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Apologies following an adverse medical event: The importance of focusing on the consumer's needs

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ABSTRACT

Objective: The lack of a theoretical framework limits educators' ability to train health practitioners how to disclose, and apologise for adverse medical events. The *multidimensional theory of apology* proposes apologies consist of one or more components which can either be self-focused (focused on the apologiser's needs) or other-focused (focused on the needs of the consumer). We investigated whether the inclusion of other-focused elements in an apology enhanced its impact in a health setting.
Methods: 251 participants responded to a video-recording of an actor portraying a surgeon apologising to a patient for an adverse event. In one condition the apology was exclusively self-focused and in the other it was both self and other-focused.
Results: The self-focused apology was viewed more positively than negatively, but the apology that included additional other-focused elements elicited a more favourable reaction; it was seen as more sincere and as denoting more sorriness.
Conclusion and practice implications: Practitioners can enhance the impact of their apologies by including other-focused elements, that is, demonstrate they understand the impact the event had on the consumers, express remorse for causing harm, and offer, or take action, to address the intangible harm caused.

1. Introduction

Many countries require health practitioners (practitioners) to disclose unforeseen adverse events or medical errors (errors) they make (for a review of the literature see [1,2]). These disclosure policies can be justified with reference to practical reasons (for a discussion see, e.g., [3]), ethical obligations [4–11] and pragmatic benefits [12], but most importantly because patients and their families (consumers) expect practitioners to disclose [13–16], and apologise for errors [1,17–19].

Many practitioners support the disclosure of errors [11,17,20,21], but some remain reluctant to disclose errors for several reasons, including uncertainty about how to disclose and apologise in an appropriate manner [21]. Educators could address this problem by training practitioners how to do so [1,15,21,22], but they lack a theoretical framework of apology and empirically based guidance on what constitutes an appropriate disclosure and apology after an error [23]. Recent research revealed the complexity of apologies and that they vary according to circumstances, but there appears to be a growing agreement that an apology should incorporate an admission of wrongdoing, an expression of regret and restorative behaviour [24–32]. Researchers [26,28,31] further submit that for apologies to be effective their components must address the needs of consumers. Slocum et al. [31] used these components, which they refer to as Affirmation, Affect, and Action, to develop the multi-dimensional theory of apology.

Slocum et al. [31] visualise these components on a continuum where, at one end, apologisers focus exclusively on their own needs (self-focus) and, at the other end, recognise the needs of consumers (other-focus). As Fig. 1 illustrates the self-focus dimension of the Affirmation component requires at least an admission of responsibility (e.g., *I accidentally made a small nick to your bowel*) and acquires an other-focus when it incorporates an acknowledgement of the consequences of the wrong on the victim (e.g., *this mistake could have led to serious infection and illness*). The Regret element of the Affect component reflects a self-focus (e.g., *I am sorry about this*), whilst apologisers demonstrate an other-focus (Remorse) by displaying sorrow for the suffering they caused

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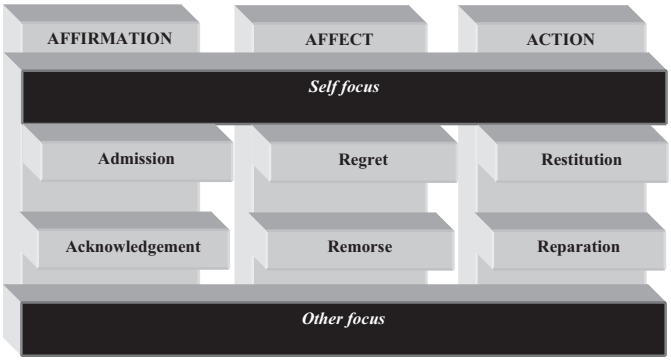

Fig. 1. The components of the multi-dimensional theory of apology and the elements representing opposite ends of the focus continuums.

the other (e.g., *I feel badly about the discomfort this has meant for you and the potential risks of the situation you were put in*). Apologisers demonstrate the self-focus dimension (Restitution) of the Action component if they offer to reverse the tangible consequences (e.g., *You will not be billed for the surgical procedure*), but they demonstrate an other-focus (Reparation) if they attempt to address the intangible needs of consumers (e.g., *I am going to review the way I do this procedure to make sure this does not happen again*).

People's inherent self-centredness makes it inevitable that all apologies will be self-focused. Apologies can range from complex to basic with the most basic apology having at least one self-focused element, but it could have two, e.g., the apology *I am sorry I accidentally made a small nick to your bowel* contains the Regret and Admission elements. A complex apology would consist of all self-focused and other-focused elements such as: *I accidentally made a small nick to your bowel, this mistake could have led to serious infection and illness. I am sorry that I caused you pain and discomfort and exposed you to the potential risks of infection. You will not be billed for the surgical procedure and I am going to review the way I do this procedure to make sure this does not happen again*. It is also possible that an apology could have any combination of self-focused and other-focused elements.

Slocum et al. [31] proposed that the inclusion of other-focused elements may enhance the effectiveness of an apology. As the multidimensional theory of apology could serve as a framework for educators guiding practitioners how to disclose and apologise for errors, our aim was to determine whether participants reacted differently to different presentations of an apology. The specific research question was whether adding other-focused apology components (Acknowledgement, Remorse, Reparation) to a basic (self- focused only) apology would influence participants':

1. Assessment of the apologiser;
2. Perception of the sufficiency of an apology;
3. Perception of the sincerity of an apology;
4. Judgement of how sorry the apologiser is;
5. Forgiveness of the apologiser; and
6. Behavioural intentions towards the apologiser.

2. Method

2.1. Participants

We recruited 251 community members from the metropolitan area of Perth, Western Australia (primarily by distributing flyers and putting up notices in various settings such as libraries, universities and social clubs) but deleted 4 participants' data because of aberrant or missing responses. The remaining 247 participants ranged in age from 17 to 87 years ($M = 48.55$ years, $SD = 24.40$ years) and 101 males and 144 females indicated their gender.

2.2. Materials

We produced videos of the same two professional male actors portraying a surgeon apologising to a post-operative patient using a scenario where the responsible person's identity was clear and the level of wrongfulness and the severity of consequences low. We used a scenario portraying a surgeon who perforated the wall of the patient's bowel during surgery because it was easy for the actor to explain and for participants to understand. Whilst some practitioners may not consider this to be an error, researchers found that patients would expect disclosure and an apology from a surgeon if this happened (see, e.g., [14,18,20,33,34]). We manipulated the six elements of the multidimensional theory of apology to develop a range of scenarios for a comprehensive study.[1] In this paper we report the comparison between the exclusively self-focused *Basic Apology* (see Table 1) and the *Complex Apology* which includes the Basic Apology plus other-focused components (for the wording of the elements see Appendix A).

We made minor alterations to the wording of scenarios in response to the feedback received from three health practitioners (who considered the authenticity of the scenarios) and 10 community members who judged their clarity and that of the questionnaire. The questionnaire consisted of 6 questions designed to determine the impact of the apology scenarios on participants. Our aim with the first question (which consisted of six sub-questions) was to determine participants' assessment of the apologiser. Participants responded to statements such as *I feel warm towards him*; *I think he is incompetent;* and *I blame the surgeon for this problem* on a six-point Likert-scale of which the anchors were *strongly disagree* and *strongly agree*. We combined the responses to these six sub-questions into a total score that indicated participants' overall assessment of the apologiser (Cronbach's alpha for this set of sub-questions were .85 and .86 for the two apology scenarios respectively). Participants then responded on a five-point Likert-scale to questions 2–5, which were:

- Do you think that the surgeon's apology was sufficient?
- How sincere was the apology?
- How sorry does the surgeon feel?
- How forgiving would you be towards the surgeon?

The purpose of question 6 was to determine how each scenario influenced participants' behaviour by asking them *What action should be taken against the surgeon?* with response options: *No action*, *An official complaint to the hospital*, or *Legal action.*

2.3. Procedure

A research assistant showed participants the videos on a laptop computer (pausing after each scenario to allow them to record their responses on the questionnaire) and controlling for order effects in the within-subjects design by alternating the presentation order of the scenarios.

3. Results

Mean scores on the outcome variables for the Basic and Complex apologies are displayed in Table 2. Assessments of the surgeon (apologiser) were, in general, marginally favourable in both the Complex Apology and the Basic Apology scenarios. The mean scores for apology sufficiency and sincerity, the apologiser's sorriness and the likelihood that the apologiser would be forgiven were all higher (more positive) than the midpoint (3) of the rating scales. The highest scores occurred for sorriness and sincerity and

[1] Full report available from authors.