent. In either case, the reasons offered as justifications and excuses may be a good place to look for opportunities to improve the conditions necessary to promote patient safety and prevent harms.

⁵⁸ Sharpe, "Taking Responsibility," 184.

⁵⁹ In cases of strict liability, even one's ignorance of the law or one's actions being in violation of the law (such as serving alcohol to intoxicated persons) does not excuse the accused from legal liability to punishment. Hart, *Punishment and Responsibility*, 20.

⁶⁰ Hart, *Punishment and Responsibility*, 14.

1.5 CASE EXAMPLE: JESICA SANTILLAN

A case of medical error that made international headlines in 2003 serves to illustrate many of the concepts discussed thus far and to prepare the reader to evaluate arguments discussed in later chapters. For this chapter's purposes, what follows is a description of the key events in this case in light of the concepts already discussed. In later chapters, I address the apologetic responses (or lack thereof) offered by the individuals and institutions involved and consider how a different ethical approach to the mistakes made might have resulted in different outcomes for the individuals and institutions as well as their witnesses in the community.

Jesica Santillan and her parents immigrated to North Carolina from Mexico in 1999 in search of treatment for Jesica's debilitating restrictive cardiomyopathy, a stiffening of the heart muscle that results in decreased blood flow and heart failure.⁶¹ On February 7, 2003, after 13 months on the transplant waiting list, 17-year-old Jesica received a potentially life-saving heart-lung transplant at Duke University Medical Center. However, the organs transplanted into her body were of an incompatible blood type: the donated organs were type A, and Jesica was type O. The resulting complications—organ rejection, a seizure, and heart attack—rendered her comatose. After several days, a heart and lung of Jesica's own blood type became available, and she received a second transplant on February 20, but her condition did not improve. Jesica Santillan was declared brain dead on February 22, fifteen days after the first, bungled, transplant.

How, at a leading academic medical center in the 21st century United States, could so simple and egregious an error have occurred? This example of a "simple" error of a blood type

⁶¹ Keith Wailoo, Julie Livingston, and Peter Guarnaccia, "Introduction: Chronicles of an Accidental Death," in *A Death Retold: Jesica Santillan, the Bungled Transplant, and Paradoxes of Medical Citizenship*, ed. Keith Wailoo, Julie Livingston, and Peter Guarnaccia (Chapel Hill: University of North Carolina Press, 2006), 2-3.

mismatch has a complicated back-story involving multiple organ procurement organizations, the recovery team, and the transplant surgeon.⁶²

When a pediatric donor's heart and lungs became available in Boston, the local organ procurement organization, New England Organ Bank (NEOB), ran a match list through the United Network for Organ Sharing (UNOS) and found no local patients awaiting transplantation who were suitable matches. Following the organ sharing protocol, the NEOB coordinator searched outside the area for other potential recipients and found two at Duke, the only potential recipients who seemed to be close enough in both physiological compatibility and geographic proximity to receive the organs. Neither of these potential donors was Jessica Santillan. The NEOB coordinator contacted Carolina Donor Services (CDS), whose coordinator called Duke's pediatric surgeon, Dr. Jagers, at home to offer the organs to a pediatric patient (Pt A) from the match list. Dr. Jagers said that Pt A was too sick to receive a transplant at the time but asked whether another of his patients (specifically, Jessica Santillan) might be able to have the organs instead. Since information on all of his patients was at the hospital, and Dr. Jagers was at home, particular details about Jessica Santillan could not be discussed immediately, but the CDS coordinator promised to check with NEOB. When CDS contacted NEOB about the suitability of the organs for Jessica, the NEOB coordinator said that Jessica was not on the match list but told the CDS coordinator to ask UNOS why. When the CDS coordinator contacted UNOS, he misspelled Jessica's name and erroneously indicated that her blood type was A (her blood type was O). The UNOS operator did not see Jessica as a match for the Boston donor's organs but found her on another waiting list. The operator and the CDS coordinator discussed the phenomenon of Jessica's absence from the match list but did not consider a blood type mismatch

⁶² The following sequence of events is taken from Richard I. Cook, "Hobson's Choices: Matching and Mismatching in Transplantation Work Processes," in Wailoo, Livingston, and Guarnaccia, *A Death Retold*, 64-65.

in their conversation. The CDS coordinator then called an adult cardiac surgeon at Duke to offer the organs for Pt B, the second match on the NEOB list, but the surgeon declined. The organs were then offered to Dr. Jagers for Jessica, and he accepted.

Time is a crucial factor in successful organ transplants. The less time the organs are deprived of a blood supply (ischemic time) between the donor body and their transplantation into the recipient, the healthier the organs are and the better their chance for successful transplantation. Surgery on heart transplant recipients is usually begun while the donor organs are in transit so that the recipient is on cardiopulmonary bypass by the time the donated organs arrive.⁶³ This was true in Jessica's case: while the recovery team traveled to Boston to remove the organs and collect laboratory data about the quality of the organs, Jessica's family was called to the hospital to begin the transplantation process. The recovery team discussed the laboratory findings about the organs with Dr. Jagers, who confirmed that he would accept the organs. The recovery team waited for 45 minutes for the chartered plane to be de-iced in Boston, and Jessica was placed on cardiopulmonary bypass in anticipation of the recovery team's arrival at Duke.

Upon their successful transport from Boston to Duke University, the organs were successfully grafted into Jessica, the heart began beating, and the surgical team closed her chest. Meanwhile, a technician running routine lab tests on the donor blood detected the blood type mismatch with the recipient and called the organ procurement coordinator. The coordinator called Dr. Jagers, still in the operating room, to tell him about the blood type incompatibility between the donor organs and the recipient.

Commenting on these events, Charles L. Bosk exhorts, "We should seek to understand how a system was designed so that a competent, well-intended individual was permitted or not

⁶³ Cook, "Hobson's Choices," 61.

prevented from making a mistake.”⁶⁴ While it would be much easier to point fingers at the transplant surgeon, we understand that many errors occurred through a combination of institutional and individual factors. With this in mind, I turn to analyze the errors that transpired over the course of this transplant process.

While follow-up on Dr. Jagers’ initial request to use the donated organs for a patient other than the specific patient named by CDS was premature in the standard order of organ matching, it is not strictly prohibited by UNOS procedures. Typically, an organ procurement organization (OPO) follows the UNOS “match list” (a rank-ordered list of potential recipients of donor organs) to find a suitable recipient. The match list includes only patient names and not specific details about the patients’ conditions that factor into their prioritization on the list. UNOS withholds this information in order to make the OPO dependent upon the UNOS system of equitable organ allocation rather than the rationales devised by transplant surgeons or OPO coordinators. In an alternative process called an “open offer,” an OPO offers a donated organ to a transplant center (rather than to a specific patient) and lets the center propose which patient it would best match. Due to the scarcity of information on the UNOS match list, the coordinators and doctors involved in open offers must deliberate about suitable matches between donor organs and potential recipients without the benefit of the same information available to UNOS.⁶⁵ In Jessica’s case, her pairing with the donor organs from Boston resulted from what might be considered a hybrid or cross between the match list procedures and an open offer; the organs were not initially offered openly to Duke, but the two surgeons in charge of the patients on the match list rejected the organs offered for those patients because of the physical condition of the potential recipients. Competition for scarce organs is great, so the attempt to make use of

⁶⁴ Charles L. Bosk, “All Things Twice,” in Wailoo, Livingston, and Guarnaccia, *A Death Retold*, 106.

⁶⁵ Cook, “Hobson’s Choices,” 62-3.

available organs led the coordinators and surgeons away from the match list to find another suitable recipient at the same institution. The system governing organ procurement and allocation is based on rules designed to control the flow of information about donors and recipients to prevent manipulation of the system and to ensure equitable distribution of scarce resources, but one consequence is that the system allows a small chance that blood mismatches could occur.⁶⁶ Thus, a “competent, well-intended individual” was permitted to factor significantly in a larger system breakdown.⁶⁷

Bosk categorizes the series of events as both a systems error and an individual error,⁶⁸ and I believe this assessment is correct. Although a double- or triple-check of the patient’s and organ’s blood types should have been performed prior to beginning surgery—a failure on the part of the surgeon—other individuals also erred. These include the individual CDS coordinator who erroneously spelled Jessica’s name and indicated her blood type as A during a conversation with UNOS about allocating the organs to Jessica instead a patient from the match list. However, Dr. Jagers is usually accorded the “individual” error rather than sharing the blame with the CDS coordinator. According to Richard I. Cook, “the UNOS operator and the CDS coordinator’s conversation led the CDS coordinator to believe that the UNOS operator had confirmed that the Boston organs were compatible with the Duke patient.”⁶⁹ This assumption was one of several that contributed to the dramatic error. Cook writes, “The accident occurred because a number of individually innocuous conditions combined to create the opportunity for the process of matching to lead not to a compatible match but to an incompatible one.”⁷⁰ In this case, the blood

⁶⁶ Cook, “Hobson’s Choices,” 67-8.

⁶⁷ Bosk, “All Things Twice,” 106.

⁶⁸ Bosk, “All Things Twice,” 114.

⁶⁹ Cook, “Hobson’s Choices,” 66.

⁷⁰ Cook, “Hobson’s Choices,” 63.

type mismatch had devastating results. The errors that contributed to this outcome, however, extended well beyond the operating room. This was a case of latent error—root causes with delayed effects—that set up the end-stage error committed by the individual or team.⁷¹ While the individual errors described here are easier to parse than the larger, systemic errors, there is greater long-term benefit to adopting a systems perspective toward error. Bosk writes, “In a systems perspective, error is not the result of individual negligence, incompetence, or momentary lapses: mistakes are viewed instead as a property of poorly designed systems that fail to anticipate sources of error and that fail to build in mechanisms for correction.”⁷² If imperfection is an inherent human feature, human systems must identify the opportunities for error and minimize the probability of its occurrence and resultant harm.

By categorizing the events in the Jesica Santillan case according to the key concepts discussed in this chapter, those abstract concepts can gain traction and, in turn, provide greater nuance to the issues in this controversial case. With regard to the standard of care, the off-list organ offer was not contrary to standard practice. However, the failure to check and double-check the patient’s critical details does constitute a breach of the standard of care. This breach occurred a number of times throughout the episode, starting with Dr. Jagers’s conversation from home with the CDS coordinator and continuing through the organ recovery and transplant procedures during which Dr. Jagers (and possibly others on his team) should have confirmed and reconfirmed compatibility details.

⁷¹ Lucian L. Leape discusses disasters such as Three Mile Island and Chernobyl that resulted from poor system design and organization. In these cases of latent error, the operator errors were either caused by the preexisting conditions or those dangerous conditions made operator errors irreversible and more devastating. See Lucian L. Leape, “Error in Medicine,” 102-103.

⁷² Bosk, “All Things Twice,” 105.

The adverse outcome of organ rejection also resulted in a swift deterioration of Jessica's health, which was not unexpected given the blood type incompatibility. This adverse outcome was the result of multiple types of error. There were errors in the process of "matching" the donated organs and in treatment decisions made on the basis of both faulty and unconfirmed information with inadequate checks and assumptions along the way, as well as likely normative errors caused by a doctor's and team's heightened emotional commitment to a sympathetic and locally publicized patient. The nature and result of these errors qualify them as sentinel events, as well: mismatched blood types, the need for additional medical care (including a second heart-lung transplant), and the hastening of the patient's death are all reportable events. The iatrogenic illness caused by the transplant error included total heart failure and coma, which required significant—yet ultimately futile—efforts to reverse the damage.

Negligence can be determined insofar as the standard practices were not pursued, constituting a breach of professional duty that resulted in unquestionable harm to the patient. Determining how the patient may have been wronged, however, is more difficult. I cannot determine that the patient was ethically wronged because her care team was acting with good intentions to benefit her and to minimize harm to her stemming from her underlying condition. I also cannot determine that respect for her personhood or autonomy was violated. Yet insofar as every patient is owed the duty of care, or care that meets the standard of care, Jessica was wronged in the breach of that duty. In this sense, every act of negligence—a breach of a standard of care owed—constitutes a wrong. One may argue that, had the individuals involved been more concerned about patient safety, they should have been more careful at every stage in the process. Perhaps it is more accurate to say, however, that the extreme desire of a well-intended set of

surgeons and organ procurement coordinators to benefit this particular patient resulted in neglect for the standard practices that could have prevented the error from occurring.

With regard to the deflection of blame through justification and excuse, I cannot see that there is any justification for the process errors that took place because no countervailing principle would override the obligation to ensure the most basic requirement of organ allocation: ensuring medical criteria-based compatibility. Furthermore, scarcity of organs and the risk of ischemia to available organs do not constitute sufficient “duress” to excuse the hasty actions and erroneous judgments in this case. If one is more concerned about implanting organs than properly matching organs to their recipients, the potential harm of error outweighs the potential benefit and does not excuse those involved from blame. There is no evidence of malicious intent in this case; I believe that the team was well-meaning and did not consciously prioritize either self (or institutional) interest or organ allocation over the safety of the patient. Rather, several individuals made erroneous assumptions about processes beyond their observation and acted within a system that allows for such errors to occur, however rarely.

In this chapter, I have laid out the key terms and concepts pertaining to medical error and the relative blameworthiness of various medical misadventures. I have also introduced the example of the organ transplantation case of Jessica Santillan and provided an analysis of the events leading to her death along the conceptual lines discussed in the chapter. In the next chapter, I turn to the multivalent phenomenon of apology to define and conceptualize it for application to the realm of medical error. Further analysis of the Santillan case reveals how the

institutions and individuals involved in the debacle responded in the wake of the errors described above.

2.0 THE COMPLEXITIES OF APOLOGIES

When confronted with the possibility of having committed an error or facing an allegation of wrongdoing, individuals and institutions may respond in a variety of ways. Offering justification and making excuses were discussed in the previous chapter as approaches that seek to absolve the agent of blame by arguing that the action was actually *right* under the circumstances (justification) or that mitigating circumstances shift or remove the blame from the agent (excuse). In this chapter, I discuss a response to an allegation of wrongdoing in which the speaker accepts responsibility: apology.

The term apology derives from the Greek *apologos*, or ‘story’, which serves as the root of one of the oldest recognized genres in rhetorical theory: *apologia*.⁷³ Dating back to Greek antiquity, *apologia* is characterized by speeches of self-defense. The most famous example from antiquity is arguably the *Apology* of Socrates, in which the condemned philosopher spoke on his own behalf to Athenian jurors in response to accusations that he had corrupted the youth of Athens and had shown disrespect to the gods.⁷⁴ Socrates’ speech was closer to expressing defiance rather than contrition; in this context, the “apology” differs from what we commonly recognize as an apology today. It was not until the late 16th century that the verb ‘to apologize’

⁷³ Nicholas Tavuchis, *Mea Culpa: A Sociology of Apology and Reconciliation* (Stanford: Stanford University Press, 1991), 15.

⁷⁴ Plato, “Socrates’ Defense (Apology)” in *The Collected Dialogues of Plato*, ed. Edith Hamilton and Huntington Cairns, trans. Hugh Tredennick (Princeton: Princeton University Press, 1961), 3-26.

was used, but still the definition linked it more closely with offering justification for one's actions rather than expressing guilt and remorse.⁷⁵ The application of the term 'apology' to a defense is still used, primarily in scholarly and religious contexts, but the common understandings and uses of the genre have evolved since its early instantiations.

The evolution of the term 'apology' is not the only source of confusion surrounding the concept. Scholars from the disciplines of philosophy, sociology, and psychology have written book-length treatments of the topic but do not reach consensus about the appropriate meanings, limitations, or even the essential elements of apology. This chapter lays out a working definition of apology, drawn from foundational works, in order to conceptualize apology within medical contexts as an ethically appropriate response to medical error. At key points, I return to the discussion of justification and excuse from the previous chapter in order to differentiate these responses to allegations of wrongdoing from apology as an ethically fitting response to medical error.

2.1 DEFINING APOLOGY

2.1.1 Constitutive Elements

Writers on the subject of apology offer varying definitions of this seemingly common phenomenon. These definitions indicate that apology is made up of components numbering from two (fundamentally, "the offender has to be sorry and has to say so"⁷⁶) to four⁷⁷ to as many as

⁷⁵ Tavuchis, *Mea Culpa*, 16.

⁷⁶ Tavuchis, *Mea Culpa*, 36.

eleven.⁷⁸ The definition I offer is derived from these models and is—I trust—sufficiently descriptive and simple to serve the purposes of this project. I propose that there are four necessary elements in a genuine apology: 1) acknowledgment that a wrong was committed; 2) acceptance of responsibility for one’s contribution to that wrong; 3) expression of remorse; 4) intent to benefit the victim through the offer of apology. Taken alone, each of these elements is insufficient to constitute an apology, but all are necessary for an apology. Furthermore, a genuine apology as I define it requires that the apology be offered directly to the person(s) wronged. As simple as this definition appears, there is much contained implicitly within each of its elements, and so I will elaborate on each of them before moving on to other considerations of apology. The criterion of who may receive and accept an apology will be discussed in greater detail in a later section.

First, the apologizer must acknowledge that a wrong occurred. Without disclosure of the wrong, there can be no apology. Necessarily, as a matter of actual interpersonal communicative process, this stage involves identifying the victim of the wrong (*To whom* is the apology addressed?) as well as coming to a shared understanding with the victim about the events that constitute the wrong (*For what* is the apology offered?). It may be that the victim and the offender do not initially agree upon the nature of the wrong allegedly committed and must negotiate a mutually acceptable interpretation of the incident. Although achieving a shared understanding of the wrong is not necessary for the apology offered to *be* a genuine apology—

⁷⁷ Aaron Lazare, *On Apology* (New York: Oxford University Press, 2004), 35. Lazare lists four parts to the apology process: “1) the acknowledgment of the offense; 2) the explanation; 3) various attitudes and behaviors including remorse, shame, humility, and sincerity; and 4) reparations.”

⁷⁸ Nick Smith, *I Was Wrong: The Meanings of Apologies* (New York: Cambridge University Press, 2008), 28-107. What Smith calls a “categorical apology” consists of eleven elements. I should note, however, that despite how much time Smith devotes to explicating the “categorical apology,” he says that he finds it more valuable to address the “forms” of apologetic meaning rather than worrying about the binary categorization of whether an expression “is” or “is not” an apology. Smith, *I Was Wrong*, 12.

i.e., to fulfill the conceptual and ethical requirements for an apology—achieving such a shared understanding is, I argue below, necessary for the apology to be successful.⁷⁹ Additionally, this stage implicitly acknowledges the norm that was breached and reaffirms the offender’s commitment to the norm as well as to viewing the victim as a moral equal.

Second, the apologizer must take responsibility for her part in the commission of the wrong. Specifically identifying one’s role in an offense indicates that one is not attempting to shirk responsibility or shift responsibility to another person. Rather, offering an honest and transparent account of one’s culpability demonstrates respect for the victim and continues the process of disclosure that must precede contrition. Again, as a practical matter of communicative process, in especially complex circumstances it may take days, weeks, or even years for all the facts of the case to be discovered; an accurate account of one’s responsibility in wrongdoing may be a work in progress while details of the case emerge.

Third, the apologizer must express remorse for her actions that constituted a breach of a norm. Psychologist Aaron Lazare defines remorse as “the deep, painful regret that is part of the guilt people experience when they have done something wrong.”⁸⁰ Without this sense of guilt and regret, there can be no apology in the genuine sense.⁸¹ Other attitudes related to remorse that might factor into an apology include shame, humility, and sincerity.⁸² While there is no practical

⁷⁹ If the victim fails to share the apologizer’s understanding of the wrong, she may not accept the apology because she will interpret it as being offered for the “wrong wrong.” See Section 2.1.3 for my analysis of genuine, successful, and accepted apologies. There, I explain that an apology need not be successful or accepted in order to *be* an apology, i.e., a genuine apology.

⁸⁰ Lazare, *On Apology*, 107.

⁸¹ Nick Smith terms this type of regret “categorical regret”—which he distinguishes from mere regret—defining categorical regret as “an offender’s recognition that her actions, which caused the harm at issue, constitute a moral failure.” This definition is more stringent than mere regret (wishing things were otherwise), which can be applied to the actions of others, unpleasant results of following the rules, natural disasters or other events for which the person expressing regret is not blameworthy. This definition for mere regret is closer to the sense of ‘sorry’ described later in this section than to the sense of remorse my definition requires, which is more akin to Smith’s categorical regret. Smith, *I Was Wrong*, 68.

⁸² Lazare, *On Apology*, 107, 114.

“sincerity test” to apply to an apology at the time it is given, expressing remorse implies that, at the time the apology is offered, the offender desires not to repeat the wrong or error. This implicit forbearance is not, however, a requirement that the apologizer must demonstrate or prove her intentions to prevent future offenses; it is only an indication that one would be justified in believing that the apologizer wants to behave differently in the future.

Fourth, the apologizer must intend to benefit the victim (i.e., improve her condition) through the offer of an apology. However, one’s intent to benefit another by apologizing does not require that the offender believe that any benefits *will* actually result from the apology, either immediately or eventually. An offender may believe, in fact, that nothing she says can undo the harm she caused or be a sufficient offering to her victim. Still, this criterion serves to guide the rhetorical and behavioral choices of the offender as she prepares to apologize to her victim, including the timing, location, content, and medium of the apology (if not face to face), in order to maximize the possibility of improving the victim’s condition. The criterion of benevolent intent also assures that our standards for a genuine apology do not allow one to discharge their ethical duty to apologize merely for their own satisfaction.

The interdependency of these four elements of apology becomes clearer after elaboration of their implied commitments. If a person believes her actions were regrettable but maintains that she should not have to take responsibility or be blamed for her behavior, her expression is an attempt to excuse her actions. She does not offer an apology because she does not accept responsibility for wrongdoing. Similarly, if a person admits responsibility for her behavior and argues that her actions were right, she is attempting to justify those actions rather than to apologize for them since one need not apologize for right actions. If someone admits a wrong occurred and is remorseful without acknowledging personal responsibility, the “apology” fails to

make a meaningful link between the apologizer and the victim. This expression is akin to an expression of sympathy or empathy rather than an apology because one can only apologize for one's own wrongs. In this case, too, remorse is a misnomer and is better termed regret or sadness. Additionally, a disclosure of wrongdoing and personal responsibility without demonstrating sincere remorse takes the legs out from under a would-be apology by leaving the discourse at the level of disclosure. Worse, it may be a sign that the offender is actually arrogant, defiant, or malicious rather than contrite and apologetic. Finally, without acting with the intent to benefit the victim through the offer of apology, an offender may compound the initial harm by acting insensitively in the process of trying to discharge her ethical duty to apologize. We would consider an apologizer who acts without regard for the feelings and other needs of her victim to lack both true remorse and appropriate humility.

In the above definition of apology, the reader will note that there is no requirement for the word 'sorry' to be included. Indeed, a genuine apology may be expressed with or without using the words 'sorry' or 'apologize.' One should also note, however, that use of 'sorry' does not necessarily indicate that an apology is being offered.⁸³ The word 'sorry' is also used to express empathy⁸⁴ ("I'm sorry for your loss; I know you really loved your dog."), to thinly veil resentment and hostility ("I'm sorry you're so touchy. Most people wouldn't be so easily offended!"), and to describe a poor condition ("After weeks of neglect, my yard was in a sorry

⁸³ Nick Smith notes that the "most significant words in an apology [are] 'I was wrong.' In the context of apologizing, these words express not only a cognitive error but also a moral lapse." Smith, *I Was Wrong*, 60.

⁸⁴ An example of an "empathic sorry" in the Jessica Santillan case example comes from Dr. Karen Frush, who determined along with another doctor that Jessica was brain dead following the second, unsuccessful transplant. According to her account: "I told them [Jessica's family] we were very sorry, but Jessica had died. They did say they did not believe that, but I had to tell them the truth. She was dead." Dr. Frush is never listed among those who bore any responsibility for Jessica's death. Her expression following the diagnosis of brain death is not an admission of responsibility for that death but, rather, empathy. Randal C. Archibold, "Focus Shifts to Decisions Made at End of Girl's Life," *New York Times*, February 24, 2003, late edition (East Coast), <http://proquest.umi.com/> (accessed October 7, 2003).

state.”). Each of these examples is obviously not an apology, though the second example may be an effort to avoid an apology by shifting blame to the interlocutor.

It will be helpful here to offer a paradigm case of an apology that fulfills the definition offered. The following apology, offered by the physician in charge of the patient’s care, may be appropriate following a non-life-threatening omission of a medication order for patient: “I was supposed to order your anti-nausea medicine to help you feel better, but I got distracted and forgot. I’m sorry I was not more attentive to your care.” The first sentence explains the wrong (forgetting to order the medicine) and explains who is responsible (the physician). The second sentence expresses remorse for the physician’s inattentiveness. Presumably, the physician intended the apology to benefit her patient by disclosing information about her condition and demonstrating respect for the patient. This apology satisfies our simple definition. In later sections of this chapter, however, I will consider what might also be said or done as part of this apology to further satisfy the patient’s psychological, physical, and material needs and expectations, as well as to allow additional expression from the physician beyond these minimum elements.

2.1.2 Goals of Apology

People may apologize in order to achieve various goals that may result from apologies. These goals may pertain to the offender, the victim, and others, but in any case point to the belief that apology can *do* something through its expression and reception.⁸⁵ Additionally, the apologizer

⁸⁵ In this way, an apology is an illocutionary act—a type of speech act. Just as the phrase ‘I do’, offered in the appropriate norm-governed setting can result in the marital union of two people, the phrase ‘I am sorry’ (or a similar expression of apology) can produce material results when offered under conditions satisfying the norms governing apologies. More full discussion of apology as a speech act is beyond the scope of this project, which is

may be responding to her own internal pressures, pressure from others, or some combination of the two when she decides to offer an apology.⁸⁶ The call for an apology, then, may come from the offender herself, the victim, or interested others who are privy to the wrongdoing.

First, the apologizer may be motivated to apologize to those whom she has wronged in order to relieve her own strong feelings. She may hope to expiate her shame for wrongdoing by confessing or coming clean to her victim and, thereby, maintain her own “moral house.” She may apologize out of personal or professional conviction that disclosing her wrongdoing and expressing remorse is the right thing to do. She may also apologize in order to seek forgiveness from her victim on the way to achieving her own personal peace or closure of the episode. Though these personal and internally motivated goals of apology may be sought, it does not follow that the apology itself must be insincere, unethical, or manipulative. We must simply remember that apology has effects on multiple parties and that various motivations to apologize may factor into a wrongdoer’s decision to offer an apology.

Second, an apologizer may be motivated to apologize in response to compelling or coercive external factors. Whether to avoid censure and punishment or to improve others’ opinions of oneself, the offender who apologizes primarily in response to pressure from others seeks to influence how the victim and others think about and act toward her. She may want to mitigate the damage to her reputation, avoid retaliation, or avoid the loss of social support.⁸⁷ For example, one’s continued employment may depend on her display of humility in the form of an apology to her superior. These externally initiated, self-oriented goals of apology may or may not correspond with the offender’s personal convictions; an “apology” offered *solely* in response to

focused on the ethical requirements of apology. See J. L. Austin, *How to Do Things with Words*, 2nd ed. (Cambridge: Harvard University Press, 1975).

⁸⁶ Lazare, *On Apology*, 134.

⁸⁷ Lazare, *On Apology*, 145.

external pressures does not fulfill the conceptual requirements of an apology, however. In the same way, an “apology” offered only as a means to achieve the apologizer’s personal goals of closure does not constitute a genuine apology. In both cases, the would-be apologizer lacks true remorse for her wrongdoing and does not specifically intend to benefit her victim. The next section will discuss in greater detail how remorse affects the ethical value of apology.

Third, apology may achieve or contribute to goals that pertain to the victim and/or witnesses to the offense and apology. These goals may not have personal value to the offender but she expects that they will be meaningful to the victim or witnesses. Apology demonstrates a respect for others, which may be important for the victim and witnesses to observe of the offender (especially presuming the demonstration of respect is authentic). Reestablishing or reaffirming the offender’s respect for the offended other, or others in general, may be a step toward the offender’s reentry or reacceptance into the social and cultural memberships shared by the offender and victim.⁸⁸ The act of apologizing can thus meet interpersonal and social goals of reaffirming and recommitting to the values shared among offender, victim, and their community.⁸⁹ Likewise, receiving an apology may provide some psychological relief for the victim who may have been afraid that her suffering was invisible or unimportant to others. The victim may feel safer or more secure in her interactions and relationship with the offender after receiving explicit confirmation that her offender recognizes previous wrongdoing and is remorseful.⁹⁰ Such psychological relief may contribute to the goal of allowing the victim the opportunity to move toward a sense of closure about the wrongdoing, even if such closure is not fully achieved until well after the apology is offered.

⁸⁸ Tavuchis, *Mea Culpa*, 22-3, 31. Additionally, Tavuchis refers to “apology’s fundamental tasks of reaccrediting membership and stabilizing precarious relations” following a transgression. Tavuchis, *Mea Culpa*, 20.

⁸⁹ Lazare, *On Apology*, 53.

⁹⁰ Lazare, *On Apology*, 59.

For the offender and the victim there is another possible goal for apology that deserves more sustained attention—namely, forgiveness. The issue of forgiveness factors prominently in discourse about apology, and though this thesis cannot give forgiveness the attention it merits, I will briefly address the relationship among apology, forgiveness, and—in the next subsection—the success of apology. Like apology, the concept of forgiveness is both foundational and complicated.

Sociologist Nicholas Tavuchis conceptualizes apology as the “middle term in a moral syllogism” that follows a call for apology and is followed by forgiveness.⁹¹ Although others may argue that forgiveness is not chronologically or conceptually tied to apology in this way,⁹² it is appropriate within this discussion of the goals of apology to consider the offer—or withholding—of forgiveness following an apology.

Forgiveness has ties to religious practices (such as confession, repentance, and atonement) that take place between individuals or between a person and God, notably within Judeo-Christian traditions. However, we can still understand forgiveness within a secular context as a “process by which the offended party or victim relinquishes grudges, feelings of hatred, bitterness, animosity, or resentment toward the offender. In addition, the person who forgives forgoes wishes and plans for retaliation, revenge, and claims for restitution.”⁹³ In this way, forgiveness is a letting go, a detachment from the justifiable feelings of bitterness or wishes for retaliation. Forgiveness may, additionally, involve the adoption of positive feelings, such as compassion or love, toward the

⁹¹ Tavuchis, *Mea Culpa*, 20.

⁹² Aaron Lazare considers four formulations of the relationship between apology and forgiveness: “1) forgiveness without apology; 2) no forgiveness regardless of the apology; 3) forgiveness that precedes apology; and 4) apology that precedes forgiveness.” Of these, numbers two and four are most relevant to the present discussion. Lazare, *On Apology*, 231-2.

⁹³ Lazare, *On Apology*, 230-1.

one who has caused her harm.⁹⁴ Like apology, the sentiments associated with forgiveness must be expressed voluntarily in order to support the moral weight of the gesture. As both an emotional and cognitive activity, offering forgiveness involves recognizing the wrongdoing for what it is and making a conscious choice to temper one's thoughts and actions in response to the wrongdoing.⁹⁵ To forgive does not mean to forget the wrongdoing—how would forgoing retaliation have meaning in such a case?—nor to pardon the offender, which is the purview of the law or other authority.⁹⁶

When one offers an apology, she offers simply a speech act, asking in return for something “exceptional and urgent: nothing less than forgiveness, redemption, and acceptance that serve to restore one's sense of reality and place in a moral order.”⁹⁷ The power to offer such redemption and acceptance through the act of forgiveness belongs to the victim, and the offender cannot demand forgiveness from her victim. A sincere apology may create the conditions necessary to allow the victim to detach from the wrongdoing through forgiveness of her offender, but forgiveness should not be expected as the “right” of the offender in exchange for an apology.⁹⁸ While wrongdoing serves as an occasion for apology, apology is not a sufficient condition for forgiveness to be offered.⁹⁹ Again, for forgiveness to be conceptually and morally meaningful, it must be offered voluntarily and in the spirit of restoring the offender and victim to wholeness.

Although forgiveness is a morally weighty process, it does not follow that it is an all or nothing phenomenon. A victim may still harbor distrust or some anger toward her offender

⁹⁴ Lazare, *On Apology*, 231.

⁹⁵ Lazare, *On Apology*, 231.

⁹⁶ Lazare, *On Apology*, 231.

⁹⁷ Tavuchis, *Mea Culpa*, 31.

⁹⁸ Nancy Berlinger, *After Harm: Medical Error and the Ethics of Forgiveness* (Baltimore: Johns Hopkins University Press, 2005), 109.

⁹⁹ Berlinger, *After Harm*, 110.

despite her detachment from retaliatory impulses. Moreover, she may have more positive feelings toward her offender following an apology and may forgive her offender without necessarily subjecting herself to possible future harm by the offender. The degree to which forgiveness is experienced or even possible may depend on the appropriateness and reception of the apology, how inclined the victim is towards forgiveness in general, and how traumatic or serious the offense was in the first place.¹⁰⁰

With regard to the goals of apology, it makes no sense to advocate apology in response to wrongdoing without also subscribing to the possibility and preference for forgiveness over retaliation.¹⁰¹ This is not to say that legal or other sanctions should not be sought in some cases of wrongdoing, only that it is ethically appropriate to teach and practice apology and forgiveness in tandem rather than to leave the “moral syllogism” unsatisfied.¹⁰² Indeed, many offenses may be most appropriately addressed through administration of legal redress in addition to the interpersonal dynamic of apology and forgiveness. However, a victim’s offer of forgiveness does not preclude the possibility that other authorities will pursue warranted sanctions through formal channels.

In summary, apology may be offered in pursuit of various goals that have particular implications for the offender, the victim, and the witnesses to the wrongdoing and/or apology. Achievement of these goals should not be considered dichotomously, but rather along a spectrum that allows for great and small shifts of attitude, behavior, and connectedness among individuals and groups. These shifts signal some degree of efficacy of apology, dependent on many variables, which should not be constrained by an unreasonable standard of perfection to be

¹⁰⁰ Lazare, *On Apology*, 231.

¹⁰¹ Tavuchis, *Mea Culpa*, 34.

¹⁰² Of course, some exceptional instances of wrongdoing may be so traumatic or serious that observers may *not* promote the offer of forgiveness, even as they advocate an apology from the wrongdoer.

interpersonally and socially valuable. The next section discusses in greater detail what it means to accept an apology and what makes an apology successful, but a non-polar approach to the effects of apology is worth introducing here and remembering throughout the forthcoming discussion.

2.1.3 Genuine, Accepted, and Successful Apologies

Considering the ambiguities of language and the range of responses to wrongdoing, we might take a moment to consider what constitutes a real or genuine apology. A genuine apology is one that meets the four-part definition described earlier and is offered—without coercion—in a spirit of sincere humility and remorse. Additionally, a genuine apology does not seek to cover up the offenses committed, soften the culpability of those responsible, nor disregard the suffering of the victim. The apologizer proceeds transparently and honestly. As indicated in a previous section, there is no clear sincerity test for apology that would indicate to a victim or witness that the offender is offering a genuine apology instead of one that refocuses attention from the offender as soon as possible. It may be that an apologizer's sincerity can be assessed more accurately in hindsight, given the presence or absence of evidence that the offender has knowingly committed similar offenses following the apology. Smith writes, “The ultimate meaning of apologies—like the meaning of promises—depends on future behavior and therefore we cannot conclusively judge them at the moment they are spoken.”¹⁰³ Some infraction in the distant future may not invalidate the past apology but may contribute to the context in which that apology is

¹⁰³ Smith, *I Was Wrong*, 81.

considered.¹⁰⁴ Still, because it is impossible to know the mental state of the apologizer, it is impossible to gauge empirically whether a speech act is a genuine apology, especially at the time the apology is offered. Fundamentally, though, we can consider a particular speech act to be an apology if it meets the four-part definition.

Following the call for an apology (by the offender, the victim, or others, as described in the previous section) and the apology itself, the “final term in this moral equation is the response of the injured party: whether to accept and release by forgiving, to refuse and reject the offender, or to acknowledge the apology while deferring a decision.”¹⁰⁵ Assessment of an apology’s *acceptance* is a more complicated matter than merely recognizing an apology as such. For a victim to accept an apology, she must first recognize it as an apology and then decide how to respond.¹⁰⁶ At the least, an explicit acceptance signals to the offender that the victim agrees with the stated parameters of the apology that has been offered (e.g., the enumeration of the wrongs/harms, the offender’s acceptance of responsibility, the identification of the recipient as a victim). Beyond this agreement, accepting an apology also indicates a positive shift—however slight—of the victim’s attitude toward the offender or about the offense. This shift may not necessarily amount to an offer of forgiveness (as described in Tavuchis’s formulation earlier in this paragraph), but an apology that is accepted accomplishes some change in the relationship or interactions between the interlocutors.

¹⁰⁴ Both Smith and Lazare offer the caveat that, in some apology situations, insincerity or other contradictions in the offender’s mental state do not *necessarily* invalidate the meaning that a victim can derive from an apology. Lazare, *On Apology*, 117-18; Smith, *I Was Wrong*, 24.

¹⁰⁵ Tavuchis, *Mea Culpa*, 23.

¹⁰⁶ While this description makes the process appear to be deliberate and rational, I suspect it is often subconscious and visceral. In many cases the recipient of the apology simply responds in whatever manner comes naturally to her at the time according to an extra-rational assessment of the apology, the offender, and how “struck” she is by the whole encounter.

As discussed in the previous section on the goals of apology, an apology's success at meeting those goals cannot be determined based on a dichotomous definition. Instead, success should be described along a continuum that appreciates subtle changes in interpersonal dynamics as a result of an apology. When an offender is readmitted into a social membership—even conditionally—following an apology for violating that community's norms or rules, the apology has achieved some success.¹⁰⁷ If a victim feels less resentment, vindictiveness, or ill will toward her offender following an apology that is presumed to be genuine, we may say that the apology was successful to some degree. When a victim responds to an apology by saying, "I accept your apology," she indicates that she recognizes the apology as such and has experience some positive shift in her perspective of the offender, however slight. The preceding apology in this case has been successful because it was accepted, whether or not forgiveness was granted.

The victim, as the recipient, is also the only one who can choose to accept or reject an apology from the offender or to offer forgiveness to the offender—no surrogate or witness can appropriately accept or reject an apology offered to another person. It may be the case that a victim prefers not to interact with her offender—including receiving an apology—or it may be that the person most wronged and harmed is physically incapable (e.g., is dead or unconscious) of receiving an apology. In the first case, an intermediary may be sought to pass along a message of apology, but this intermediary is not technically a recipient of the apology.¹⁰⁸ In the second case, an offender may seek out a family member who shares in the suffering of her loved one and direct her apology to the family member as a surrogate recipient. When wrongdoing causes the victim's death, an "apology" to the deceased cannot meet the standard of an exchange between

¹⁰⁷ However, the interpersonal goals of apology may still be unsatisfied if the victim herself does not accept the apology.

¹⁰⁸ A victim's desire to avoid further contact with her offender will be discussed in more detail in section 2.2: "What Warrants an Apology."

moral equals where the offender expresses remorse and the victim chooses to accept or reject the apology. However, one may appropriately apologize to the family members of the deceased for the specific wrongs committed against *them*—namely, the failure to fulfill one’s obligation to meet the standard of care and, therefore, the resultant death of their loved one. In such a case, the family’s interests, as well as the late victim’s interests, have been thwarted, and the offender ought to recognize and speak to the resultant harm.¹⁰⁹ Whereas justifications and excuses can be offered to a third party (e.g., to a witness, accuser, or adjudicator), as well as to the person who was allegedly harmed or wronged, apology is appropriately offered only to the victim(s) of the wrongdoing. Still, an offender should be mindful of the scope of her wrongdoing and the degree to which she has harmed multiple people as a result.

According to the above explanations, a genuine apology depends on the actions and sincerity of the apologizer, whereas an apology’s relative success depends on the mental state of and reception by the victim. Therefore, it is possible that one can offer a genuine apology that is also unsuccessful. There are many reasons why a victim may not be able to accept an apology the first time it is offered—or ever:¹¹⁰ the victim’s general disposition (or not) toward forgiveness, a history of abuse or exploitation of the victim (by the offender or more generally), the victim’s perception of the gravity of the harm, the victim’s belief that the offender does not fully appreciate and acknowledge the degree to which she has hurt the victim, the victim’s perception of the offender and/or the apology, and the victim’s fears of being too soft on her offender may all factor in to a victim’s rejection of an apology. It may take time for a victim to

¹⁰⁹ Joel Feinberg makes the connection between wrongdoing and harm: “One person *wrongs* another when his indefensible (unjustifiable and inexcusable) conduct violates the other’s right, and in all but certain very special cases such conduct will also invade the other’s interest and thus be harmful.” *The Moral Limits of the Criminal Law*, vol. 1, *Harm to Others* (New York: Oxford University Press, 1984), 34.

¹¹⁰ Aaron Lazare discusses the timing and negotiation of apologies—both in relation to the success and meanings of apologies—in two chapters of his book, *On Apology*.

be in an emotional and physical state where she can engage with her offender in the process of receiving an apology and accepting the apology. Still, to claim that an apology was genuine is to consider the offender's ethical duty to apologize as having been discharged, regardless of the apology's reception.

Conversely, an apology's recipient can have the impression that an apology is offered in good faith (a "genuine" apology)—and accept it—when, in fact, the apologizer bears some resentment about having to be forthright with the victim or otherwise fails to fulfill the four conditions of apology. An insincere apology may be accepted by the victim if the offender's deception is convincing, or if the victim cares more about the disclosure of information and display of humility than the offender's actual emotions or assumption of responsibility for the incident.¹¹¹ To the same end, "apologies, genuine or not, can be effective (or regarded as successful) when the offender is humiliated and the offended has their dignity restored."¹¹² Feigned contrition may be morally offensive or unsatisfactory, but "we are so disturbed by the lack of remorse [when others explicitly reject our norms], in fact, that we may find fraudulent expressions of remorse more acceptable than its absence, as if we are somehow comforted by believing that wrongdoers know the rules of society, even if they choose not to honor them."¹¹³ Even so, an insincere apology does not bear the moral value of a genuine apology regardless of the reception it receives.

Despite the counterarguments allowing for some degree of feigned contrition, an ethical account of apology must require genuine apology as the standard. Offering a would-be apology

¹¹¹ Lazare, *On Apology*, 117-18; Nick Smith also contends that the success of an apology—in terms of how satisfactory it is to the recipient—depends on what the recipient expects from the apology. Smith, *I Was Wrong*, 152.

¹¹² Lazare, *On Apology*, 225.

¹¹³ Lazare, *On Apology*, 113-14.

“begrudgingly, equivocally, or evasively can embrace or compound the initial wrongdoing rather than repudiate and correct it.”¹¹⁴ If one goal of apology is to reaffirm and restore moral order among persons, offering an ethically bankrupt “apology” flies in the face of this goal and, in fact, does not qualify as an apology at all. The genuine apology speaks not only to the mental state of the offender, but also to the approach the offender takes towards the moral worth of the victim. A genuine apology is an encounter between moral persons where there is explicit regard by the offender for the victim as a moral equal; this recognition of the victim’s moral worth can be demonstrated simply by acknowledging that the victim deserves an apology because the offender “recognizes the victim not as a mere obstacle to the offender’s self-interests but as a moral interlocutor who shares values with her.”¹¹⁵ An added benefit of genuine apology is that the victim has reason to trust that the offender’s sincere remorse will lead to self-motivated and, one hopes, successful efforts to reform.¹¹⁶ In the next section I will address how apologies called for by the victim or third parties relate to genuine apologies.

Clearly, the assessment of apologies is fraught with imperfect inferences and ambiguities. Still, in assessing what is required for a genuine and accepted apology, it is the victim’s perspective on the apology that is most important and relevant to its acceptance, due to apology’s nature as a remorseful response to the one who has been wronged. In the context of evaluating apology, reference to the expectations of a “reasonable person” is a useful device. The reasonable person standard facilitates the application of the four conceptual criteria for a genuine apology to actual situations. Inquiring about what a fictitious, normative “reasonable person” would expect or understand permits us to interpret what is meant by—and required of—

¹¹⁴ Smith, *I Was Wrong*, 11.

¹¹⁵ Smith, *I Was Wrong*, 60.

¹¹⁶ Smith, *I Was Wrong*, 60.

acknowledging wrongdoing, taking responsibility, feeling remorse, and intending to benefit the wronged party.

A wronged person has the right to be treated as a moral equal. Therefore, the offender must consider how to convey to the victim an ethical, genuine apology in such a way that the victim can recognize it as an apology and choose whether or not to accept it. Offenders offering an apology to their victims ought to consider what a reasonable person in their victim's position would want and need to hear in order to understand that they had received a genuine apology. The reasonable person standard is applied to other norm-governed contexts, such as disclosure for informed consent or discovery of a standard of care in tort law. In the informed consent process, for example, a physician is ethically required to address the information and concerns that any reasonable person in the patient's position would have regarding the risks and benefits of the proposed intervention. In this way, the reasonable person standard helps protect the patient both from the physician's potential paternalism or manipulation and from an inappropriately minimal degree of disclosure that might advantage the professional community. Instead, the patient receives disclosure judged appropriate according to a standard reflecting a patient perspective. The reasonable person standard provides a benchmark that is not idiosyncratic but attends to the dynamics of specific communication contexts. Like informed consent, apology takes place between moral equals who experience a disparity of power and information: the victim has suffered as a result of the offender's actions, and the offender has information about those actions. In the case of medical error, the power disparity between patient and provider compounds even further the imbalance of the offender/victim relationship. Given this imbalance, it is all the more important for an apologizer to address her victim as a moral equal and as a person with reasonable expectations for a genuine apology. By crafting an apology according to

a reasonable person standard, the offender accommodates the needs of the less powerful interlocutor in order to help mitigate the relational imbalance.

As witnesses and analyzers of apology, we may put ourselves in the position of the recipient to consider whether a given apology addresses the four components of the definition in a way that would satisfy our reasonable expectations and understandings of acknowledging wrongdoing, taking responsibility, expressing remorse, and intending to benefit the victim. As noted above with regard to future action, the reasonable person—once apologized to—would be justified in believing that the offender desires not to repeat the offense in the future, even if the offender does not provide proof of such reform. But “if the offender’s intentions do not correspond to the victim’s or the community’s expectations, this can seriously damage the significance of the apology.”¹¹⁷ For example, if the would-be-apology is laced with expressions that aim to excuse or justify the offender’s actions, the victim would have reason to believe that the offender is not, in fact, remorseful, and the recipient would not be able to regard the expression as a genuine apology according to the reasonable person standard nor be able to accept it.

Additional applications of the reasonable person standard help us to determine which speech acts may be eligible for analysis as apologies (whether or not we conclude that they *are* apologies). Use of the reasonable person standard also helps us to understand how and why people give accounts of an encounter as an apology *per se*, even though it fails to rise to the standard of an ethical apology. When examining apologies, we can make several distinctions with regard to conceptual, epistemological, and psychological perspectives. First, does it satisfy the four conceptual conditions for a genuine apology (as far as we can determine)? Second, was

¹¹⁷ Smith, *I Was Wrong*, 95-6.

the speech act recognized as an apology by the victim? Third, did the speech act result in the victim's change in attitude toward the offender (i.e., was the apology accepted? did the victim offer forgiveness or other favorable response)? As discussed earlier, even a non-genuine "apology" may be accepted as a true apology by a victim who is misled by her "apologizing" offender. Likewise, an offender may stammer through an explanation or an excuse and still explicitly be offered forgiveness by her victim, despite not having offered a genuine apology. Conversely, genuine apologies are not always accepted by their recipients. In other words, even a genuine apology may not be recognized *as* an apology, or it may be recognized as such but not be accepted or result in forgiveness or other changed psychological state on the part of the recipient. The reasonable person standard helps us to understand when one's ethical duty to apologize has been discharged, regardless of whether the victim recognizes or chooses to accept the apology.

Let us return for a moment to our paradigm apology. A reasonable person would surely recognize the physician's expression as an apology, particularly if it were delivered in a manner consistent with remorse (e.g., not blurted hastily while rushing by the room or offered in a sarcastic tone). Still, a reasonable patient may wonder what the remorseful physician plans to do about the missing medication, especially if she is still suffering. In a case like this, the physician's apology may be improved by a statement addressing the patient's concern: "I was supposed to order your anti-nausea medicine to help you feel better, but I got distracted and forgot. I've ordered the medicine now, and a nurse will be here in a minute to give it to you. I'm sorry I was not more attentive to your care." By stating what the physician has done to ameliorate the patient's suffering, she implicitly expresses that she understands the standard of care and is committed to providing high quality care to the patient, despite her previous lapse of

attention. Additionally, the physician may choose to offer an empathic statement to explicitly recognize how her failure has affected the patient by prolonging the patient's suffering. She may, for example, add: "I'm sorry I was not more attentive to your care and that you've been feeling crummy because you didn't get the medicine you needed." These additions to the apology may help witnesses (and the patient) more easily regard it as genuine and may also make the apology more palatable to the patient who is then more likely to be able to accept the apology. According to our definition of an ethical and genuine apology, as well as a reasonable person's expectations, these additional sentiments should be offered out of the apologizer's sincerity and not solely out of a selfish concern for avoiding negative repercussions.

2.2 WHAT WARRANTS AN APOLOGY

Blame for wrongdoing is appropriately attached to an agent in only some cases of alleged wrongdoing, as in other instances the agent's action or behavior may be justified or excused. The question that concerns us here is under what circumstances an agent may or must offer an apology following wrongdoing and under what circumstances an apology would be inappropriate. *A priori*, our definition of apology requires that a wrongdoing has occurred and that the apologizer is able to assume responsibility for some part, if not all, of that wrongdoing. With these prerequisites in mind, we must turn to the details that so often complicate accounts of apology.

As discussed earlier, sociologist Nicholas Tavuchis conceptualizes apology as the "middle term in a moral syllogism" that follows a call for apology and is followed by

forgiveness.¹¹⁸ Having already addressed the issue of forgiveness, let us focus on the “call.” For Tavuchis, this is a crucial step: “[U]ntil there is a mutually understood response to a call (emanating from the offender, offended, or interested third parties), there is no occasion for an apology, and the meaning of the act remains ambiguous or subject to other interpretations.”¹¹⁹ Before an apology can be offered there must be a precipitating event as well as recognition of the event as an offense to which apology may be an appropriate response. Furthermore, it may be neither the victim nor the offender who identifies the need for an apology, though we should expect that the offender will internalize the need for the apology by the time she offers it to the victim, according to the definition of a genuine apology.

This call, or recognition of the need for an apology, may develop on the basis of varying conditions. Specifically, deontological and consequentialist perspectives motivate people to apologize for different reasons. For example, “if we believe that apologies convey deontological meaning then we might desire them regardless of whether any living person or group feels personally wronged.”¹²⁰ By contrast, a consequentialist might require or advocate apology only in cases where the recipient or a witness can respond in such a way that makes the effort of apology worthwhile to the offender, for example by withholding retribution or penalties. If one’s apology seems to be offered primarily because one regrets or fears the consequences of getting caught or wants to earn the good favor of others—rather than because one feels remorse for the “inherent wrongness of an offense” itself—we would characterize the “apology” as non-genuine and criticize the offender as being selfishly rather than ethically motivated.¹²¹ In this thesis, I

¹¹⁸ Tavuchis, *Mea Culpa*, 20.

¹¹⁹ Tavuchis, *Mea Culpa*, 25.

¹²⁰ Smith, *I Was Wrong*, 221.

¹²¹ Smith, *I Was Wrong*, 56.

take a deontological perspective—though a moderate one—and this position deserves more explanation.

My claim that one has a duty to apologize in certain circumstances follows from the obligations not to wrong others that were discussed in the previous chapter, including honoring the rights of others and meeting one’s role-based obligations to meet particular standards of care or practice. When one violates or fails to uphold these obligations with respect to others, an apology may be warranted for partial or complete redress of the wrong committed. The duty to apologize is, therefore, consistent with the principle of restorative justice—righting the wrongs one commits.

To clarify this position, let me offer examples from the field of medicine. Clinicians have particular obligations stemming from their duty to care, which include meeting the standard of care in their treatment of each of their patients. If their actions result in an error that causes harm to the patient, they have a moral duty to apologize to the victim of the harm, even if the victim may never be aware of the error or the harm. The extent of the harm may be minor—a physician’s delay in visiting the patient because the patient’s chart was misfiled—or it may cause increased morbidity and require additional medical care in consequence, as in the case of wrong-site surgery. The moral obligation to apologize following a harm caused by one’s error is the most cut-and-dry exigency.

A more complicated situation is one where a significant (moral) wrong committed appears not to cause harm.¹²² For example, if a physician permits a trainee to practice performing a physical exam on a patient while she’s under anesthesia for colposcopy, there may be no

¹²² As noted earlier (see footnote 109 in this chapter) Joel Feinberg contends that nearly all wrongs cause some degree of harm. He adds: “There *can* be wrongs that are not harms *on balance*, but there are few wrongs that are not *to some extent* harms. Even in the most persuasive counterexamples, the wrong will usually be an invasion of the interest in liberty.” Feinberg, *Harm to Others*, 35.

demonstrable harm to the patient in spite of the moral wrongdoing. In this case, the patient did not consent to serve as a trainee's practice case and she did not benefit from the additional exam. Although the patient may not know about the wrongdoing—particularly because she does not recognize suffering any harm—the attending physician has an ethical obligation to disclose and apologize for the unwarranted and unapproved examination. The trainee, too, may be culpable, depending on the circumstances. Of course, it may be the case that the patient may be quite disturbed to learn about such an infraction as compared to not knowing, but she has a right to know about the use to which her body was put and to respond to her physician accordingly. She may, for example, respond by distrusting her physician and seeking care by another professional with whom who she feels safer and more comfortable.

In cases where the wrongdoing is minor and there is no harm—physical, economic, psychological, etc.—there is no clear ethical mandate to apologize. This particularly applies to so-called near misses, where an error is *almost* committed or where an error is caught and remedied before there are any harmful consequences. For example, if a physician orders the wrong dose of a medication but the pharmacist detects and corrects the mistake before the medication is administered to the patient, this near miss would not require apology to the patient, although the pharmacist and physician would likely need to discuss the event with each other and perhaps disclose it to the patient. Whether or not disclosure—and apology—should be made likely depends on the magnitude of the departure from standards of practice, the magnitude of harm that was (perhaps narrowly) avoided, as well as other features of the “near miss.” In any case, one should be careful not to overlook or disregard less obvious harms in order to avoid offering an apology that may in fact be warranted.

In cases where there is no wrongdoing, including no error that breaches a standard of care, there is no ethical reason to apologize. In fact, an apology offered for an unpreventable adverse event would be nonsensical and confusing. Tavuchis, for example, claims, “Where an actor’s responsibility and intentionality are deemed to be minimal or the consequences as trivial or accountable, an apology is superfluous.”¹²³ Instead, an expression of empathy or regret may be appropriate and possibly morally required. For example, we may rightly criticize the spouse who does not express empathy when his wife’s close friend passes away because his relationship to his wife includes some commitment to emotional support. Likewise, the physician who says nothing after being unable to remove an entire malignant tumor may be blameworthy for not meeting a nontechnical aspect of her duty to care for patients. We expect that in a caring relationship it is inappropriate to demonstrate indifference or callousness to the other’s suffering. In both of these examples, the person from whom we expect empathic expressions has a relationship with the one who is disappointed and hurt, and it is that relationship that grounds the moral requirement of empathy. Without the relational bond, such an expression of empathy is not required. Although expression of empathy or sympathy on the part of one who witnesses another’s suffering may still be appropriate or supererogatory depending on the circumstances, it is the special relationship of caregiver to patient or between spouses that requires expression of empathy or sympathy in these cases.

Physician Michael S. Woods claims that three groups of people may properly compel a clinician to apologize by demanding or mandating such an action: patients, patients’ families, and healthcare organization administrators. Yet, he cautions that a wrongdoer should take a few moments to think through the situation in order to offer a thoughtful apology rather than an

¹²³ Tavuchis, *Mea Culpa*, 21.

inadequate, impulsive apology in the face of confrontation.¹²⁴ Examining this position in light of the Tavuchis model of call-apology-forgiveness, we more appropriately understand that patients, patients' families, or administrators may call for an apology, but the apologizer must internalize that call in order to offer a genuine apology. Since remorse cannot be coerced, it makes no sense to speak of a coerced genuine apology. Additionally, we tend not to honor—or at least do not give full credence to—contracts or confessions derived from coercion. While Smith maintains that a coerced apology can serve as a form of punishment of the offender because it forces a display of humility and demonstrates the power that an authority holds over the offender,¹²⁵ it is more appropriate to call that expression something other than 'apology' due to its insincere and forced nature.

Sometimes, for pragmatic reasons an offender may delay offering an apology until the completion of a full investigation of the potential wrongdoing, for example, so that she may know the extent of her responsibility. While an accurate account of one's responsibility is important to genuine apology, a prolonged silence from the offender following a call for apology may be interpreted by the victim as avoidance, denial of responsibility, or heartlessness. Still, when one is relatively certain that she played a role in harming another, she should speak to what she knows in an apology and leave open the possibility of offering a more comprehensive account in a subsequent apology or disclosure when more details are known.

Finally, it is important to note that the ethical duty to apologize for wrongdoing is not absolute. There may be empirical conditions that create an ethical duty *not* to apologize. Consider, for example, a victim who has expressed her strong desire not to see or correspond

¹²⁴ Michael S. Woods, *Healing Words: The Power of Apology in Medicine* (Oak Park, IL: Doctors In Touch, 2004), 47.

¹²⁵ Smith, *I Was Wrong*, 151.

with her offender. If the offender continued to pursue an apology encounter with her victim, she would be violating the victim's expressed wish to be free of continued trauma from her offender. In cases where an offender's apology (or attempted apology) is expected to cause harm, distress, or other harm to the victim, the offender has an ethical duty *not* to apologize. The expectation of harm resulting from apology must not simply be derived from the offender's fears of facing her victim, but should be based upon the expressed wishes of the victim or the reliable account of mutual acquaintances that further communication or other encounters between the offender and the victim would be most unwelcome by the victim. In the absence of an explicit appeal to avoid contact with the offender, the determination of one's duty not to apologize should be consistent with the judgment of a fictitious, normative reasonable person.

In summary, apology is called for when one has committed a wrong that causes harm to another person or that person's interests. If a wrong is committed that does not appear to result in harm, an apology may still be warranted; the situation may require further discussion between the wronged person and the offender to achieve a mutually satisfactory understanding of the situation and the appropriate response by the wrongdoer.¹²⁶ Near misses (errors that are corrected prior to being harmful) and harms that result from non-blameworthy causes do not require apology, though one might appropriately express empathy for another suffering an adverse medical outcome from an unpreventable accident or even a bad outcome that results from appropriate care. In these circumstances, the potential empathizer's relationship with the sufferer will bear on her moral duty to provide that kind of emotional support. In any case of apology, we can determine whether an offender's apologetic speech act indeed qualifies as a

¹²⁶ Lazare maintains, "Like the doctor-patient interaction, an apology is best understood not as what one party (the offender) does or offers to another party (the offended), but as a process in which both parties reach agreement through a 'give and take' as a way to deal with the initial problem." Lazare, *On Apology*, 204-5.

fulfillment of her ethical duty to apologize according to the reasonable person standard: if the speech act fulfills the four conceptual conditions described herein and if a hypothetical “reasonable person” would recognize the utterance as a genuine apology and would be able to accept it as such, we recognize the apologizer’s ethical duty as having been discharged even if the victim does not accept the apology. Finally, the potential apologizer should use good judgment regarding whether or how to proceed with offering an apology. The reasonable person standard helps us understand in which exceptional cases the victim may be more traumatized by additional contact with her offender than by the absence of an apology. Likewise, the rhetorical and behavioral choices of an apologizer should be driven not only by the four conceptual criteria but also by consideration of what a reasonable person in the victim’s position would expect (normatively and epistemologically) of a genuine apology.

2.3 APOLOGIZING ON BEHALF OF OTHERS

To this point, the discussion of apology has largely referred to apologies offered by individuals in response to their own wrongdoing. However, our earlier discussion about medical practice and medical error reminds us that individuals act neither purely independently nor in isolation in modern medical practice; responsibility for error may be shared among many individuals throughout an institution. Within the context of apology, this understanding of interdependence and responsibility leads us to the question: Who can give an apology?

The legal notion of “standing” provides a good starting place for determining who may apologize and for what. Standing is “a procedural requirement ensuring that only legitimate disputants adjudicate claims and that random parties cannot bring actions simply because they

may hold an intellectual interest in the outcome.”¹²⁷ In the earlier discussion about genuine apologies, I asserted that the offender must offer genuine apologies to the correct victim. In the language of standing, we can now say that an offender with standing to apologize offers a genuine apology to a victim with standing to receive the apology. That is, the person offering the apology must be able to identify her own causal responsibility for the wrong to particular victim(s), who must be identified as the “correct” victims to receive the apology based on their having been wronged by that offender.

Additionally, there are cases where one has vicarious responsibility for harms caused by particular others, as parents may have for their small children and employers may have for their employees. The nature of such vicarious responsibility “means that they are agent-responsible, in a forward-looking sense, for the state of the world that is free of harm caused by these children or employees, and agent-responsible, in a backward-looking sense, for harm the children or employees do cause. In these cases of vicarious responsibility, those who are responsible for the harm are not those who have caused it.”¹²⁸ If a supervisor asks her subordinate to administer an incorrect dosage of medication to a patient, the supervisor has responsibility for the error even though she did not personally administer the dose; the subordinate acted as the agent of the supervisor. In such a case, the supervisor would have standing to apologize for her responsibility in the error because, but for her instructions, the subordinate would not have administered the erroneous dose. In cases where the one committing the wrong was acting as an agent of another (e.g., performing an action at the behest of another), the responsibility for the wrong and standing for the apology belongs to the authority on whose behalf the wrong was committed.

¹²⁷ Smith, *I Was Wrong*, 52.

¹²⁸ Kurt Baier, “Moral and Legal Responsibility,” in *Medical Innovation and Bad Outcomes: Legal, Social, and Ethical Responses*, ed. Mark Siegler, Stephen Toulmin, Franklin E. Zimring, and Kenneth F. Schaffner, (Ann Arbor, MI: Health Administration Press, 1987), 104.

Had the subordinate acted independently in her administration of an incorrect dose, the supervisor would not have standing to apologize for the error on the subordinate's behalf. However, if the supervisor (or parent) had failed to discharge her duties or obligations appropriately, thereby causing or failing to prevent the wrong (e.g., by failing to prevent the subordinate from acting), the supervisor has standing to apologize for her own failings that contributed to the ultimate harm.

In one's role as employer, supervisor, or parent, one may be liable for damages caused by those within one's responsibility or influence. If my child breaks a neighbor's window while playing catch in the yard, I would be responsible to compensate my neighbor for the damage regardless of whether I failed in any parental or neighborly duty to prevent such damage. Likewise, a hospital may be responsible to compensate a victim of medical error committed by a member of the hospital's staff even if proper safety policies were in place. Just as one may compensate a victim without accepting fault for the events that caused the harm, one may be liable to compensate (or liable to legal responsibility) without having the standing to apologize. Since I am responsible for my child, I might try to apologize to my neighbor for damage my child caused, but the child—not I—has the standing to apologize for her own error or recklessness; an apology from me would be inappropriate. If I was indeed negligent, perhaps by failing in my parental duties to teach my child due care, then I both have standing to apologize for my wrongdoing and responsibility to ameliorate the harm that resulted.¹²⁹ Responsibility to compensate for those harms is separate from both the ethical requirement for an apology and having the requisite standing to apologize. However, an apology would be inappropriate in cases

¹²⁹ “The concept of responsibility itself contains such normative principles, for example, that no one can be answerable except through failing in a social requirement, whether a duty or a task-responsibility, and that no one can be liable for something unless answerable and so task-responsible for it.” Baier, “Moral and Legal Responsibility,” 114.

where there has been no wrongdoing (e.g., an adverse event) even if compensation is offered to the person harmed.

To say that one is apologizing on behalf of another might indicate to the victim that the speaker recognizes the wrong committed against her and demonstrate the speaker's empathy, but it does not make sense as a genuine apology without the personal acceptance of blame and responsibility, as well as a personal expression of remorse and not merely regret for the circumstances. Likewise, it does not make sense for a third party to accept an apology offered to another. The stipulation of standing does not limit the number of people who may be found blameworthy for an offense and, therefore, eligible and responsible to offer an apology, nor does it limit the number of people who may be counted among the victims awaiting an apology.¹³⁰ Standing, as it applies to ethical apology, requires that we account for and identify the agents most relevantly involved in an offense so that a genuine apology is offered by the blameworthy individuals for their own actions.

In addition to this basic sense of apology as an individual apology, a great deal of literature deals with what is variously termed organizational, corporate, collective, or institutional apology. We may define institutional apology as an expression offered by an institution (through a spokesperson or media release) or an individual within the institution who responds to alleged wrongdoing by the institution as a whole or select individuals or groups acting within their institutional roles. However, while these expressions are called 'apologies' by witnesses, media reports, and theoretical literature, they do not satisfy all four criteria for genuine apology as defined in this thesis. For the purposes of this section, it will be convenient to

¹³⁰ Smith discusses the complications of proximate causation as compared to direct causation, concluding that the nuances of causation color the meaning of apologies. He favors the reasonable limits of causation provided by the proximate causation perspective, and I am inclined to agree. Smith, *I Was Wrong*, 38-46.

use the broadly accepted terminology of ‘institutional apology,’¹³¹ though I will explain why this is, in most cases, a misnomer. In this section, I will briefly consider three variations of “apologies” that involve institutions and explain what differentiates these so-called institutional apologies from interpersonal individual apologies.

One version of an institutional apology is an individual apologizing on behalf of her institution, what I call the “non-representative institutional apology.” This individual has not been delegated the authority of an institutional representative by her institution, but she speaks on behalf of the collective nonetheless. The apologizer may be an employee or member of the institution who is ashamed of some institutional policy or practice. However, this would-be apologizer lacks standing to apologize for the institution, and her remarks may even be repudiated by the institution. The victim(s), too, may be dissatisfied by the speaker’s lack of standing and authority to offer an apology. The non-representative institutional apology is the most tenuous of the three institutional apologies discussed here. Tavuchis puts it more firmly: “[A]n apology proffered without the proper credentials, that is, lacking the moral imprimatur of the group, amounts to no apology at all. It means nothing because it represents the unaccredited One and not the mandate of the Many.”¹³² The non-representative may better be considered as expressing shame or embarrassment because of one’s association with wrongdoers, as well as sympathy or empathy with the victim.

A second form of institutional apology is offered by an institutional representative on behalf of an employee or member of the institution. The “representative/individual apology” affixes blame on an individual within the institution and offers an apology for that individual’s

¹³¹ Temporarily accepting the term “institutional apology” avoids the need to repeat the clumsy phrase “so-called institutional apologies” and acknowledges that these instances of institutional rhetoric are intended to serve some of the same functions as genuine interpersonal apologies.

¹³² Tavuchis, *Mea Culpa*, 101.

actions. The responsible agent may be unwilling or unavailable to offer an apology, or the institution may want to control what statements are made publicly by members of the institution. Here again, the issue of standing casts light on the conceptual failings of such an apology; the institutional representative's lack of standing significantly diminishes the apologetic meaning of such an expression, particularly if the responsible person is unrepentant and refuses to apologize. Although someone in authority in the institution has delegated responsibility for the apology to the representative (who may be an executive, public relations officer, or department head, for example), the culpable person may not have authorized the delegation and, in any case, the speaker cannot express remorse for another's actions. Smith offers one reason that an apology-by-proxy may be acceptable to the victim, however: "In some cases, victims may be entirely uninterested in whether the apologizing party possesses standing to speak on behalf of the wrongdoers. If the victim is primarily concerned with an institution revising a policy or providing redress, a ranking member may be much better positioned to generate this meaning than those directly responsible for the harm."¹³³ According to Smith's caveat, the victim accepts the replacement of genuine apology with redress and/or reform, but the apologetic meaning and ethical value is still largely lost.

The third form of institutional apology relevant here is offered by an institutional representative for the institution's failings. This "representative/collective apology" makes use of the same types of spokespersons as the representative/individual apology, but this representative purportedly speaks on behalf of the institution as a whole. The representative/collective apology is commonly offered following events that are publicly embarrassing to the institution or following an accusation of wrongdoing that is considered sufficiently severe or endemic to the

¹³³ Smith, *I Was Wrong*, 220.

institution that a collective apology is considered warranted. The critical conceptual concern with regard to this form of apology is not standing so much as the issue of collective responsibility.

Genuine collective remorse and apology can only be expressed and offered in cases where the collective is extremely cohesive, like-minded, and “bound by considerable solidarity,” and where each and every member is able and willing to express personal responsibility and remorse for wrongdoing.¹³⁴ Since an institution or collective meeting these requirements is extremely rare, we should be suspicious of apologies by institutional representatives that are offered on behalf of the “institution” in an abstract sense rather than offered by identifiable individuals for their particular roles in the wrongdoing. A problem with collective apologies is that they “allow wrongdoers to diffuse blame into the ether of institutional doublespeak,” rather than ensure that all responsible will be included in the apology.¹³⁵ It is ethically preferable for each of the culpable agents to offer an apology rather than allow the institution to obscure the details of the wrongdoing because “collective apologies often serve as poor substitutes for categorical apologies from individual members of the group even if they can provide important meanings as supplements to individual apologies.”¹³⁶ The additional “important meanings” of collective apologies may hold significance for interested third parties in addition to the victim(s); these additional meanings or uses of collective apologies include establishing the historical record of the events and the apology,¹³⁷ endorsing particular values,¹³⁸ and rehabilitating the institution’s identity in the public eye.¹³⁹ One can see, however, that these important functions of institutional “apology” need not derive from explicit, anthropomorphized statements

¹³⁴ Smith, *I Was Wrong*, 245.

¹³⁵ Smith, *I Was Wrong*, 199.

¹³⁶ Smith, *I Was Wrong*, 185-6.

¹³⁷ Lazare, *On Apology*, 39-40; Smith, *I Was Wrong*, 247; Tavuchis, *Mea Culpa*, 108-9.

¹³⁸ Keith Michael Hearit, *Crisis Management by Apology: Corporate Response to Allegations of Wrongdoing* (Mahwah, NJ: Lawrence Erlbaum, 2006), 203; Lazare, *On Apology*, 55; Smith, *I Was Wrong*, 247.

¹³⁹ Hearit, *Crisis Management by Apology*, 202-3; Lazare, *On Apology*, 203; Tavuchis, *Mea Culpa*, 108.

acknowledging collective wrongdoing or expressing remorse. The ethical import of apology is compromised in significant ways by its translation into institutional applications.¹⁴⁰

In addition to the elements described above, institutional apologies vary from individual apologies in other ways. First, the apologizer in an institutional apology is not necessarily an agent significantly responsible for the wrongdoing at issue. We have already discussed how an apology-by-proxy is unacceptable according to the criteria of genuine individual apologies, but institutions tend to offer such apologies without considering the logical and ethical problems inherent in such an arrangement. The voice of the institutional apology may be either an abstraction of the institution (issued as a press release, for example) or a spokesperson speaking on the institution's behalf. The apologizer may even be the head of the institution apologizing for the offenses of past administrations.¹⁴¹ In any case, the voice of the apology is dissociated from the agent(s) of the wrongdoing.

The “absence of legal and ontological equivalence between the parties” involved in institutional apologies differentiates them from interpersonal, individual apologies and raises complications for how we might consider institutional apologies and the “nature of the Many.”¹⁴² But “collectivities can, do, and at times, must apologize to persons they have harmed, *in a manner of speaking.*”¹⁴³ The constraints of this “manner of speaking” deserve explanation. First, institutional apologies tend to be more formal, indirect, and allusive as compared to

¹⁴⁰ As Smith claims, “Rarely, I argue, do collective apologies add significance with respect to groups accepting blameworthiness. Instead, collective apologies often serve as declarations of the values and intentions of members of a group. Such meaning can be momentous, but we can clearly distinguish between the ethical significance of categorical and value-declaring apologies.” Smith, *I Was Wrong*, 203.

¹⁴¹ President Clinton's apology in 1997 for the United States Public Health Service's infamous Tuskegee Syphilis Study (1932-1972) is an example of such an apology. William J. Clinton, “Remarks in Apology to African-Americans on the Tuskegee Experiment,” *Weekly Compilation of Presidential Documents* 33 (1997), 718-20.

¹⁴² Tavuchis, *Mea Culpa*, 97.

¹⁴³ Tavuchis, *Mea Culpa*, 97.

individual apologies.¹⁴⁴ Perhaps because institutional apologies usually become part of the historical record and perhaps because some institutional “apologies” are crafted in such a way as to abstract from and occlude the specifics of the wrongdoing to which it responds, institutional apologies leave little to no room for the spontaneity and dynamics of human conversation. The formality of the language can shield the institutional representative from being candid or direct, or prevent her from admitting more responsibility than officials might want to acknowledge, and this poses ethical and conceptual problems. Such an apology may not meet the reasonable person standard if the apology seems designed to be vague or opaque. If one may reasonably be left wondering whether the institutional statement was an apology, then we may assume that it fails to meet either the reasonable person standard or the four conceptual criteria, for genuine apologies.

Second, collective apologies tend to be offered to multiple and wider audiences than individual apologies. A collective apology may explicitly or implicitly address concerned third parties, a broader community, and the history and legacy of the institution in addition to the specific victim(s).¹⁴⁵ For an institution, allegations of wrongdoing may have higher stakes than allegations against an individual, therefore the purposes of such an apology extend beyond redressing wrongs between offenders and victims and work to rehabilitate the collective’s reputation and reaffirm its values to members and non-members alike. An institutional apology is likely to be more complex than our four-component definition of apology in order to address these other motives and concerns, incorporating additional elements that may not be recognizable as apologetic by our “reasonable person.”

¹⁴⁴ Tavuchis, *Mea Culpa*, 97, 100.

¹⁴⁵ Tavuchis, *Mea Culpa*, 97.

But what are institutional members apologizing for? An apology may be warranted for faulty or unethical policies that may be unsatisfactory for several reasons. The policies may be ineffective (e.g., may not adequately prevent harm to others), unenforceable or unclear about who is to enforce them, unnecessarily complex, vague or loophole-ridden, or contradictory with current laws and policies, or they may refer to an abstract goal without specifying implementable procedures. Additionally, policies may be unethical because they are discriminatory, infringe unnecessarily upon others' rights and interests, impose an unfair burden on a particular group, require that which is itself unethical, or otherwise disregard the status of others as moral beings.

If the alleged wrongdoing is the poor or inadequate implementation of institutional policies, an institutional apology is essentially an apology for the behavior of others, which is ethically inappropriate. Only the culpable individuals, rather than institutional proxies who lack the appropriate standing, may appropriately offer an apology. When an apology for institutional policy is warranted it would be best offered by the policy framers or those who have allowed the policy to remain in effect, rather than by an institutional representative who offers a diffuse and impotent apology for the institution at large or for others' misdeeds.

While much more could be said about the way that institutional apologies are used and received in the public sphere, it will suffice at this point to wrap up the observations and criticisms discussed thus far, and to relate these to the claim that animates this project. In our complex medical systems, apology is an ethically reasonable and appropriate response to errors and wrongs committed by individuals, especially if the wrongs or errors result in harm. Furthermore, the individuals who may appropriately be found blameworthy for the occurrence of error and the commission of wrongs include both clinicians *and* administrators. We can recognize a difference in practice between wrongs one commits directly and wrongs one

commits through a failure to institute and maintain policies and systems—acted upon, by, and through others—designed to promote safety and prevent error. Ethically, however, there is no difference in blameworthiness between the clinical and administrative wrongs insofar as both warrant an apology offered from the individuals with agency in their realms of responsibility to the victim(s) affected by the failure to provide the standard of care and the neglect of moral norms. While “institutional apologies” offered by representatives on behalf of individuals or, more often, a whole institution are commonly accepted and evaluated as apologies in the media and the public eye, this analysis raises concerns about the conceptual and ethical disconnections between the institutional rhetoric and what we understand a genuine apology to entail. In light of these conceptual and ethical concerns, we can regard the three formulations of institutional apology discussed in this section as falling short of the criteria for genuine apologies. Instead, apologies can appropriately be offered only by individuals for their own institutional role-related actions.

2.4 RELATED BEHAVIORS

In addition to apology—or instead of apology—there are other actions an individual or institution may take in response to wrongdoing. Indeed, in light of the previous discussion, these related behaviors are more reasonable for an institution to offer than an apology. For example, an institution may offer compensation to mend the damage done and/or make pledges to reform policies and future practices to prevent the recurrence of the wrong committed. These actions do not constitute an apology on their own, but may supplement or take the place of apology in some cases. We must be sure to differentiate these related behaviors from the essence of apology in

order to avoid confusion about claims and policies regarding apology, especially as they pertain to institutions. To that end, this section addresses the question: What is the relationship, or rather lack of conceptual relationship, between provision of an apology, provision of compensation, and pledges to reform future practices/behavior?

Apology, according to our definition, does not require the provision of tangible compensation to victims or their families. An offender might demonstrate her sincerity and commitment to making the victim whole by offering reparations for the harm caused by her wrongdoing, but the absence of compensation does not disqualify an apology from being genuine. Moreover, compensation for harm does not indicate remorse for the wrongdoing. Institutions or individuals sometimes offer compensation to a victim without acknowledging fault or liability (or apologizing), as in legal settlements. Again, these behaviors are sometimes interpreted as acknowledgment of guilt or remorse, but they are not apologetic expressions *per se*. Just as one may offer disclosure of an error without apologizing, one can also withhold apology while still disclosing and offering compensation for harms. One reason for offering compensation without taking responsibility for the harm is that one may have a duty to care for others—regardless of the cause of their injuries—because “we can distinguish between responsibilities to redress injuries we cause and for which we should accept blame and duties to care for those harmed by others.”¹⁴⁶ In either case, the provision of redress for harms does not constitute an apology. In our paradigm apology case, the physician could have ordered the patient’s anti-nausea medication as soon as she realized her previous failure to do so, without ever apologizing to the patient; furthermore, we would judge the physician to be negligent,

¹⁴⁶ Smith, *I Was Wrong*, 55.

reckless, or even intentionally culpable if she had not tried to right her wrong, whether or not she offered an apology to the patient.

Apology also does not require a wrongdoer to pledge a change in behavior or a shift in policy to affect future actions. Like an offer of compensation, an offender may take specific actions toward preventing a recurrence of the wrong that precipitated the apology both in order to show sincere remorse and to prevent future wrongs. Still, the apologizer is not required to offer an explicit promise to take steps to avoid repeating the wrong. Conversely, an offender can make a specific effort to avoid wronging and harming others in the future without offering an apology for a particular wrong already committed. However, a genuine apology cannot be paired with an offender's implicit or explicit expression that her behavior *won't* change or that, in retrospect, the offender would have behaved precisely the same way if given the chance.

Without diverting to an exhaustive discussion of all the ways in which one might invalidate or compromise an apology through one's behavioral and attitudinal expressions, it bears repeating that the reasonable person standard is useful in making such determinations. We can employ the criteria of this standard in order to parse which behaviors are appropriately apologetic and which would seem to undermine an apology. In the example above where the physician failed to order the anti-nausea medication, even after apologizing for doing so, a reasonable person would doubt the sincerity of the physician's apology for being distracted and forgetful. Likewise, if the physician appeared to be distracted or hurried while she offered her apology, we would judge that apology to fall short of fulfilling the criteria set out by a reasonable person standard for apology. We recognize that many behaviors, including antagonistic or careless behavior, are incompatible with what a reasonable person would expect in the presence

of true remorse, and thus such behaviors and attitudes invalidate or undermine the would-be apology.

2.5 APOLOGIES AND RESPONSES TO ERROR IN THE SANTILLAN CASE

Armed with a better understanding of what offenses warrant an apology and who may apologize for what offenses, we return to the case of Jessica Santillan and the error-ridden heart-lung transplant performed by Dr. Jagers at Duke University Hospital to examine and analyze the individual and institutional responses to the errors that have been recorded publicly. According to the analysis in this chapter, the transplantation error is one for which apology is warranted because it was a preventable error that resulted in harm. Moreover, there are identifiable agents in the series of events who were responsible for the miscommunications and mix-ups. In this section, I offer a critique of three primary statements offered by Dr. Jagers, Duke University Hospital CEO Dr. Fulkerson, and Duke University.

Following the revelation of the blood type mismatch in Jessica Santillan's heart-lung transplant, the already well-publicized case of a life-extending transplant was transformed into a national and international story of an unthinkable error at a top medical center. Naturally, the media firestorm required public statements from the hospital and the surgeon in addition to whatever private interactions occurred among hospital administrators, the transplant team, and the Santillan family. Many of these statements have been published in local and national newspapers as well as on Duke's website.

2.5.1 Public Statement from the Transplant Surgeon

A statement from Dr. James Jagers, the transplant surgeon, was released to the media on February 22, 2003. In it, Dr. Jagers said:

Today our focus is on the Santillan family. Our heart goes out to them as we mourn the loss of Jessica. [...] This process of organ donation is a very complicated one—one in which there's many institutions, many organizations, and many steps. At each step, there is an individual, and individuals can make mistakes. Unfortunately in this case, a mistake was made.

As Jessica's surgeon, I take responsibility for those errors and I take responsibility for the entire team. After the first transplant, I spoke to Jessica's family and told them of this error, but then I did everything possible to save Jessica's life, including another heart and lung transplant. Many people at Duke aided me in this process, including the pediatric ICU staff and the other transplant surgeons.

I know that everybody at Duke was behind us. I know that everybody at Duke mourns the loss of Jessica. I hope that we and others as we go through this process can make it a safer one, and one that will benefit even more patients. One that will encourage organ donation. To do otherwise would dishonor Jessica and dishonor her memory.¹⁴⁷

The statement opens with an expression of empathy for and sympathy with the Santillan family, and includes Dr. Jagers among the mourners for Jessica. These expressions and his inclusion of

¹⁴⁷ Duke Medicine News and Communications, "Statement from Dr. James Jagers Concerning Jessica Santillan," February 22, 2003, <http://www.dukehealth.org/HealthLibrary/News/6421> (accessed October 8, 2008).

himself among those who mourn are appropriate regardless of Dr. Jagers's specific errors in the case; indeed, as Jessica's caregiver, Dr. Jagers would appropriately mourn her death. Members of the hospital staff, the media, and the broader community shared similar feelings of sorrow, sympathy, and even loss. But we look to this statement not for a reflection of public sentiment but for insights into the mind of the surgeon at the center of the controversy.

After a very brief account (omitted above) of Jessica's need for heart and lung transplants and the nationwide tragedy that thousands of potential organ recipients die before they can receive the necessary organs, Dr. Jagers speaks to the complexity of the organ transplantation process and the potential for error amid this complexity. While he acknowledged that an error occurred within the complex system of coordinated individuals, Dr. Jagers gave no specifics beyond saying, passively, that "a mistake was made." Immediately following, Dr. Jagers directly "[took] responsibility for those errors and [...] for the entire team."

While he accepted ultimate responsibility, we may wonder from this statement just what part he played in the commission of an error. In medical culture, the attending surgeon bears a role-related responsibility for any errors that occur "on his watch" and Dr. Jagers, as the attending surgeon, took responsibility for the errors in Jessica's care. However, those involved in the matching, procurement, and transplantation of unsuitable organs extended beyond those on Dr. Jagers's surgical transplant team. Others involved in organ transplantation include the coordinators in the transplant department; coordinators at the various organ procurement organizations (OPOs) involved in the geographic regions of the donor and recipient; a procurement team (including a transplant surgeon) that travels to remove and retrieve the donated organs; a transplant fellow (in Jessica's case, specifically); and the transplant team itself, which includes the attending surgeon, other assisting surgeon or surgical fellows, nurses, and

anesthesiologists. As the attending surgeon, Dr. Jagers oversaw the efforts of the surgical teams (the procurement team and the transplant team), though he was not a supervisor to the OPO coordinators. Disclosure about the communication errors and lack of redundant verification in the transplantation mix-up had been made by Duke spokespersons to the media already, so Dr. Jagers's stated acceptance of responsibility for the errors (note his use of the plural) implicitly accepts the published accounts. But Dr. Jagers took responsibility for his errors as well as for those of the entire transplant team. This presumably means that he accepted responsibility for the transplant fellow's failure to communicate the donor organs' blood type to the rest of the transplant team, including Dr. Jagers himself, and for the failure of the rest of the procurement team to do so. It is unclear whether he also intended to take responsibility for the recording mix-ups of Jessica's blood type and name spelling that occurred at CDS or for the failure by the CDS coordinator to specifically request Jessica's blood type and compare it to the blood type of the donor organs. However, it does not seem appropriate to assign blame to Dr. Jagers for the combined individual omissions of others even if they were associated with his omissions. Still, Dr. Jagers claimed responsibility, vaguely, for all of the errors.

While he mentioned having a conversation with the Santillan family, he did not specifically mention whether he apologized to them. This omission may have been out of respect for the Santillan family's privacy, or perhaps out of a personal desire not to dwell any longer on his admission of wrongdoing. There is no public record of what Dr. Jagers said to the Santillan family when he disclosed the error to them, so we must limit our assessment of his responses to recorded public statements.

Dr. Jagers stated that, following the error, he "did everything possible to save Jessica's life, including another heart and lung transplant." In so doing he expressed his professional

dedication to Jessica's care, despite the lapse that occurred previously. While Dr. Jagers deserves no extraordinary praise for doing his job (which included trying to save Jessica's life), he may have used this statement and the evidence of his continued efforts in order to reassure others that he had no intent to harm Jessica and that, in fact, he was a very dedicated physician. He also shared credit for these efforts with other members of the hospital staff involved in Jessica's care. His sweeping comments that "everyone at Duke" was behind his team and mourned Jessica would be unacceptably broad claims if taken literally, but the hyperbole may be acceptable in this context where expressions of solidarity and empathy are called for by the rhetorical situation.

The statement closes with a forward-looking expectation, phrased as a hope, that lessons learned from the debacle would lead to safer patient care in the future, not only by Dr. Jagers's team but also by those who witnessed or heard about the events at Duke. Dr. Jagers expresses the goal of increased safety and organ donation as an obligation to the memory of Jessica, a moral duty in response to the tragedy that resulted from the errors.

One might reasonably evaluate this statement as an expression of concern for the Santillan family and for the reputations of Duke University Hospital and its staff members. Additionally, Dr. Jagers accepted responsibility for "those errors" in this public statement. Still, employing the reasonable person standard, it is dissatisfying as a genuine apology because he was vague about the wrongs committed and how it was that he should be held responsible for those wrongs. Without these specifics we must *infer* that Dr. Jagers was remorseful, though his statement is more closely tied to regret. Overall, Dr. Jagers seems to be sincere about the expressed attitudes of empathy, grief, and regret in his statement and seems to intend to serve the Santillans as best he can in the wake of the error. He gives the impression of being an ethical, compassionate, and mindful physician who is painfully bewildered at his own involvement in

such a simple, yet devastating, incidence of error. However, this public statement is not quite robust enough to meet our criteria for a genuine apology. Of course, it was a statement directed to a broader public, not to the Santillan family exclusively, so there was not a specific ethical imperative to apologize to that audience.¹⁴⁸

2.5.2 Public Statement from the Hospital’s Chief Executive Officer

Since that the transplantation error occurred at a large medical center and involved interrelated systems of organ procurement and transplantation, it is reasonable to expect that a Duke University spokesperson would contribute to the public discourse about the error. Duke’s Office of News and Communications posted an article online on February 22, 2003 that included a statement by Dr. William J. Fulkerson, the vice president and chief executive officer of Duke University Hospital. In the statement, Dr. Fulkerson says:

All of us at Duke University Hospital are deeply saddened by Jessica’s passing. Jessica’s care team is especially saddened. We want Jessica’s family and supporters to know that we share their loss and their grief. We very much regret the heartbreaking circumstances surrounding her care.

The original mismatch was a tragic error, and Duke accepts responsibility for our mistake. Every effort was made to save Jessica’s life. I give my heartfelt

¹⁴⁸ One could argue that the public is indirectly harmed by the loss of viable donated organs that could have been used to save another life and that Dr. Jagers is responsible for contributing to a shortage of organs that could potentially affect others in the region. But focusing on the more direct wrong committed against Jessica, and thus her family, we can support the claim that—most directly—Dr. Jagers owed an apology to Jessica’s parents.

sympathy to Jessica's family and supporters, and I thank the entire care team who worked so hard to sustain her.¹⁴⁹

Dr. Fulkerson's role in offering a statement differed from Dr. Jagers's in that Dr. Fulkerson was not directly involved in the processes of organ matching, procurement, and transplantation in the Santillan case. Still, as an executive within the institution where the transplant surgery took place, Dr. Fulkerson was an appropriate figure to offer public comment on a case that was closely followed by local and national media.

This statement, like Dr. Jagers's, began with an expression of grief for Jessica's death and sympathy for the Santillan family and their supporters. However, he offered these sentiments on behalf of "all of us at Duke" including, specifically, Jessica's care team rather than for himself, personally. He extended this collective expression to include regret for the "heartbreaking circumstances surrounding her care." Dr. Fulkerson used the pronoun 'we' in this portion of his statement, though it is unclear to whom 'we' referred. If it was the care team, then Dr. Fulkerson seemed to be including himself in that team (though he was not) and speaking for the whole team. Dr. Jagers was a more appropriate figure to speak for the care team, and he explicitly took responsibility for that team. Dr. Fulkerson may have been speaking on behalf of the whole hospital, but that would be overreaching. If he purported to speak for the entire hospital, his statements should not be regarded as an accurate representation of how each individual member of the institution felt about the situation. Indeed, we can expect that there was a variety of emotional responses among members of the hospital staff: shock, anger, grief, resentment, frustration, or even relief about not having been involved in the situation. Furthermore, the

¹⁴⁹ Duke University Office of News and Communications, "Duke Continues Review of Jessica Santillan Case," February 22, 2003, <http://www.dukenews.duke.edu/2003/02/santillan0203.html> (accessed October 8, 2008).

politicization of Jessica's case spurred broader arguments about the ethics of medical tourism, immigration, and the distribution of scarce donor organs.¹⁵⁰ A third and more appropriate possibility is that Dr. Fulkerson spoke as a member of the hospital who was included in a line of responsibility extending from Jessica's care team through high administrative levels, though he was not explicit about this standpoint. While Dr. Jagers also made general claims about how Duke as a whole supported his team and grieved for Jessica, he does not speak from the same position of authority as Dr. Fulkerson and may be given more latitude for his assertions about the institution. Dr. Fulkerson, however, must be careful about how he represents the institution in which he is the highest executive.

In the next portion of the statement, Dr. Fulkerson called the blood type mismatch "a tragic error," and said that "Duke accepts responsibility for our mistake." It is this second claim that is conceptually troublesome. Even though Dr. Fulkerson, as CEO, has the standing to represent the institution, he cannot accept blame or responsibility on behalf of others in the institution. To say that 'Duke' made a mistake is to anthropomorphize the institution and to abstract from actual events to a nonspecific and inaccurate representation of what happened in a similar process as the "representative/collective apology" discussed in a previous section. Surely, more than one individual was involved with the lack of communication and miscommunication in the organ matching process. Additionally, specific procedures in Duke's transplantation department could have been established to prevent against such communication problems. However, those responsible for the specific error included at least one member of the external organ procurement organization and possibly a representative from the United Network for

¹⁵⁰ Susan E. Morgan and others, "America's Angel or Thieving Immigrant?: Media Coverage, the Santillan Story, and Publicized Ambivalence toward Donation and Transplantation," in *A Death Retold: Jessica Santillan, the Bungled Transplant, and Paradoxes of Medical Citizenship*, ed. Keith Wailoo, Julie Livingston, and Peter Guarnaccia (Chapel Hill: University of North Carolina Press, 2006), 19.

Organ Sharing (UNOS) in addition to members of the transplant team at Duke. Also, the individuals at Duke responsible for verifying organ compatibility were identifiable, not unknown “somebodies.” This statement of collective responsibility on the part of Duke omits specific acknowledgment of *how* the institution was responsible for “our mistake.” If the institution, in addition to the specific individuals identified above, was indeed partly to blame for the error, it would have been for the inadequacy, absence, or lack of enforcement of specific policies concerning the verification of patient information before beginning an intervention. Responsibility for these policies rests with administrators in the transplant department, as well as those overseeing the hospital as a whole, but responsibility ought not be abstracted to the entire institution.

Dr. Fulkerson’s statement closes with similar elements to Dr. Jagers’s statement: assurance that the doctors made “every effort” to save Jessica, a personal offer of sympathy to Jessica’s loved ones, and his appreciation to the care team for their efforts to keep Jessica alive. These expressions are appropriate for Dr. Fulkerson to offer, just as they were appropriate in Dr. Jagers’s statement, especially because he offers them on his own behalf in this case rather than on behalf of Duke or the care team.

Like Dr. Jagers’s statement, Dr. Fulkerson’s includes an acceptance of responsibility for the mistake that took place but does not disclose any details of the error or specifically identify how Jessica was wronged. Dr. Jagers accepted responsibility personally but his vagueness and lack of explicit remorse compromised the statement’s potential as an apology. Likewise, Dr. Fulkerson’s statement cannot meet the conceptual criteria for apology because it does not specify the wrongdoing and, furthermore, does not identify *who* is to blame. An institution as a whole cannot express remorse for wrongdoing committed by select individuals, nor can Dr. Fulkerson

express personal remorse on behalf of another or an institution. The statement does, however, communicate Dr. Fulkerson's regret for the error (though he uses the pronoun 'we') and empathy for the Santillan family, expressions that the family and the public almost certainly expect to hear from a representative of the institution where the surgery took place.

2.5.3 Public Statement from Duke University

About two weeks after Jessica's death, Duke Medicine News and Communications issued a retrospective statement (presumably written by Dr. Fulkerson, as it incorporates first-person discourse) to discuss the media portrayals of events following the botched transplant and Duke's consequent interactions with the Santillan family, the media, and the United Network for Organ Sharing (UNOS). The statement reads, in part:

The issues surrounding Jessica Santillan were unlike anything we've experienced as individuals or as an institution. In just a few days, her case forced Duke to grapple with some of the most troubling questions that face today's hospitals and physicians: medical questions about mistakes in care and how to prevent them, ethical questions about organ transplantation and end-of-life issues, and communications questions about balancing a patient's right to privacy, the needs of the family, and the public's right to know.

We at Duke tried to find the right answers to these questions. In most instances, I believe we were successful, but there were also things that we wished we had done better. But I am certain that, every step of the way, we at Duke were completely honest with Jessica's family, and I know we provided her the best available care under the most trying of circumstances. For any hospital or

physician, these are the crucial obligations, and I am confident we fulfilled our medical responsibilities and did all we could to save Jessica's life.

As much of America knows, Jessica received a heart-lung transplant at Duke on Feb. 7. Because of a misunderstanding between her surgeon, Dr. Jim Jagers, and the organ transplant coordinating agency that provided the heart and lungs, Dr. Jagers did not learn until surgery was nearly complete that the organs came from a donor with a different blood type than Jessica.

Immediately after surgery, Dr. Jagers and Duke took several key actions. Jessica's family was notified immediately by Dr. Jagers that an error had occurred and he explained in detail what had happened, enabling them to make informed decisions about her care. Duke offered all its medical resources to treat Jessica. We hope that what we have learned will contribute to the development of new national guidelines that will prevent such a mistake from happening anywhere.¹⁵¹

After addressing several specific concerns about the aftermath of the error (which I summarize later), the statement closes:

None of us will ever forget the profound sense of loss with the death of Jessica, and none of us wants to relive an outcome such as occurred here. We are committed to providing our patients with the very best available medical care with compassion. We are committed to learning from this event, improving the system, and sharing that information with others. And, we are committed to earning the

¹⁵¹ Duke Medicine News and Communications, "Jessica Santillan and Duke: What We Learned," March 11, 2003, <http://www.dukehealth.org/HealthLibrary/News/6436> (accessed October 8, 2008).

continued trust of our patients. Jessica’s memory compels us all to accept nothing less.¹⁵²

This statement pinpoints the error as a miscommunication between the transplant surgeon and the coordinator from Carolina Donor Services and offers evidence to support the claim that Duke “fulfilled [their] medical responsibilities.” This claim about fulfilling responsibilities must be referring to Jessica’s care after the erroneous transplant, for it would be absurd to claim that medical responsibilities were fulfilled despite the breach of standard practice that calls for verification of donor and recipient compatibility.¹⁵³ This statement also provides greater detail than earlier public statements about the nature of the error and who was involved in its commission.

The description of the actions taken by Dr. Jagers and Duke following the surgery indicate that they offered prompt disclosure to Jessica’s family and offered remediation for the harms (“Duke offered all its medical resources to treat Jessica.”). Additionally, the statement expressed an interest by Duke’s administration to reform their own system and promote safety initiatives on a national scale. The reform-minded comments come both toward the beginning of the statement and in the closing paragraph, which also includes an expression of grief and regret for Jessica’s death. The specific details of the policy changes enacted by Duke to prevent recurrence of such an error—over twenty reforms between the transplant division and the

¹⁵² Duke Medicine News and Communications, “Jessica Santillan and Duke: What We Learned,” March 11, 2003, <http://www.dukehealth.org/HealthLibrary/News/6436> (accessed October 8, 2008).

¹⁵³ In some cases, surgeons can transplant organs of a different blood type than the recipient if the donor organ is predicted to deteriorate slowly enough in the course of rejection that it can provide some short-term benefit until a more compatible organ can be procured. In these cases, however, there must be explicit confirmation by the procurement and transplant teams that the blood type mismatch is acceptable. See Richard I. Cook, “Hobson’s Choices: Matching and Mismatching in Transplantation Work Processes,” in Wailoo, Livingston, and Guarnaccia, *A Death Retold*, 53-56.

administration of the Medical Center—are summarized by surgeon Thomas Diflo,¹⁵⁴ though Duke’s publicity usually only mentions the new requirement of triple verification of blood type by key members of the transplant team.¹⁵⁵

Sociologist Charles L. Bosk comments, “The new policies and procedures have the look of an instrumental set of actions, but they have the feel of expressive behavior.”¹⁵⁶ The policies are presumably meant to convey concern for patient safety and commitment to maintaining the institution’s reputation as one of the top medical centers in the nation. Indeed, this statement offered on behalf of Duke may fit the description of a “value-declaring apology,” which admits the wrongdoing of *others* (and, thus, is a misnomer as an ‘apology’) and declares to uphold other values in the future.¹⁵⁷ The statement asserts Duke’s commitment to providing high-quality patient care and setting an example for other hospitals through its policy reforms in response to the error.

The rest of the statement, excluded from the excerpt above, reads like a piece of classic *apologia*: a statement in explanation and defense of the actions taken by Duke Hospital. It addresses the various accusations by members of the public and media about particular actions Duke took following the error and justifies those actions in the name of the patient’s confidentiality and family’s privacy, honoring the family’s wishes, following standard medical procedures (especially in light of Jessica’s advancement to the top of the transplant list for her second heart-lung transplant), infection control, and limiting distractions for the care team.

¹⁵⁴ Thomas Diflo, “The Surgeon’s Perspective on the Bungled Transplant, in Wailoo, Livingston, and Guarnaccia, *A Death Retold*, 78-9.

¹⁵⁵ See, for example, Associated Press, “A Year Later, Efforts Are On to Avoid Another Botched Transplant,” *New York Times*, February 22, 2004, late edition, <http://proquest.umi.com/>; Lawrence K. Altman, “Even the Elite Hospitals Aren’t Immune to Errors,” *New York Times*, February 23, 2003, late edition, <http://proquest.umi.com/>.

¹⁵⁶ Charles L. Bosk, “All Things Twice, First Tragedy Then Farce: Lessons from a Transplant Error,” in Wailoo, Livingston, and Guarnaccia, *A Death Retold*, 115.

¹⁵⁷ Smith, *I Was Wrong*, 148.

Despite the mentions of “improving the system,” and Duke’s acceptance of responsibility for the mistake (according to Dr. Fulkerson’s own statement), the only specific failure of the system mentioned in these statements is miscommunication between Dr. Jagers and the CDS coordinator, who is never named. No other individuals are identified as culpable, nor does the statement identify why the “system” should be improved if an individual (or set of individuals) is to blame. These admissions are thorny: the hospital accepted responsibility for unspecified systems errors that led to the tragic mistake, but also specifically named and blamed the transplant surgeon, Dr. Jagers, for not verbally double-checking the donor organ’s blood type. Since no details are given about the preconditions for the error (e.g., no rigorously enforced policy for patient information verification before beginning a procedure) a reader may be left wondering why the institution accepted responsibility if Dr. Jagers is to blame. An administrator with standing to disclose specific policy or procedural failings did not do so; rather, he drew attention to one individual who had already taken full blame for the error.¹⁵⁸ This assigning of blame and subsequent shaming, even after the hospital admitted to systems flaws, did not strike many as problematic, however, because Dr. Jagers willingly accepted the responsibility and blame for his actions in the transplant ordeal.¹⁵⁹ The problem with the Duke statement is not that Dr. Jagers is identified as culpable but that the statement does not extend its analytical eye beyond Dr. Jagers to the administrative failings that allowed such a misunderstanding and error to occur in the first place.

This statement serves as an explanation and defense of the individual and institutional actions taken in the wake of Jessica’s first transplant. Like the statements by Dr. Jagers and by

¹⁵⁸ This is not to say that Dr. Fulkerson is the administrator to blame for policy or enforcement failings. The potentially responsible persons at the departmental and hospital levels are never addressed or named in this or any other account I have read.

¹⁵⁹ Bosk, “All Things Twice,” 111, 113-14.

Dr. Fulkerson, this statement expresses regret for the adverse outcome that resulted from a procedural error. Also like the statements already analyzed, this is not an apology according to the conceptual criteria. The author does not take personal responsibility for any wrongs, but rather explains what others have done and offers a declaration of values to reaffirm the institution's commitment to providing high quality patient care, learning from the event, and earning the trust of its patients.

2.5.4 Reactions to the Public Statements

Commentators evaluating these statements and the media reports of such statements show ambivalence about the nature of the responsibility-taking expressions as well as the implications of systems reform in the wake of errors such as this one. Dr. Jagers's acceptance of responsibility also granted Duke, CDS, and UNOS reprieve from blame by condensing the fault into his own role as the surgeon and head of the transplant team.

The media accounts of the Santillan case revealed a tension between the public perception of Duke as an elite hospital with top-notch physicians that happened to be involved in a larger, system-wide error and the criticism of Duke as “‘image conscious’ and ‘insensitive,’ as ‘piranhas,’ or as bureaucrats who ‘dragged their feet’ or who were most concerned with public relations and ‘wip[ing] the tarnish off their image.’”¹⁶⁰ These criticisms were derived, ostensibly, from the perception that Duke was “not being forthcoming with the family and with the public,”¹⁶¹ an allegation specifically addressed in Duke's retrospective statement. This chapter's analysis of statements by Dr. Fulkerson on behalf of Duke indicates that there was, indeed,

¹⁶⁰ Morgan and others, “America's Angel,” 29.

¹⁶¹ Morgan and others, “America's Angel,” 29.

opportunity to increase the ethical value of the public disclosure by acknowledging a broader range of wrongdoing involved in the transplantation error and by providing the opportunity for the responsible individuals to offer genuine apologies for their roles in the event.

Dr. Jagers, the only individual to speak publicly about his responsibility for the error, fared much better in the public eye, though reports about the surgeon negotiated the tension between understanding him as well-respected and compassionate or as reckless and dangerous. Perhaps his early and direct admission of guilt helped earn him respect among the public, or perhaps it was the consistent praise of his character and skill by colleagues and even the Santillan family that the public found so admirable.¹⁶² Additionally, a report from a Santillan family spokesperson that Dr. Jagers had “wept after telling the family that he had made that tragic mistake” conveyed the image of a remorseful, compassionate, and forthright surgeon, an image that the public can find sympathetic.¹⁶³ Furthermore, media stories attributing the cause of the error to broader systems flaws “relieved Jagers of personal culpability, even as at the same time (ironically) he freely accepted responsibility. It is unclear to what extent his initial public display of remorse and his overt acceptance of accountability influenced the tenor of subsequent media coverage, allowing writers and commentators to grant him a kind of preemptory reprieve” from shaming.¹⁶⁴ By these accounts, Dr. Jagers’s public and private conduct in response to the error were ethically sound and accepted by the Santillan family and the public as authentic expressions of remorse and sorrow.

However, the public statements by Dr. Jagers and Dr. Fulkerson fall short of our definition of genuine apologies, though Dr. Jagers’s statement approaches it much more closely

¹⁶² Morgan and others, “America’s Angel,” 31-2.

¹⁶³ Morgan and others, “America’s Angel,” 32.

¹⁶⁴ Morgan and others, “America’s Angel,” 32.

than Dr. Fulkerson's for reasons already discussed.¹⁶⁵ Still, Duke's statements, as well as Dr. Jagers's, serve to establish and corroborate the public record of the events by identifying where the errors occurred and who was responsible for their commission, though there is room for improvement in the quality of this disclosure. Following a root-cause analysis and other investigation, Duke provided more comprehensive reports to the Joint Commission on the Accreditation of Healthcare Organizations as well as to UNOS, detailing the events of the error (which are consistent with the account provided by Cook and summarized in the previous chapter) and the steps Duke took immediately and in the weeks following the error to improve their internal processes of transplantation and patient safety, including hiring at least three patient safety administrators.¹⁶⁶ Duke contributed to the public record about the events surrounding Jessica Santillan's transplantation surgeries and death by releasing these internal documents in addition to the public statements discussed earlier in this chapter.

I am convinced that the staying power of the public controversy following the transplantation error at Duke is due in some part to public dissatisfaction over the statements issued by the institution, Dr. Fulkerson, and Dr. Jagers. While many other factors were clearly in play, such as Jessica's immigration status and the general concerns regarding scarce resources being dedicated to her second transplant, I believe that individual and institutional responses

¹⁶⁵ Interestingly, Susan E. Morgan and colleagues refer to Duke's statements specifically as an apology, but they also acknowledge the ambivalence about the ethical interpretation of the statements that was not resolved in the media coverage: "In the context of heated accusations and the extraordinary error, Duke's apology could be read in different ways: was it admirable forthrightness under difficult circumstances? Or were their words read as superficial and unsatisfying attempts to shape future discussions about the institution's liability?" The irresolvable tension about the meaning of Duke's public statements indicates a failure of those statements to pass muster with the reasonable person standard of genuine apology. Morgan and others, "America's Angel," 30.

¹⁶⁶ Diflo, "The Surgeon's Perspective," 77-8; Duke Medicine News and Communications, "Update on Sentinel Event Review and CMS/JCAHO," March 21, 2003, <http://dukehealth.org/HealthLibrary/News/6454> (accessed October 8, 2008); Duke Medicine News and Communications, "Duke Releases Letter to UNOS Concerning Jessica Santillan," February 21, 2003, <http://dukehealth.org/HealthLibrary/News/6419> (accessed October 8, 2003).

provided to the public promoted confusion over how the error occurred and who was responsible because they did not combine transparent disclosure with personal expressions of remorse. Additionally, no administrator came forward to accept his or her portion of the responsibility for the error even though Dr. Fulkerson identified Duke's system as faulty. These gaps in the processes of disclosure and apology left room for doubt about the practical and ethical resolution of the wrongdoing at Duke. Following the error, Dr. Jagers remained at Duke and many institutional reforms were enacted, but those responsible for overseeing the policies and practices are never mentioned as having neglected their duties or having failed to prevent wrongdoing. Instead, the institutional statements clouded over any specific enumeration of administrative responsibility for policy failings in favor of the vague mention that "Duke accepts responsibility for our mistake"¹⁶⁷ and the specific claims about Dr. Jagers's failure. In the next chapter, I will lay out in greater detail my proposal for the promotion of a culture of responsibility within healthcare institutions and imagine how responses to the Jessica Santillan case might have been different if there were such a culture at Duke.

In this chapter I have conceptualized apology according to its requisite components, goals, measures of assessment, and the exigencies that call for apology. Additionally, I have discussed behaviors that are related to apology and which may supplement or substitute for apology in some cases. I have argued that "institutional apologies"—offered by an institutional representative on behalf of another institutional member or the institution as a whole—are

¹⁶⁷ Duke University Office of News and Communications, "Duke Continues Review of Jessica Santillan Case," February 22, 2003, <http://www.dukenews.duke.edu/2003/02/santillanase0203.html> (accessed October 8, 2008).

ethically meaningless due to the apologizer's lack of standing to apologize and the absence of personal remorse and responsibility for the wrongdoing. Instead, I claim that apologies by institutional members may only be offered by individuals for their own institutional role-related wrongdoing. This claim will be further developed in the next chapter, where I introduce the concept of a "culture of responsibility-taking" and advocate such a culture for health care institutions. As a transition from interpersonal apologies to a culture of responsibility, let me offer a quotation from Nicholas Tavuchis on the scope and power of apology:

"A consummate apology, no matter how personal or private an act, is rarely the sole concern of the principals. It is not easily contained because it inevitably touches upon the lives and convictions of interested others while raising both practical and moral questions that transcend the particular situation that prompted it. In this sense, it is quintessentially social, that is, a *relational* symbolic gesture occurring in a complex interpersonal field, with enormous reverberatory potential that encapsulates, recapitulates, and pays homage to a moral order rendered problematic by the very act that calls it forth."¹⁶⁸

¹⁶⁸ Tavuchis, *Mea Culpa*, 14.

3.0 TOWARD A CULTURE OF RESPONSIBILITY

In the first two chapters, I have explored the topographies of medical error and apology, arguing that apology is an ethically appropriate response to instances of medical error that result in harm. What remains to be addressed in this final chapter is a closer examination of how apology can be offered in response to instances of medical error and the benefits of developing a “culture of responsibility” to which apology may contribute in medical institutions. My concluding remarks look both back to the claims of this thesis and ahead to the implications of this argument and the possibilities for ethical considerations of apology in future research.

First, though, I return to the Jessica Santillan case to imagine how a different institutional culture at Duke may have resulted in different responses to the errors made in Jessica’s care. While my recommendations in this thesis have little, if any, direct bearing on the faulty policies and practices that led to Jessica Santillan’s harmful transplantation surgery, they do hold significance for the communicative and behavioral responses to the error. The following section proposes an imaginative reconstruction of the events following the revelation to Dr. Jagers that the organs he had just transplanted into Jessica were blood type A and not compatible with Jessica’s blood type O. This hypothetical version of the events at Duke University Hospital allows us to consider how the individuals involved might have responded if their institution subscribed to and endorsed a culture of responsibility-taking. The following imagined events take place over the course of several days with attention to timeliness rather than haste. While the initial

disclosure of error is made to the family as soon as possible after surgery, other follow-up discussions and activities occur in the days and weeks following the transplantation error.

3.1 IMAGINING A CULTURE OF RESPONSIBILITY IN THE SANTILLAN CASE

In this reconstruction, immediately after learning about the donor organs' blood type from the lab technician, Dr. Jagers alerts the rest of the team in the operating room to the incompatibility of the organs transplanted into Jessica and calls an error response officer to alert her to the error. The transplant team applies best-known medical practices to forestall the inevitable rejection of the organs. As soon as surgery is complete, Dr. Jagers and the error response administrator (joined by a translator) approach Jessica's parents to disclose the error. Dr. Jagers speaks: "We've completed the surgery and Jessica is currently in critical condition in the intensive care unit, but there has been a terrible error. While finishing the surgery, I learned from the hospital's laboratory that the heart and lung we transplanted into Jessica were from a child with a different blood type than Jessica. I did not know this when I accepted the organs from the donor or even when I began the surgery to remove Jessica's own heart and lungs. We need to investigate how this error was allowed to happen, but, as Jessica's surgeon, it was my responsibility to check and double-check that the organs I transplanted were right for Jessica. I failed to do that—I just assumed they were correct—and I am so terribly sorry.

"So what does this mean for Jessica? I expect that within hours, Jessica's body will begin to reject the new organs, and she will eventually go into heart failure and maybe even a coma. We are already doing everything we can to keep these organs working for Jessica as long as possible, but they will not keep working for more than a number of days. I am so sorry that I

wasn't careful enough while doing my job. [Here, Dr. Jagers briefly explains the treatment options, including another transplantation with properly matched organs if they are available in time.] The hospital will make sure that Jessica's medical needs are taken care of at no cost, either here at Duke or at another hospital if you choose. I want you to know that we will answer all of your questions as completely as we can, and we will keep you updated with any information we learn about this error and how it affects your family. Ms. Smith, the error response officer, will come to talk with you about what Duke can do for you."

In having this conversation, Dr. Jagers sits down with Jessica's parents, looking them in the eyes when he speaks. He is visibly upset about the bad news he had to share with them. He stays with them to answer medical questions they have about Jessica's prognosis and waits to leave the room until they have asked all they could at the time. As he leaves, he tells them, "Please feel free to call me at any time to ask questions or talk to me about your concerns—I mean that."

Jessica's family decides to keep her at Duke with the same care team because her condition is so fragile and because, up to the transplantation, Jessica had received excellent treatment at that hospital. Still, they are in shock that such an error could have happened at such a highly respected institution. They are confused, sad, and frightened for Jessica's future.

Later, Duke's error response officer visits the Santillan family to leave her contact information and a note indicating that the family should contact her when they are ready to talk about the hospital's extra-clinical response to this error. The officer indicates that she is available to answer the family's questions about how Duke intends to help the family with Jessica's medical expenses and her parents' living expenses due to the extra care Jessica requires as a consequence of the transplantation error. The officer also tells the family that they may consult a

lawyer about their legal options. When the family meets with the error response officer a few days later, she is forthright with the family but tells them that there is much more information to be learned about how the error happened. The officer promises to tell the family everything that the hospital learns about the error. In all subsequent conversations and negotiations with the family regarding financial compensation, the error response officer and other institutional members foster a spirit of cooperation rather than taking an adversarial approach toward the family.¹⁶⁹ The hospital's representatives understand that protracted disputes and haggling over compensation are contrary to a culture of responsibility and serve to undermine the psychological and social benefits of apology. The error response officer considers it part of her job to resolve issues of medical error with as little additional pain and anger possible for all those involved.

Even before the transplantation error, Jessica's story about immigration and the search for life-saving medical treatment had been reported in the local media.¹⁷⁰ However, when the media learn of the error—possibly through the Santillan family's patron and advocate, Mack Mahoney—Dr. Jagers and various hospital administrators are barraged by reporters' phone calls

¹⁶⁹ Within a culture of responsibility, the offer of compensation by the hospital is voluntary and takes place through a cooperative arbitration in which the interests and needs of the patient (or her family, in the case of death) are heard by an objective arbitrator. Compensation might be assessed according to a standardized schedule for death and disability (similar to a worker's compensation system) with some flexibility to accommodate the particular circumstances of the patient and her affected family members. In any case, the determination and provision of compensation following medical error is not undertaken as a means of "buying off" the patient and her family but as a means of making fair restitution for injuries suffered as a result of preventable medical error. Nancy Berlinger discusses three different models of fair compensation and no-fault compensation programs already established in the United States. Some models offer fair compensation to injured patients (and encourage the patient to have legal representation during the settlement) if the patients waive their right to sue the hospital at a later date. Other models do not require such a waiver but also do not allow the patients to have a lawyer participate in the compensation determination. See Nancy Berlinger, *After Harm: Medical Error and the Ethics of Forgiveness* (Baltimore: Johns Hopkins University Press, 2005): 69-80.

¹⁷⁰ Susan E. Morgan and others, "America's Angel or Thieving Immigrant?: Media Coverage, the Santillan Story, and Publicized Ambivalence toward Donation and Transplantation," in *A Death Retold: Jessica Santillan, the Bungled Transplant, and Paradoxes of Medical Citizenship*, ed. Keith Wailoo, Julie Livingston, and Peter Guarnaccia (Chapel Hill: University of North Carolina Press, 2006), 27-8.

seeking more information, including personal confessions and any consequences for the responsible person(s). In response to the media fervor and with permission of the Santillan family, Dr. Jagers¹⁷¹ issues his public statement: “Jessica Santillan underwent a heart-lung transplant at Duke Hospital to treat her life-threatening illness. Unfortunately, there was a terrible error: I inadvertently transplanted organs that were an incompatible blood type for Jessica, and the organ rejection she is experiencing has made her critically ill. As Jessica’s surgeon, it was my responsibility to verify and re-verify that the organs were appropriate for Jessica; I failed to do this. The doctors and nurses who are caring for Jessica are tremendously talented and are doing everything they can for her. I grieve with her family and with members of the medical team for the trauma Jessica has suffered. Please keep them all in your thoughts and prayers.”

Dr. Fulkerson, the chief executive officer and vice president of Duke University Hospital, also issues a statement with the Santillan family’s permission: “We at Duke are deeply saddened and troubled by the transplant error that occurred on February 7. We continue to investigate how such an error happened and we are cooperating fully with the relevant agencies, such as the Joint Commission on Accreditation of Healthcare Organizations and the Health Department, which assess hospital quality. It is evident that individuals besides Dr. Jagers contributed to the ultimate error of transplanting incompatible organs into Jessica Santillan. This error was the result of major and minor failings throughout Duke and the organ sharing network. As far as Duke is concerned, we did not have adequate policies and practices in place to assure double-checking all key information before beginning this medical procedure. These policies and practices are an

¹⁷¹ Most medical errors are not publicly announced nor garner such intense attention from the media as the Duke transplantation error, so we would typically expect the physician to be focused on patient care rather than public relations concerns. However, Dr. Jagers was a key figure in this highly publicized case of a celebrated surgeon’s terrible mistake. Additionally, he had been involved with Jessica’s medical care for at least the year that she was on the waiting list for a heart-lung transplant at Duke. It is reasonable to expect that Dr. Jagers—with the Santillan family’s permission—would offer a public statement in this case, given the combination of intense media attention and Dr. Jagers’s extended involvement with Jessica’s care.

administrative responsibility, and we will address them as such. As an executive of this hospital, I'm sorry that I failed to recognize and address the dangerous flaws in our transplant procedures. Dr. Jagers is a well-respected and important member of our institution, and we will be working with him and all members of the transplant department to assess, discuss, and possibly alter the protocols for various procedures in that department. Please be assured that Duke will do everything possible to correct our institutional failings and to assure the safest patient care possible. It is my responsibility to oversee these investigations and improvements and you have my word that they will be done thoroughly. Meanwhile, I am keeping Jessica and her family in my prayers and hoping for the best possible resolution to this tragic situation.”

In the days following the transplantation surgery, Jessica's condition continues to deteriorate, and Jessica's family and the surgical team eagerly hope for a new heart and lungs to allow for a second transplant. Whether or not new organs become available or whether Jessica will even be healthy enough for a repeat transplant, the doctors in charge of Jessica's care keep her family up-to-date with all the developments of her care and include them in decisions about possible treatment or end-of-life care. The Santillan family is also invited to participate in patient safety discussions regarding prevention of medical errors such as the ones that affected their daughter. Ultimately, the Santillan family decides not to pursue a malpractice case against Duke or Dr. Jagers. Throughout Jessica's post-transplantation time at Duke, her medical care is provided at no cost to her family. Following Jessica's death, resulting from organ rejection of the blood type A heart and lungs, Duke settled with the Santillan family to provide fair compensation for the fatal medical error. These financial provisions, the full disclosure of all information related to the transplantation error and the hospital's remediation efforts, and the

personal and heartfelt apologies from Dr. Jagers, Dr. Fulkerson, and the CDS coordinator¹⁷², assured the Santillan family that nothing else could be done to make the tragic situation any better for future patients at the hospital, the Santillan family, or their daughter.

3.2 ON APOLOGIES AND TAKING RESPONSIBILITY

In this chapter, I have referred to a “culture of responsibility.” This concept deserves explanation, particularly as it relates to the conclusions in the first two chapters of this thesis and the hypothetical case example above. The definition of apology I have developed requires that an offender 1) acknowledge that a wrong was committed; 2) accept responsibility for her contribution to that wrong; 3) express remorse; and 4) intend to benefit the victim through the offer of the apology. We understand that apology requires explicitly taking responsibility for one’s wrongdoing, but the converse is not true: Taking responsibility for one’s actions does not necessitate an associated apology, whether or not a justification is offered for those actions. Still, it is ethically troubling to admit fault for an error that has harmed another person (in the absence of justification) without also expressing remorse and, thus, apology for the harmful error. Therefore, my argument for a culture of responsibility considers responsibility to be both retrospective and prospective. One may take responsibility retrospectively by recognizing and acknowledging her effect on those around her when she has erred in some way. This approach recognizes human fallibility and attempts to maintain civil relations by affording a means of

¹⁷² Due to the CDS coordinator’s culpable role in the organ mismatch, he has the standing and ethical obligation to apologize. However, the coordinator is not within the jurisdiction of Duke’s system and is subject to his own institutional culture and responsibilities. His apology is not included in this fictitious reconstruction of events in order to keep the focus on Duke’s imagined institutional culture of responsibility.

assuming responsibility and expressing associated emotions while avoiding the negative effects of finger-pointing behaviors that merely blame and shame.¹⁷³ Taking responsibility prospectively in a culture of responsibility incorporates goal-setting, moral reasoning and deliberation, and the role-based obligations that adhere to members of institutions.¹⁷⁴ Looking forward with a sense of responsibility helps to anticipate and prevent harmful error from occurring. After an error, taking responsibility should occur in both directions: retrospectively by recognizing and admitting one's role in an error and prospectively by fulfilling one's role-based obligations to attend to the consequent needs of the victim. The offender may also need to deliberate with other members of the institution to set goals for preventing similar occurrences in the future. In such a culture, the practice of genuine apology is not a rarity but, rather, proceeds naturally from retrospective responsibility-taking.

When one takes responsibility and genuinely apologizes to the victim of one's wrongdoing, the encounter can have significant positive effects on the apologizer, the victim, and their community or social context.¹⁷⁵ To that end, sociologist Nicholas Tavuchis writes, "An apology thus speaks to an act that cannot be undone but that cannot go unnoticed without compromising the current and future relationship of the parties, the legitimacy of the violated

¹⁷³ The distinction between guilt and shame is important here. Guilt is "the capacity to apply standards of right and wrong to our behavior toward others" and is an acknowledgement of culpability for a specific instance of wrongdoing. Shame is "an emotional reaction to the experience of failing to live up one's image of oneself" and "appears to be a response to a more general judgment about the self," often resulting in a desire to avoid one's victims rather than to make amends. Appropriate feelings of guilt are healthy for the individual and are socially beneficial, whereas the perpetuation of shame can be emotionally and socially damaging. Aaron Lazare, *On Apology* (New York: Oxford University Press, 2004): 135-6.

¹⁷⁴ Virginia A. Sharpe, "Taking Responsibility for Medical Mistakes," in *Margin of Error: The Ethics of Mistakes in the Practice of Medicine*, ed. Susan B. Rubin and Laurie Zoloth (Hagerstown, MD: University Publishing Group, 2000), 185-6.

¹⁷⁵ Nick Smith, *I Was Wrong: The Meanings of Apologies* (New York: Cambridge University Press, 2008), 23.

rule, and the wider social web in which the participants are enmeshed.”¹⁷⁶ For the victim, receiving an apology signals that her offender recognized the wrong *as a* wrong and is an occasion when the victim is treated as a moral equal with (and by) her offender. The victim, if convinced of the offender’s true remorse, can have renewed confidence in the shared values that operate within their relational context. The epistemic benefits (transparency, knowledge, resolved confusion, sharing information) of open disclosure also accrue to the recipient of a genuine apology.

For the offender, an apology may be an important step in processing the shock and pain from realizing she has harmed another person. Bioethicist Nancy Berlinger puts it this way: “Saying ‘I’m sorry’ – and meaning it, and accepting the full consequences of these words – is a time-honored way to expiate paralyzing feelings of guilt or shame that a psychologically healthy person feels after having unintentionally harmed another person.”¹⁷⁷ Ethical apology is not a quick fix to eliminate feelings of guilt, but it may be restorative for both offender and offended. Still, when authentically engaged, apology can be a very uncomfortable experience for the offender, who is exposing herself to scrutiny, criticism, and censure by reminding herself (and, perhaps, others) of the wrong she committed. While some of this discomfort might be avoided by offering a written apology in lieu of a face-to-face conversation, “there is, quite simply, nothing as effective and unsettling as having to address in person someone we have wronged, no matter how much a culture stresses writing, print, or electronic communication to the detriment of speech.”¹⁷⁸ Being unsettled by the realization and direct admission of one’s wrongdoing is a

¹⁷⁶ Nicholas Tavuchis, *Mea Culpa: A Sociology of Apology and Reconciliation* (Stanford: Stanford University Press, 1991): 13.

¹⁷⁷ Nancy Berlinger, *After Harm: Medical Error and the Ethics of Forgiveness* (Baltimore: Johns Hopkins University Press, 2005), 96.

¹⁷⁸ Tavuchis, *Mea Culpa*, 23.

natural—and perhaps necessary—element of restoring moral order between offender and victim. Indeed, if an offender is not somewhat uncomfortable facing her victim to offer an apology, we might wonder whether the offender is uncomfortable with wrongdoing in general.

The social context within which an offense occurs can also be strained as a result of the infraction. A genuine apology offered from offender to victim reaffirms the expected norms in that context and reminds witnesses of those expectations and consequences.¹⁷⁹ If the norms of memberships in various communities (professional or familial, for example) are acknowledged and validated by our fellow members, then our compliance with communal expectations are a sign of our moral commitment to the membership and its stability.¹⁸⁰ The community bond is strengthened when an offender is reminded of how she has jeopardized her membership by violating the trust of the others, and “it is only by *personally* acknowledging ultimate responsibility, expressing genuine sorrow and regret, and pledging henceforth (implicitly or explicitly) to abide by the rules, that the offender simultaneously recalls and is re-called to that which binds.”¹⁸¹

The material benefits of apology are worth noting, as well. Berlinger argues that offering an apology and compensation to injured patients reduces the perceived need to sue the offender “because these words and actions, offered together, satisfy each of the needs—to know what

¹⁷⁹ Offering an apology, like following rules of etiquette, signals the performer’s familiarity and compliance with social and moral norms. Moreover, apologies and manners demonstrate consideration and respect for others as moral equals and preserve (or restore) harmonious social relations. The ethical import of apology is not just in the acceptance of responsibility and remorse for wrongdoing, but also in the explicit, expressed apology statement that serves as an outward display of morality, much like the display of manners is taken to be a sign of one’s moral and ethical consideration for others. This argument for the moral significance of manners is made by Sarah Buss: “If, as seems obvious, the essential point of these [etiquette] rules is to instruct people on how to treat each other respectfully, and if, as I have argued, treating people respectfully is essential to treating them with respect, then the essential point of good manners is a moral point: to enable us to treat one another with respect.” See Sarah Buss, “Appearing Respectful: The Moral Significance of Manners,” *Ethics* 109 (July 1999): 795-826.

¹⁸⁰ Tavuchis, *Mea Culpa*, 7-8.

¹⁸¹ Tavuchis, *Mea Culpa*, 8.

happened, to have one's suffering taken seriously, to repair, literally and symbolically, the damage caused by the mistake—that along with anger at nondisclosure, lack of apology, and lack of compensation, drive lawsuits.”¹⁸² Aaron Lazare also acknowledges this relationship between malpractice suits and apology, noting that the patient is less likely to sue if she believes that her “views, values, and perspectives have been respected” by her doctor.¹⁸³ Recent studies have shown that when a clinician honestly discloses errors to her patients and offers a timely apology her patients are less likely to sue and, if they do sue, tend to settle for smaller settlements resulting in decreased legal fees and malpractice premiums.¹⁸⁴

Apologies affect those who offer, receive, and witness them, so it is appropriate to understand a culture of responsibility as being concerned with the reception of and possible follow-on activities to apology in addition to the specific offers of apology themselves. The hierarchical and peer relationships within institutions bear on the initiation and maintenance of a culture of responsibility; the next section describes how administrators and clinicians (and superiors and subordinates, generally) have responsibilities within this culture. Additionally, the next section will discuss the new norms for these institutionally structured relationships in the culture of responsibility, including how responsibility-taking and apology-giving acknowledge, restore, and maintain the working relationships among administrators, clinicians, patients, and families.

¹⁸² Berlinger, *After Harm*, 67-8.

¹⁸³ Lazare, *On Apology*, 173.

¹⁸⁴ These beneficial consequences of open disclosure and apology have been noted by: Stacey Butterfield, “Apologize Like a Pro,” *ACPHospitalist* (January 2008): 15; Aaron Lazare, “Apology in Medicine: An Emerging Clinical Skill,” *Journal of the American Medical Association* 296, no. 11 (September 20, 2006), 1401; Maura Lerner, “Hospitals Learn to Say Sorry,” *Star Tribune* [Minneapolis-St. Paul, MN], March 29, 2008; Kevin Sack, “Doctors Say ‘I’m Sorry’ Before ‘See You in Court,’” *New York Times*, May 18, 2008; and Doug Wojcieszak, John Banja, and Carole Houk, “The Sorry Works! Coalition: Making the Case for Full Disclosure,” *Joint Commission Journal on Quality and Patient Safety* 32, no. 6 (June 2006): 346.

3.3 APOLOGIES IN HEALTH CARE INSTITUTIONS

As described in this thesis, the social practice of apology has psychological benefits to the dyad of giver and receiver as well as social benefits to the communities in which it is practiced. A culture of responsibility-taking, complete with the promotion of genuine apology, within health care institutions can also contribute to the broader goals of safe and effective patient care. We would hope that in all health care institutions, both administrators and clinicians are concerned with the provision of high quality care while looking for ways to improve patient care and safety at every level. Taking responsibility for errors is a necessary first step to improving the quality of care because, “rhetorically, it can be difficult to deny responsibility for an offensive act and then announce corrective action. After all, if one is not responsible for an offense, then what is there to correct?”¹⁸⁵ An institution with a culture of responsibility would strive to foster and maintain an animating atmosphere of collective responsibility for the well-being of others.

Ideally, health care institutions would promote a culture of safety and high quality care that would encourage individuals at every level of care and service to feel a sense of responsibility for others with regard to promoting safety and preventing error. Embrace of this culture of safety could not be a strict legal obligation; rather, it would be an attitude and an approach inculcated and supported by reasonable policies and the examples set by senior members of the institution. This culture resembles the theory of continuous quality improvement (CQI) described by Sharpe and Faden, which “depends in large part on the willingness of leadership in health care institutions and organizations to abandon the practice of finger-pointing in favor of supportive and cooperative goal-setting. In such a context, the incentive system will

¹⁸⁵ Richard L. Johnson, *Crisis Communication: Case Studies in Healthcare Image Restoration* (Marblehead, MA: HCPro, 2006), 45.

be oriented to rewards for cooperation rather than penalties for non-compliance.”¹⁸⁶ Additionally, subscribing to a culture of responsibility means that all institutional members will come together to learn from each other when errors occur rather than seek to shun and shame the one who has committed the error.¹⁸⁷

When errors inevitably occur, however rarely, the responsible parties in an institution with a culture of responsibility would transparently and compassionately disclose the error to the patient (or appropriate representatives) and work with other members of the institution to provide the affected patient with clear and complete information about her injury and the measures taken to restore her to wholeness.¹⁸⁸ In addition to disclosure, the responsible parties would also be able and encouraged to offer a genuine apology to the victim without fear of condemnation by peers or administrators for the admission of fault. Within health care institutions, a culture of responsibility would not condone browbeating members into submission to an apology policy

¹⁸⁶ Virginia A. Sharpe and Alan I. Faden, *Medical Harm: Historical, Conceptual, and Ethical Dimensions of Iatrogenic Illness* (Cambridge: Cambridge University Press, 1998), 144.

¹⁸⁷ One example of institutional members coming together to learn from error may be the surgical Mortality and Morbidity (“M&M”) conferences routinely held following unexpected adverse outcomes. Charles L. Bosk describes the “M&M” conference as a ritual in which the “actors accept responsibility for error, point out lessons this sad experience has taught them, and detail the steps necessary so that others are able to avoid just such errors in the future.” [“All Things Twice, First Tragedy then Farce: Lessons from a Transplant Error” in Wailoo, Livingston, and Guarnaccia, *A Death Retold*, 115.] However, these conferences serve a limited purpose and should not be used as a general model for error response and quality improvement. First, attendance at these private conferences is limited to the surgical housestaff and attending physicians and does not include other care teams, patients, their families, or all relevant hospital administrators. Also, the “M&M” conference limits the scope of peer review to the actions taken by the surgical team and tends to rely on formal, technical explanations for adverse events rather than normative and quasi-normative errors. These explanations reinforce perfection as a goal but acknowledge that bad outcomes happen even without the commission of error. At these reviews, the attending surgeon takes ultimate responsibility for good and bad outcomes, regardless of the specific actions of his or her subordinates who are protected from public shame in the surgical training culture. “M&M” conferences may be included within a culture of responsibility, but they cannot serve as a substitute for the transparent and cooperative clinical and administrative practices I advocate as part of a broader, ethical institutional culture.

¹⁸⁸ Disclosure and apology need not be offered by the same person, though genuine apology may only be offered by the one(s) responsible for the wrongdoing. Health care institutions may have personnel who are better positioned to provide timely and accurate information to patients than the primary caregiver, for example. Disclosure may be an ongoing process as new information emerges. Also, apology may occur in a separate discussion from the disclosure, although genuine apology cannot precede disclosure of the wrongdoing and harm. An offender may apologize more than once, especially if she learns that she has more to apologize for than she included in her initial apology. In any case, the institution is responsible to assure that the victims of error receive full disclosure of the error and information about how it will affect them.

that fails to consider the ethical dimensions of such an encounter. Since apology includes an expression of the offender's genuine remorse, it must arise from appropriate humility and an assumption of responsibility or feeling of guilt rather than from policy-driven shaming by others. A culture of responsibility seeks to develop in institutional members a greater regard for the ethical treatment of patients than their own desire to avoid or deny the situation by concealing, minimizing, or manipulating information and interactions with the patient and her family. Such a culture recognizes and seeks to develop in members an appropriate perspective on human fallibility and an understanding of the need both to reduce error-prone practice and to recognize when they owe an apology to others.

In light of these ethical goals of an institution with a culture of responsibility, the charge for institutions is threefold. First, institutions must teach the value of apology to their members. This value extends beyond providing the offender's sense of personal closure or expiation to include addressing the patient's need for acknowledgement, empathy, and psychological safety. Second, institutions must foster a culture of responsibility through policies designed to facilitate and not impede apologies between those responsible for error and those who have been affected by error. Ongoing training and institutional support for forthright and ethical communication between institutional members and patients can contribute to the ethical culture of the institution, as will the institution's fulfilled promise to those it serves that its members will disclose error, apologize for wrongdoing, discuss measures taken to prevent recurrence of wrongdoing, and compensate for harm caused by error. Third, institutions must support the clinicians and administrators, as well as the victims of error and their families, throughout the whole ordeal.

Chaplains,¹⁸⁹ counselors, or others who can offer psychological support may be made available to both the offender and victim if requested. Patients should expect to be able to ask questions and receive clear answers, and the offenders should be able to count on access to the advice and training necessary to uphold their ethical duties to speak openly and ethically with their victims. If a victim does not wish to see or speak with the person who committed the harmful error, that wish should be honored and the institution should provide a patient advocate to act as a liaison to facilitate the flow of information to and from the victim (though this advocate cannot apologize on behalf of others but could convey an apology from the offender if the victim were amenable to that arrangement). Furthermore, the institution should not try to help the offenders ignore the personal ramifications of error or “brush it off.” Rather, providing emotional support to help offenders recognize and deal with their guilt in a healthy and productive way can avoid the dangers to current and future patients that may result when an offender rationalizes her actions, views herself as infallible, or is debilitated by shame and fear of ever making another mistake.¹⁹⁰

Another charge for the institution adhering to a culture of responsibility is to assure that subordinates do not take an undue measure of blame for error that is more appropriately shared with those in higher authority.¹⁹¹ In a hierarchical system, it may be easy for those higher up the ladder to pass on blame to their subordinates, but a culture of responsibility requires that attention be given at every level to the quality of care and service offered and to institute changes in policy and practice as necessary to provide safe and high quality care, regardless of who may have initially drawn attention to the need for change.

¹⁸⁹ Although some people rely on religious understandings of human fallibility to make sense of error, I suggest the possible involvement of chaplains for two practical reasons. First, most hospitals already have chaplains available on staff and, so, would not need to hire additional staff. Second, both wrongdoers and victims may request that someone pray with them, regardless of their own views about the spirituality (or not) of human fallibility.

¹⁹⁰ Berlinger, *After Harm*, 106-7.

¹⁹¹ Berlinger, *After Harm*, 101.

This last consideration raises the issue of whether medical errors are caused by individuals, systems, or both. As sociologist Charles L. Bosk claims, “One can build a case that all medical errors are systems errors. One can also build a case that all errors are the result of individuals making misjudgments. The choice between the terms ‘systems error’ and ‘individual misjudgment’ is as much political as it is empirical. Either term contains a metaphor about how the world is broken and how it is best fixed.”¹⁹² It is also a false choice, because errors in institutional systems naturally involve the actions of fallible individuals who act within those flawed systems. Attributing error to individual deficiencies may be counterproductive to a culture of responsibility because it “naturally engenders an atmosphere of defensiveness (such as the tendency to offer excuses) and evasiveness.”¹⁹³ At the same time, however, failing to identify any responsible individuals is also likely to stunt the development of a culture of responsibility by indicating that individuals are not expected to take personal responsibility for their own actions and reform. An institution that recognizes individual contribution to error yet engages in structural reform to improve care system-wide may avoid the ethical and functional pitfalls of an institution that focuses exclusively on either scapegoating individuals or blaming vague “systems errors.”¹⁹⁴

¹⁹² Charles L. Bosk, “All Things Twice, First Tragedy Then Farce: Lessons from a Transplant Error,” in Wailoo, Livingston, and Guarnaccia, *A Death Retold*, 103.

¹⁹³ Virginia A. Sharpe, “Taking Responsibility for Medical Mistakes,” in Rubin and Zoloth, *Margin of Error*, 187.

¹⁹⁴ Nick Smith, *I Was Wrong: The Meanings of Apologies* (New York: Cambridge University Press, 2008), 234

3.3.1 Apologies by Clinicians

The challenges clinicians face in embracing a culture of responsibility begin early in their careers. During medical¹⁹⁵ training, future and newly minted doctors must manage the tensions of the “hidden curriculum,” which insidiously teaches them to deviate from the explicit “professional obligation to tell patients the truth about their health—and to learn, by observing their senior colleagues, how to avoid doing this very thing.”¹⁹⁶ Moreover, the drive to demonstrate professional competence and flawlessness opposes the demands and permissions of a culture of responsibility, which allows and indeed requires clinicians to recognize human fallibility and the inevitability of error. Troublingly, clinicians may avoid taking appropriate responsibility by obscuring facts and culpability through rhetorical tactics such as specialized jargon (“It’s a simple bowel perforation.”), euphemisms (“an unfortunate complication”), and passive construction (“A pneumothorax occurred.”).¹⁹⁷ These behaviors violate a clinician’s professional and ethical obligations to be clear and truthful with their patients and colleagues about the nature and known causes of the patient’s condition. Furthermore, deception and defensiveness work against the ultimate goals of patient safety and effective patient care by diminishing opportunities for the culpable clinician, her peers, and hospital administrators to learn about dangerous practices or faulty policies that contribute to medical error and patient injury.

According to the definition of apology used in this thesis, we understand that clinicians’ responsibility to apologize must be limited to those medical errors to which their own actions or

¹⁹⁵ While I focus on physicians in this discussion, many of these points are equally applicable to all clinical care providers.

¹⁹⁶ Berlinger, *After Harm*, 2.

¹⁹⁷ Berlinger, *After Harm*, 23-4.

inactions contributed substantially and which resulted in patient harm (regardless of the patients' knowledge of the harm). An apology is in order when a clinician has failed to meet her ethical and professional obligations of due care. A pamphlet about disclosing adverse events published by the American Society for Healthcare Risk Management admits that the circumstances warranting an apology are sometimes difficult for a clinician to determine:

“Do we know if we have betrayed patient trust? Do we know if we have contributed to unmet expectations? For physicians who can tune into their own feelings, this is easier to determine. However, when fear of reprisal, belief that there is no responsibility or lack of empathy for the effect on the patient/family intervenes, then knowing that an apology is in order becomes a challenge.”¹⁹⁸

A genuine apology from a clinician achieves more than simply fulfilling a duty to disclose to patients and filing a report to administrators. Authentic remorse for the wrong contributes to a demonstration of empathy, which draws the apology's focus to the victim's suffering in addition to other concerns such as “the violated principle, the offender's failures, or the process of the offender's redemption.”¹⁹⁹

3.3.2 Apologies by Administrators

In the literature on apologies in medical contexts, the focus has been on doctors apologizing to their patients for harming them through error or negligence. However, I argue that hospital administrators also have a professional and ethical obligation to apologize to those harmed by

¹⁹⁸ American Society for Healthcare Risk Management, “Risk Management Pearls on Disclosure of Adverse Events” (Chicago: American Society for Healthcare Risk Management, 2006), 31.

¹⁹⁹ Smith, *I Was Wrong*, 100.

faulty policies or procedures (or failures to enforce appropriate ones) that are within the responsibility of those administrators. The systems perspective on the commission and prevention of errors enlarges the scope of scrutiny beyond the individuals at the nexus of patient-clinician interaction in care delivery to include other individuals involved in processes, including those who write, review, and enforce policies at the departmental and institutional levels. Berlinger correctly argues that when we talk about “systems errors,” we also ought to be thinking about the individuals with moral agency within that system who have responsibility for those errors: “‘The system’ may provide the context for a medical mistake, but does not, in and of itself, provide an adequate explanation for a mistake.”²⁰⁰ Faulty policies, practices, or traditions may be traceable to particular administrators who have or share responsibility for those policies or have the power to reform institutional rules and practices through policy change.²⁰¹ Also, the failure to institute or enforce policy may be a culpable institutional-level or administrative error. Attention to individuals’ roles in or contributions to errors need not result in a return to castigating culpable individuals as “bad apples” and removing them from the system; instead, identifying all those who share in the responsibility for error can more effectively lead to resolution of the past error and systems improvement to prevent future errors.

It may also be that the administration has wronged patients or the public through broader failings for which particular administrators may be held responsible.²⁰² For example, if there is a pattern of wrongdoing by members of the institution, the leadership may be held accountable for failing to address the repeated wrongdoing. Additionally, administrators may be guilty of ignoring or concealing evidence of wrongdoing by subordinates in the institution, thereby

²⁰⁰ Berlinger, *After Harm*, 96-7.

²⁰¹ Smith, *I Was Wrong*, 246.

²⁰² Smith, *I Was Wrong*, 187.

compounding the initial wrongs. These and other administrative failings warrant public disclosure, apology from responsible persons, and possibly remediation.

Representatives of the institution who are not responsible for wrongdoing can also be involved in the processes of disclosure and compensation that may accompany apology. The process of disclosure is essential to genuine apology, but it may be provided by someone other than the person who committed the wrong. In fact, thorough and accurate information may be more accessible to someone other than the person (e.g., clinician) who committed the error or wrongdoing. If the wrongdoer refuses to communicate with her victim, or if the victim prefers not to speak with her offender, the administration needs to provide a liaison to provide disclosure and keep in touch with the patient and her family about the effects of the wrong on her health. If a health care institution subscribes to a program of fair compensation for medical error, much like the institutions described in Berlinger's book, other administrators and institutional representatives will be responsible to discuss with error victims the compensation the institution is prepared to offer for their injuries or loss. The individual(s) responsible for the error may not be responsible (or able) to promise or provide compensation for harm, but their genuine apology to their victims is an important element in the larger program of an institution's ethical response to medical error.

3.4 CULTIVATION OF RESPONSIBILITY-TAKING

The establishment of a culture of responsibility as described above is undoubtedly a long-term effort that requires the participation of every level of institutional hierarchy. In the case of medical error and the hegemony of malpractice and risk management discourses, establishing a

culture of responsibility requires instituting robust policies and the unflagging support of senior administrators. The top-down model gives appropriate confidence to those clinicians who are already inclined to apologize to their patients following an error that they will not suffer sanctions or shaming by the administration for admitting fault for errors. Additionally, a culture of responsibility that begins with administrative action makes a stronger public statement, for which the institution may more readily be held accountable. Current and future employees of the hospital will have a clearer picture of the ethical attitudes and practices of that institution. Beyond simply establishing policy, administrators must also demonstrate support for a culture of responsibility by readily admitting responsibility for their own failures to fulfill their professional and ethical obligations and apologizing to those harmed as a result. Administrative apologies may be particularly meaningful to injured patients who expect the traditional defensive stance of risk management lawyers, but these apologies also serve as an example to subordinates and clinicians throughout the institution.

Clinicians are on the “front lines” of a culture of responsibility. They are the first to learn about adverse events and medical errors and have the most direct interactions with their patients. Their apologies to patients affected by their errors contribute fundamentally to the institutional ecology. However, clinicians may feel they have the most to lose from exposing their wrongdoing to patients and thereby exposing themselves to legal liability. For this reason, a culture of responsibility must be supported by institutional policies and procedures that meet the psychological, epistemological, physical, and financial needs of those injured by medical error in order to decrease patients’ needs for resolution through costly litigation.

A culture of responsibility is cultivated and maintained through the interdependence of administrative and clinical roles and responsibilities. Moreover, the individual actions of

administrators and clinicians—paradoxically—configure and are constrained by the institutional culture in which they take place. For a culture of responsibility to develop and thrive in the long-term, institutional members must practice taking responsibility and offering apologies consistently with the training and support of their supervisors and peers. It is only with such institutional support and consistency that the members may be convinced of the ethical, personal, and professional benefits of apology.

4.0 CONCLUSION

This thesis has analyzed the ethics of apology in response to medical error by examining each element in part, starting with analyses of errors, wrongs, and responsibility. In the first chapter, I provided a typology of medical error, discussed the ethical implications of various medical misadventures, and explicated the relationship between harms and wrongs. Justification and excuse were discussed as responses to allegations of wrongdoing that are legitimately offered in particular circumstances. I also introduced the case example of Jesica Santillan's heart-lung transplantation error that took place at Duke Hospital and the affiliated organ sharing network in February 2003.

The second chapter conceptualized apology and introduced several goals of genuine apology sought by those who offer them. Responses to apology, such as acceptance of the apology and forgiveness, were discussed as taking place along a continuum rather than as all-or-nothing phenomena. Additionally, the differences between interpersonal and institutional apologies were examined, culminating in my claim that institutional "apologies" are a misnomer for a particular kind of institutional rhetoric that lacks the ethical value of apology offered by an individual with standing and who feels personal remorse for individual wrongdoing. I used this conceptual framework to analyze the statements offered by the transplant surgeon, the hospital's chief executive officer, and Duke Hospital in the wake of Jesica Santillan's transplantation error.

Finally, the third chapter tied the above analyses together by describing and advocating a

“culture of responsibility” in health care institutions. I argue that the culture of responsibility is essential to safe patient care and ethical interactions within institutions—such a culture and the practice of genuine apology are mutually reinforcing. The characteristics and benefits of a culture of responsibility were described, as well as the responsibilities incumbent upon both clinicians and administrators within health care institutions. To illustrate how a health care institution subscribing to a culture of responsibility might respond to medical error, I provided a hypothetical case example based on the Duke transplantation case described in the first chapter.

I have argued that apology is an ethical and moral act, not simply an expedient or practical act. Therefore, it is appropriate to consider how ethical rationales support some goals of apology and a culture of responsibility. Most simply, apology is a demonstration of respect for the persons harmed by one’s mistakes or negligence. An apology acknowledges that the victim did not receive the care and treatment due her as a moral person and expresses the offender’s remorse for having committed a wrong toward another person. The offender also demonstrates her empathy for the victim by acknowledging the injustice of the harm her victim has suffered. Taking the victim’s perspective, the “view from below,” is advocated by Dietrich Bonhoeffer as the proper moral standpoint with regard to those who suffer.²⁰³ Berlinger describes the “view from below” as “the condition of suffering, whether temporary or permanent” that also “denotes the ethical obligation incumbent on those who are not suffering.”²⁰⁴ This ethical obligation is to work to alleviate the suffering of others, particularly when one has caused that suffering through her own action or inaction. In a medical context, this means that clinicians and administrators responsible for harming a patient have an ethical obligation to work in the patient’s interests

²⁰³ Nancy Berlinger, *After Harm: Medical Error and the Ethics of Forgiveness* (Baltimore: Johns Hopkins University Press, 2005), 9.

²⁰⁴ Berlinger, *After Harm*, 10.

rather than their own, considering the needs of the victim in her subordinated position “below” their own positions of power.²⁰⁵

As discussed in earlier sections, the ethical and professional duty to disclose to patients information about their health and affecting their health care decisions can be met without necessarily offering an apology for error, though a genuine apology is impossible without disclosure. Trustworthy caregivers must be forthright and honest with their patients. However, honest disclosure may, in fact, undermine patients’ trust in their caregivers and the institutions with which they are affiliated. When a patient learns that no positive verification took place before her doctor performed an incorrect procedure on her or that no one caught the overdose of medication she was given, she may feel strongly—and rightfully, perhaps—that her doctor or health care facility are dangerous and unworthy of trust. The consequences of disclosure are more complicated when it concerns errors that do not lead to harm: Should one disclose the “near misses” and risk undermining patient trust? While there is no clear ethical imperative to apologize for harmless minor wrongs or “near misses,” clinicians and administrators should recognize their fear of diminished patient and public trust as legitimate and work to increase their own trustworthiness through improved patient care. Indeed, this recognition of one’s possible untrustworthiness can be traumatic for an offender and may serve as the impetus to right her wrongs.²⁰⁶ If a clinician feels strongly that she needs to “come clean” to her patient about an error that did not cause any expected harm to the patient, her supervisors and administrators would be ethically remiss to discourage such transparency for fear of reprisal or diminished trust. Health care institutions earn and maintain public and patient trust not by concealing their faults

²⁰⁵ Berlinger, *After Harm*, 113.

²⁰⁶ Aaron Lazare, *On Apology* (New York: Oxford University Press, 2004), 134.

but by adhering to ethical policies and safe protocols and by striving to improve patient care before errors occur or complaints are filed.

The concept of forgiveness also confers ethical obligations upon offender and victim. Following Berlinger's logic, we ought to take seriously the notions of apology and forgiveness following mistakes that are inevitably committed by fallible people. She reasons that, since we understand rationally that mistakes will occur, we need to think about the consequences and responses to those mistakes. Furthermore, if we recognize that truth-telling and fairness are valued more than concealment and neglect according to our social and professional standards, we should follow those standards and norms in our responses to error. Finally, if we believe that forgiveness is a valuable response to error because it can help victims and offenders detach from some of their trauma, we should not compromise the value of forgiveness by settling for "cheap grace" if genuine forgiveness cannot yet be offered.²⁰⁷ Put simply, one's harmful error or negligence serves as the occasion for a genuine apology to be offered to the victim, but one's apology is an insufficient condition for forgiveness to be offered in return. Forgiveness, as an ethically and morally rich act, ought not be impulsive, insincere, or empty. Rather, it may take considerable time for a victim to feel ready to offer forgiveness, if she is ever able to at all. The expectation of forgiveness should never serve as the sole motivation for apology, and a victim must not be pressured by her offender or anyone else to offer forgiveness before she is ready to do so.²⁰⁸

In summary, the ethical principles of demonstrating respect for persons and treating others as moral equals require that an offender offer a genuine apology to her victim(s) for her wrongdoing, but it does not require that a victim immediately respond with forgiveness of her

²⁰⁷ Berlinger, *After Harm*, 113.

²⁰⁸ Berlinger, *After Harm*, 109.

offender. Disclosure, an ethical and professional duty, is a precondition of apology but can open up individuals or institutions to criticism and diminished trust by those who have suffered at their hands. Apologizers risk losing the regard of their victim and other witnesses as a consequence of humbling themselves before their victims during an apology, but forthrightness and acting in the interests of the victim (adopting the “view from below”) takes moral precedence over protecting one’s self-concept through manipulation or deception. In several ways, then, do ethical principles support a culture of responsibility that includes apology, a culture essential to the safe and ethical provision of patient care.

I have argued that the concept of an institutional apology, offered by a representative of an institution or offered on behalf of an entire institution, is ethically vacuous because it necessarily omits the key elements of personal remorse and empathy for the suffering of the victim(s). Such “apologies” often neglect the act of taking personal and specific responsibility for wrongdoing, thereby diminishing the statement to simple disclosure of wrongdoing or declaration of the values to which the institution purports to be committed. Instead, institutions should encourage individual members to take personal responsibility for their wrongdoing and support members as they offer personal apologies for wrongdoing. Administrators, as well as clinicians, may be culpable of wrongdoing and should be included among those who share responsibility in the commission of errors or the ineffectiveness of current policy.

Fostering and maintaining a culture of responsibility that includes apology may be more feasible now than in the past due to shifts in law and policy designed to protect certain apologetic expressions as inadmissible evidence in malpractice litigation.²⁰⁹ Additionally, several health care institutions have demonstrated increasing support for truth-telling and apology through

²⁰⁹ Berlinger, *After Harm*, 51-2.

attitude shifts and internal policies that aim to provide apologies and fair compensation to victims of medical error.²¹⁰ Whether the impetus for these programs of apology and compensation was to reduce legal costs or to act ethically and justly to victims of medical error, the policies have brought about improvements in both categories. Additionally, such programs have the potential to increase awareness about institutional policies or practices that may contribute to medical error and support the change of such policies and practices. Whether such apology and compensation programs will proliferate or even become the new norm in medical institutions is uncertain, but it is clear that an ethical approach to medical care necessitates honest, forthright communication between caregiver and patient, including the offer of genuine apology in response to medical error.

²¹⁰ Berlinger, *After Harm*, 69-78.

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