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The value of an apology in medical malpractice conflicts

by

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Abstract

The following dissertation explored the value of an apology in medical malpractice conflicts. Through a mixed methodology, it was analysed data from different sources, as reports from government offices and previous research. Interviews were conducted to help to determine the value of the information. It was explored the elements and meanings of an apology. It was explained that medical malpractice conflicts are complex and different methods can be used to help manage it or solve each one with their pros and cons. After analysing all the data and literature, it was concluded that there is a value in delivering an apology in medical malpractice conflicts with evidence suggesting that it can help to restore the trust and the relationship between doctor and patient, de-escalate the conflict and help to solve it.

Introduction

An apology is a simple act that it is within ourselves, an action that is easy for us to recognise. A conflict, in simple terms, happens when different points of views, values, identities, interests, needs clash positively or negatively. It can be a simple or a complicated process, and its consequences vary dramatic- from a simple discussion to a world war. To solve conflicts, one can use several methods like negotiation, conciliation, mediation, arbitration and litigation. Different methods that aim to do the same thing: resolve a conflict in the best way possible, or at least manage it, de-escalate it.

When we get sick, one of our first action is to go to a General Practitioner (GP) or a hospital. While receiving care, when an error occurs that causes harm or injury to the patient, the relationship between doctor and patient, that is based on trust get damage and a conflict arises. According to Robbennolt (2009), apologies is one way doctors respond to medical error, and it "can decrease blame, decrease anger, increase trust, and improve relationships" (p 376).

This dissertation aims to study the value of an apology in medical malpractice conflicts. To achieve this objective, it will be analysed in Chapter 1, conflicts in general and the meaning of an apology and its elements.

In Chapter 2 will be analysed four principles of Biolaw and Bioethics, the Principle of Human Dignity and its function in health care, the nature of the doctor and patient relationship, and informed consent. Medical malpractice will be defined, and it will be noted the concept of litigation. The concept of medical negligence will be explored, and criteria to set it will be brought. The use of mediation to manage or solve medical malpractice will be examined, and the example of the New Zealand no-fault system, an alternative to the tort

system to medical malpractice will be brought.

In Chapter 3 will be analysed the Open Disclosure programs. It will be explained what open disclosure is, its elements, and successful implementations. The Irish Open Disclosure policy will be examined, including legislation that helps to promote or manage malpractice claims and the CervicalCheck program scandal that prompted some changes to that policy.

In Chapter 4, the relationship between apologies and Open Disclosure programs will be analysed, and for such the opinion of two professional was asked. Previous research about the use of apology in medical malpractice was reviewed.

In Chapter 5, the literature review, previous research, the data from the government reports and interview was analysed, and a conclusion was reached.

This research brings some alternatives to litigation and the management of medical malpractice conflicts. However, it is necessary to highlight that further research is required. In Ireland, open disclosure is a recent phenomenon, and its legal, psychological and sociological consequences need more time to be observed.

Aims and Objectives

This dissertation aims to study the value of an apology in conflicts originated from medical malpractice while exploring the consequences of an apology delivered in that context. This dissertation will try answering the question: is there a value of an apology in the medical malpractice conflict resolution process? In other words, does it worth to deliver an apology when a conflict arises from medical malpractice?

From a humanitarian perspective, having the principle of Human Dignity as an interpretative guide to understand the medical malpractice conflict. Knowing that medical malpractice conflicts are complex and its consequences dramatics, it will be analysed the meaning of an apology and how the process of apologising influences the dynamics of this type of conflict within the following objectives:

- Approaching the main literature and theoretical issues related to the apology from a humanitarian, social, legal and psychological perspective
- Investigate the use of an apology in the medical malpractice cases
- Analysis of the Health Service Executive office (HSE) use of apology in their disclosure program
- Analysis of the CervicalCheck scandal
- Critically analyse disclosure programs and the use of apology in medical malpractice conflicts focusing on its consequences
- Study the legal implications - if some- of an apology

Research Methodology and Methods

Methodology can be understood as "macro-level frameworks that offer principles of reasoning associated with particular paradigms assumptions"(O'Leary 2017, p 378). It differs from methods that are "techniques and procedures used to obtain and analyse research data"(Saunders et al. 2019, p 808). The present dissertation will be based on a mixed methodology.

Mix methodologies can be understood as the use of qualitative and quantitative methods. Blaxter et al. (2011) explain probably a research will not be completely quantitative or qualitative. This methodology was chosen because it provides more accuracy, contribute to the evaluation of the subject from different perspectives, is practical and can help to compensate for the weaknesses and strengths of each method (Denscombe, 2017). However, it imposes some challenges as noted by Denscombe (2017) it can increase time and costs, it is needed the development of skill to use several methods, and sometimes the "the findings of different methods do not corroborate one another" (Denscombe, 2017).

Presentation of Data and Data Analysis

It will be presented data from primary and secondary sources. Primary sources can be defined as "an original source of information"(Wisker, 2019). Secondary source is understood as "narrative-based or evaluative information sources collected from other actors"(Wisker, 2019, p XVII). The most used sources of data presented in this dissertation were reports from government agencies, previous research and interviews.

It is important to make some considerations about interviews. Interview can be understood as "a method of data collection that involves researchers seeking open-ended answers related to a number of questions, topic areas or themes"(O'Leary, 2017). The advantages of the interviews according to Denscombe (2017)are that they provide good detail and in-depth information, it can provide the researcher with some insights, the equipment used is simple, and it can be a "rewarding experience" (Denscombe, 2017).

However, interviews present some weakness, as Saunders et al. (2019) point out there is a level of bias involved in interviews and cultural differences, the information can not be reliable, and it can be a time-consuming process(Denscombe, 2017).

The documents that analysed in this research were reports from government offices, bills and acts. The reports from government agencies provide a good source of data however as noted by Denscombe (2017), it should be analysed with caution, as "it would be naive in research terms to simply accept information from such sources as self-evidently true and beyond the need of scrutiny."(p250)

The data will be analysed correlating the findings and different arguments to reach a conclusion, a mix of a deductive and systematic approach to interpreting it. Deductive logic can be understood as the use of "an overarching principle to conclude a specific individual

fact or event”(O’Leary, 2017).

Chapter 1- Conflicts and Apologies

1.1.Introduction

Conflicts are an inherent aspect of our social life. It is inevitable, and it is a "fact of life"(Cahn and Abigail, 2007). It is within us since the beginning of our history (Jeong, 2008). Folger et al. (2013) define conflicts as "the interaction of interdependent people who perceive incompatibility and the possibility of interference from others as a result of this incompatibility" (p 4). In the broader sense, it has been used to describe "any discord resulting from almost every aspect of social situations."(Jeong, 2008, p 6).

A conflict does not necessarily have to mean something harmful and bad (Kriesberg and Dayton 2016) if it delivers a change for our society and, at the same time, if the group and individual goals are achieved, a constructive outcome it will result (Jeong, 2008). As explained by Jeong (2008), a positive/ constructive outcome do not mean only compensation and apologies for what happened, but it means to prevent future victimization.

About the core causes of the conflicts (Jeong, 2008) teaches that "most conflicts involve value differences and power disparities, whereas misperception and miscommunication play an important role in the evolution of adversarial relationships" (p 15). As the author explains, conflicts can escalate and develop into a more complex conflict that involves a multi-source of issues, as the difference of identity and needs. Understanding the core causes of the conflicts is a step forward to managing it and preventing it (Jeong, 2008).

According to Victor and Borisoff (1998), "all conflicts need to be managed" (p 5). Conflict management can be understood as "the type of interaction that will lead to productive

conflict" (Folger et al., 2013, p 14); or "the behaviour a person employs based on his or her analysis of a conflict situation"(Cahn and Abigail, 2007, p 12). According to Jeong (2010), the way the conflict is dealt with depends on its nature. Effective conflict management, according to Mujtaba and McCartney (2010), "requires "thinking win-win" with the goals of jointly learning, growing and cooperating" (p 35)

Conflicts are not statics, "they gradually can become more intense"(Glasl, 1999, p 71) and "failure to acknowledge or to address a situation adequately can exacerbate difficulties between individuals" (Victor and Borisoff, 1998, p 25).

To counter a conflict, the parties can adopt different approaches (Jeong 2010). There are various ways of conflict resolution/ management; the most common are negotiation, mediation, arbitration and litigation. According to Goldberg et al. (2007), negotiation is the most common form of conflict resolution. It can be defined as "a process to resolve differences in goals that arise from dissimilar interests and perspectives" (Jeong, 2010, p 151). Mediation that can be defined as "negotiation carried out with the assistance of a third party" (Goldberg et al., 2007, p 107). Arbitration is "a private dispute resolution procedure, designed by the parties to serve their particular needs" (Goldberg et al., 2007, p 213).

In dispute resolution, different techniques can be used; an apology could be an excellent strategy to help manage it, de-escalate it or even solve it, (infra). According to O'Hara and Yarn (2002), an apology constitutes an essential element in dispute resolution "and any useful model of conflict resolution must acknowledge a human preference for apologies" (p .1122). Goldberg et al. (2007), in the same sense, explains that "the first lesson of dispute resolution that many of us learn as children is the importance of apologizing" (p 137). An apology can help solve a dispute or de-escalating it (Goldberg et al., 2007); can be used to try to restore the trust in the relationship (Lewicki et al., 2016,p 1), or the relationship itself (Goldberg et

al., 2007).

However, like alert Goldberg et al. (2007), there are some barriers to the use of an apology in dispute resolution. Apologies can be "hard to extract" (Goldberg et al., 2007, p 138), and an apology could be used as an admission of fault.

The present dissertation intends to explore the value of an apology in the conflicts that originated from medical malpractice. Fisher and Ury (2012) teach that in some cases:

> an apology can defuse emotions effectively, even when you do not acknowledge personal responsibility for the action or admit an intention to harm. An apology may be one of the least costly and most rewarding investments you can make.".(Emotion, para 11)

One aspect of conflict management is Risk management; it can be defined as "the forecasting and evaluation of risks in business and commerce, combined with the identification of procedures to avoid or minimize the impact of such risks"(Oxford English Dictionary - OED) [1]. According to Hull (2010), the function of risk management is to "understand the portfolio of risks that the company is currently taking and the risks it plans to take in the future." (p 1). Risk can be defined as "the chance of injury, damage or loss"(Chorafas, 2007). In medical malpractice conflicts, when the malpractice happens in the hospital environment, usually the risk management team/office is assigned to manage it.

An apology in conflict resolution can be used to de-escalate a conflict, repair trust and the relationship. However, what means to apologize? Is there a right or wrong of apologizing? Before investigating the use of an apology in medical malpractice conflicts, it is essential to understand its meaning.

[1] https://oed.com/view/Entry/166306?redirectedFrom=risk+management#eid114601228

1.2. Apology

1.2.1 Introduction

The act of apologising is intrinsic in us. We are taught to apologise when we misbehave ever since we were young, as explains Smith (2008) "apologies provide one of the most familiar and significant occasions when we think explicitly about our shared values." (p 37). It seems like a simple act of saying "I am sorry" or a more complicated process. To apologise is not an easy action "they are difficult and potentially humiliating" (Tavuchis 1991, p 9), and for being a complex process is a "complicated and courageous act" (Taft 2000, p.1138). It is different from a justification, excuse and an explanation because it "accepts both responsibility and blameworthiness" (O'Hara and Yarn 2002), p 1132).

1.2.2. The Meaning of Apology

According to Smith (2008, p 24) "The meaning of any apology derives from its particular actors and context"; therefore, there is not only one meaning to the act of apologising. The way the parties to a conflict perceive and how the conflict itself develop will influence the apologies and its meaning. The definition of apology will be analysed from a linguistic, social,-and psychological point of view.

In the English language, the meaning of apology, according to the Oxford English Dictionary[2] is:

1. The pleading off from a charge or imputation, whether expressed, implied, or only

[2] https://oed.com/view/Entry/9332?rskey=8BPW9t&result=1&isAdvanced=false#eid

conceived as possible; defence of a person, or vindication of an institution, etc.from accusation or aspersion.

2. Less formally: Justification, explanation, or excuse, of an incident or course of action.

3. An explanation offered to a person affected by one's action that no offence was intended, coupled with the expression of regret for any that may have been given; or, a frank acknowledgement of the offence with expression of regret for it, by way of reparation.

4. Something which, as it were, merely appears to apologise for the absence of what ought to have been there; a poor substitute.

From the definitions above, it can be extracted some possible elements of an apology: explanation and acknowledgement of an offence, expression of regret and reparation.

From a social perspective, "apologies abound and figure prominently in often invisible and unnoticed normative patterns that shape our moral expectations"(Tavuchis, 1991, p 2).

They are demanded because of the infraction of a social rule, as (Tavuchis 1991) explain "apologies call attention to what we may endanger valued social ties; some forms of transgression can be remedied only by apology; apology has the power to rehabilitate the individual and restore social harmony" (Tavuchis 1991, p 9), and he explains that an apology involves "acknowledgement of the legitimacy of the violated rule, admission of fault and responsibility for its violation, and the expression of genuine regret and remorse form the harm done" (Tavuchis 1991, p 9)

The Psychiatrist Aaron Lazare (2004, p 23) teaches that an "Apology" refers to an encounter between two parties in which one party, the offender, acknowledges responsibility for an offence or grievance and expresses regret or remorse to a second party, the aggrieved"

Taft (2000) explains that an apology is a moral act because of its acknowledgement of "the existence of right and wrong" (p 1142), the confirmation that a behavioural norm has been

broken and the exposure of the person who apologises to the consequences of his acts. (Taft 2000)

Apologies are common in all social classes and sectors (Tavuchis 1991), can be verbal and nonverbal, public and private, and it differs between cultures, gender and languages (Lazare 2004). Tavuchis (1991) explains that there is a paradox of apology stating that the function of an apology is to "resolve conflicts" (p 4) and "somehow restore an antecedent moral order (...) by expunging or eradicating the harmful effects of past actions"(p 4) but it "does not and can not *undo* what has been done. And yet, in a mysterious way and o according to its own logic, this is precisely what it manages to do"(Tavuchis, 1991, p 4). It is a simple and a complex process at the same time (Tavuchis 1991; Lazare 2004)

From the definitions and explanations above it can be deduced that the act of apologising involves at least one of the following elements: 1) an expression of regret 2) acknowledgement of an offence; 3) acknowledgement of responsibility; 4) offer of reparation, 5) an explanation, justification of an offence.

It is important to highlight that, although you can extract some elements that are common while apologising, as warn Smith (2008, p 27) "apologies leave us drowning in a sea of indeterminateness", and even if you apologise correctly, the apology can end up no reaching the offended/ receiver.

1.2.3. The act of apologising

Could be an apology expressed with a simple "I am sorry"? Lazare (2004) explains that the expression "I'm sorry" *per se* does not mean to apologise, as tells Smith (2008) "Apologies are complex interactions, and many attempts to simplify them use 'sorry' to obscure injustices

rather than to accept blame for wrongdoings. Many apologies lie" (p17)

According to Lazare (2004), the act of apologising involves at least four elements: the acknowledgement of an offence, expression of remorse, explanation of the offence and reparation.

The process apologising for affects at least two sides, as "apology does not exist in isolation;" (Taft, 2000, p 1142); the person who was offended and the offender, each has its perspectives and expectations of what they want from it. As explains Smith (2008), the different meanings an apology can have for the offender and the offended:

> The person apologising accepts blame for our injury and she explains why her actions were wrong. This validates the victim's beliefs, and she can begin or resume a relationship based on these shared values. The offender also treats us differently at the most fundamental level when she apologises to us: instead of viewing us as an obstacle to her self-interests, we become a person with dignity. If the apologiser regrets her actions and promises not to repeat them, we can take some security in the hope that she will not harm us again. This provides a reason to trust the offender and may be terribly important if she is someone for whom the victim cares deeply. An apology can also provide the victim with relief for her injury, ranging from nominal gestures of communion to considerable economic compensation. (p 10)

According to Lazare (2004), the offended (s) expect that one of the following needs to be addressed:

> the restoration of respect and dignity, assurances that they and the offender have shared values, assurances that they were not at fault, assurances that they are safe from further harm by the offender, knowledge that the offender has suffered as a result of their offense, a promise

> of adequate reparations, and the opportunity to communicate their suffering and other feelings about the offense. (pp 34,35)

While the offender is motivated by "shame, guilt, and empathic regard for those they have offended" (Lazare, 2004,p 34); they want to try restoring the relationship and prevent retaliation, damage, abandonment and any further punishment (Lazare, 2004). Thus to deliver an effective apology, the offender should, according to:

> first take time-before initiating communication with the offended party-to "name" the offense, that is, to become clear about the norm that has been violated and about what it is that calls the offender to apologise. During this time, the offender is engaged in an internal process in which he comes to terms with his error, names it, and identifies himself with the action. In this process, the offender moves to a willingness to admit he is wrong and to express remorse for the result of his act. The offender has heard the call to repent and has prepared himself to respond. Once the commitment to respond is sealed, then comes the apology itself. (Taft, 2000, p 1140)

Another reason the offender wants to apologise is to others perceive that they did not have much control of the offence as "Apology breaks the link between the negative act and the perception that the transgressor intended to produce the act" (O'Hara and Yarn, 2002, p 1142).

Lazare (2004) points out that considering the differences between expectations and perceptions of the parties and the fact that they usually are "unaware of each other's needs, it is understandable that many apologies end up not satisfying either party." (p, 35).

1.2.3.1.The Elements of an Apology

As stated above an apology has at least five elements: a) an expression of regret b) acknowledgement of an offence; c) acknowledgement of responsibility; d) offer of reparation, and e) an explanation, justification of an offence. While apologizing, it is not necessary the use of all components cited above because each situation and conflicts demand different approaches.(Lewicki et al., 2016; Lazare, 2004; Smith, 2008)

a) Acknowledgement of an Offence

Lazare (2004) teaches that this element is the foundation of the apology, and without "the process cannot even begin." (p75). This element involves four parts (Lazare, 2004): a) the identification of the party or parties responsible for the offence and the ones which should be apologizing to; b) acknowledgement of the offence in details; c) acknowledgement of the repercussion that the offence had on the offended(s); d) to confirm that the offence was "a violation of the social or moral contract between the parties" (Lazare, 2004, p 75)

b) Expression of regret/remorse

According to Lazare (2004), the remorse feeling is "To feel remorse for an action is to accept responsibility for the harm caused by it"(p 107). Remorse in the modern English language means (OED)[3]: "Deep regret or guilt for doing something morally wrong; the fact or state of feeling sorrow for committing a sin; repentance, compunction" (para 2 a); "An attack of sincere regret or guilt" (para 2 b); "a remorseful feeling"(para 4).

As Lazare teaches (2004), the result of remorse is forbearance, and it means to abstain from doing the same thing in the future.

[3] https://oed.com/view/Entry/162286?rskey=nI1scQ&result=1&isAdvanced=false#eid

c) Explanations

An explanation, a justification, is the "why" the offence occurred, "which is an effort by the violator to affect the victim's sense-making about the violation in a way that might make the violation seems more understandable, less intentional, or less dissonance-creating to the victim" (Lewicki et al. 2016, p 191)

According to Lazare (2004), it has four dimensions: a)The offence was not intentional thus not personal; b) "The behaviour is not indicative of the real self of the offender" (p 121); c) "The victim is blameless" (p 121); d)Similar offence is not going to happen because of the unique circumstances.

d) Reparations

It can be explained as "An offer of repair, which may restore the tangible or economic damage that occurred as a result of the violation" (Lewicki et al., 2016, p 191). Raper (2011) explains that it is an attempt to restore the relationship to the condition before the conflict, "which is often difficult if not impossible" (p 296) and some compensation can be arranged (Raper, 2011).

5) Acknowledgement of Responsibility

An essential part of the process of apologizing is the acknowledgement of responsibility for the offence. As explains Smith (2008), is the admission of "causation and wrongdoing" (p 34). Lazaro (2004) explained that failure in accepting responsibility could fail to acknowledge the offence; therefore, an apology without acknowledgement of an offence cannot occur (supra).

1.2.4. The Healing Effects of Apology

According to Taft (2000), apologies can heal because "there is a restoration of moral balance-more specifically, a restoration of equality of regard" (p 1137). Lazare (2004) teaches that from the psychological perspective, an apology heals the relationship because they fill one or several psychological needs.

1.2.5. The effectiveness of an apology

In this section, previous research about the use of an apology and some of its effect on the offended and/or offender

Cremer et al. (2011) while analysing the importance of an apology for the individual, found out that "people overestimate the value and behavioural impact of an apology"(2011,p 47). According to them, an apology had a higher value when, after the offence, the offended imagined receiving it that when they actually did. The offended demonstrated more trust behaviour when they imagined receiving an apology than when they actually did. As they explained "people may have more faith in an apology's effectiveness as a reconciliation or trust-repair tool when they consider its value beforehand than when they actually receive one"(Cremer et al., 2011,p 47)

About the best timing for an apology, Frantz and Bennigson (2005) found out that delayed apologies were more efficient than an early apology, and an early is more efficient than none. According to them delaying is more effective than an early or none as "delaying an apology until after the victim has a chance to feel heard and understood may be the most effective way

to right wrongs. (2005, p 206)

Lewicki et al. (2016) analysing the components of apology and exploring the effectiveness of it and trust repair, found out that the more components in an apology, the more an apology was perceived as more effective. Some components are more crucial than others are, but it depends on the number of components and the context of the apology. According to their findings, the components (when individually expressed) that were more important (in order of importance): acknowledgement of responsibility, offer of repair and explanation. The most efficacious components used while apologising (using more than one component while apologising) were offer of repair and declaration of repentance, and the third was the acknowledgement of responsibility (2016)

Chapter 2- Legal Aspects

Considering that the conflict originated from medical malpractice can result in legal consequences, it is necessary to understand how this conflict is perceived from a legal perspective. The proposed approach to the medical malpractice conflict is the humanitarian, for such is needed to discuss the principles that constitute the foundation of Biolaw and Bioethics in the European Union (EU), in particular, the Principle of Human Dignity.

2.1. The Four Principles of Biolaw and Bioethics in the E.U.

According to the Report to the European Commission on the Project Basic Ethical Principles in Bioethics and Biolaw 1995-1998 (RECPBEPBB; Kemp, 1999), the four basic principles of bioethics and biolaw are the Principle of Autonomy, Dignity, Integrity and Vulnerability. To analyse the medical malpractice conflict is necessary to examine the four principles that constitute the base for bioethics and biolaw. They are essential guides to assist doctors and legal professionals to interpret laws and rights and solve difficult conflicts that involve difficult moral and legal dilemmas.

a) Autonomy

Rendtorff (1998), explains that autonomy entails "the capacity to make your own decisions about your own life"(para 16), and explains that decision does not need to be taken alone it can be taken in collaboration with other people and other values.

According to the RECPBEPBB (Kemp, 1999), autonomy should be understood from five aspects (p 9): "1) the capacity of creation of ideas and goals for life, 2) the capacity of moral insight, "self-legislation" and privacy, 3) the capacity of rational decision and action without coercion, 4) the capacity of political involvement and personal responsibility, 5) the capacity of informed consent."

b) Integrity

Integrity involves the human person and its personality in two dimensions: the physical and physiological (Rendtorff, 1998). Respecting human integrity is "is respect for privacy and in particular for the patient's understanding of his or her own life and illness. Integrity refers to the coherence of life of beings with the dignity that should not be touched and destroyed" (Kemp,1999, p 4). The European Court of Human Rights recognises the right to integrity and the positive obligation of respecting it [45]

c) Vulnerability

Is the understanding and acceptance of the fragility of the human condition as explain Rendtorff (1998, para 35)"Vulnerability motivates ethical concern for the fragility of the human condition. The human condition is marked by an extreme degree of fragility because of the temporal and finite character of all human life." According to the RECPBEPBB (Kemp, 1999), the ones that have their integrity and dignity threatened of violations are the ones who are most vulnerable.

d) Dignity

[4] Glass v. the United Kingdom (2004) - http://hudoc.echr.coe.int/eng?i=001-61663
[5] V.C. v. Slovakia (2011) - http://hudoc.echr.coe.int/eng?i=001-107364

Dignity in the context of bioethics and biolaw can be understood as "the capacity for autonomous action, the capacity for experiencing pain or pleasure, being human (in the biological sense) or being a living organism or even system"(Kemp 1999, p 8)

2.2.The Principle of Human Dignity and Patient Care

Before analysing the legal consequences - if some, of an apology delivered in conflicts, originated from medical malpractice, it is important to understand how in modern society the laws are interpreted. In the most advanced legal system, the basilar principle that commands the interpretation of every law and is a source of individual rights is the Principle of Human Dignity.

Considering that the doctor-patient relationship deals with the human being in its most elemental forms (from before conception to after death- from the right to life to the right of a dignified death), the study of the Principle of Human Dignity and its consequences in the legal system becomes paramount. As explains Barroso (2012,p 8) "Human dignity plays a prominent role in this renovated jurisprudence, where social facts and ethical values strongly influence the interpretation of legal norms."

2.2.1.Generalities

The human dignity "is conceived as a universal ethical and legal principle stressing that all human beings have intrinsic worthiness and inalienable rights by the mere fact of being human" (Andorno and Pele, 2015, p5). In the same sense, explains Barroso (2012) "human beings have no price and cannot be replaced because they are endowed with an absolute inner

worth called dignity" (p 360).

As explained by Andorno (2011), the lack of legal definition does not mean that the concept of human dignity is hollow, as international laws provide directions for its understanding. The Human Dignity principle can be found in the United Nations Universal Declaration of Human Rights -preamble and art.1; in the European Convention of Human Rights - preamble; European Charter of Fundamental Rights - preamble, chapter one, art. 1; and in several national constitutions.

The human dignity principle has two roles, one as a source of rights and duties and the other as an interpretative guide (Barroso, 2012,p 356). The difference between human dignity and human rights is that the foundation of human rights is human dignity (Andorno,2011, p 6). One is the reflection of the moral values from a philosophical point of view, the other is the moral in the form of law, reflecting towards individual rights (Barroso, 2012); or as O'Mahony (2016) explains "principle from which the human rights of the individual derive" (p 1)

The Principle of human dignity is in the Irish constitution on the preamble, meaning that the Irish legal system adopted the Principle of Human Dignity. Therefore this principle is a source of fundamental rights and an aid to interpret the Irish legal system. As explained by Andorno and Pele (2015, p 1) "human dignity is now formally incorporated into national and international legal instruments, and requires that all social, political and scientific institutions comply with the requirement of respect for the inherent worthiness and rights of every human being". Thus it must be respected.

O'Mahony (2016) reminds that Irish Constitution is the oldest national document that brings the Principle of human dignity meaning that "the primary goals towards which the enactment of the Irish Constitution is directed is the assurance of the dignity of the individual. "(p 3).

An example of the use of human dignity as an interpretive guide and right by the Irish court in Re a Ward of Court [1996] 2 I.R. 79:

> An unspecified right under the Constitution to all persons as human persons is dignity – to be treated with dignity. Such right is not lost by illness or accident. As long as a person is alive, they have this right. Thus, the ward, in this case, has a right to dignity. Decision-making concerning medical treatment is an aspect of the right to privacy; however, a component in the decision may relate to personal dignity.

2.2.2.Human Dignity in Health Care

The idea behind the human dignity concept is that all humans should be "treated with unconditional respect and entitled with basic rights regardless of age, sex, physical or mental abilities, ethnic origin, religion, political ideas, socio-economic status, or any other particular condition or circumstance" (Andorno, 2011, p 2). According to Andorno (2011), the principle of human dignity has two roles, one as a foundation to guide the norms and regulations and the other "as a standard of health care reflects a concrete and context-specific understanding of the patient as a "person" (2011, p 9)

The human dignity in health care can be approached in two ways, an objective approach that "it refers to the inherent value that society recognizes in each of us; it is about how others see each of us" (Andorno, 2011, p 6). And a subjective approach where the patient is seen as a subject, and not an object, "it is a consequence of the inherent value that I recognize in myself; it is about how I see myself" (Andorno, 2011, p 6) consequently the health care professional is expected to have, reasonable, certain attitude and behaviour (Andorno, 2011)

Andorno (2011) explains that the reason why human dignity should be observed in the healthcare environment is because of the vulnerable condition of the patient (Andorno 2011) as they are "deeply dependent on the assistance of others, not only for the improvement of their health condition but also for meeting their most basic needs" (p 6).

It is important to notice that one of the principles that guide the bioethics is the principle of vulnerability, and it is connected to human dignity as "The worthiness of the human person is here exposed in its nakedness; it is shown in its pure form." (Andorno, 2011, p. 7)

2.3. The Doctor-Patient Relationship

Before discussing the topic of medical malpractice is important to understand the nature of the doctor-patient relationship. As stated before, the process of apologizing has at least two parties involved - the person who was offended and the offender; each one has its expectations and perception of the offence. Understanding the nature of the doctor-patient relationship will help to clarify the value an apology could have on the process of solving, managing a conflict that originated from an error that caused harm or injury to the one part.

According to Chipidza et al. (2015), the relationship between the doctor and patient involves trust and vulnerability:

> the doctor-patient relationship represents a fiduciary relationship in which, by entering into the relationship, the physician agrees to respect the patient's autonomy, maintain confidentiality, explain treatment options, obtain informed consent, provide the highest standard of care, and commit not to abandon the patient without giving him or her adequate time to find a new doctor. (para 5)

There are four key points that constitute the foundation of the doctor-patient relationship (Chipidza et al., 2015; Ridd et al., 2009): Knowledge, trust, loyalty and regard. Knowledge it stands to "knowledge of the doctor, and doctors' knowledge and understanding of the patient"(Ridd et al. 2009, p 6). Trust, "involves the patient's faith in the doctor's competence and caring, as well as the doctor's trust in the patient and his or her beliefs and report of symptoms" (Chipidza et al., 2015, para 5). Loyalty is the " patient's willingness to forgive a doctor for any inconvenience or mistake and the doctor's commitment not to abandon a patient." (Chipidza, et al., 2015, para 5). And regard is how the patient perceives the doctor as individuals and that they are on their side (Chipidza et al., 2015)

Another important aspect of the doctor-patient relationship is communication, being "a central clinical function that cannot be delegated."(Simpson et al., 1991, p 1385). The information gathered during the communication process helps it to achieve the fundamental objective of health care - the best outcome in patient care and patient satisfaction (Ha et al. 2010). Communication can also be associated with medical malpractice claims, according to Levinson et al. (1997), improving communication between doctor and patient can reduce the risk of malpractice.

2.4. Informed Consent

Every person is an autonomous being, as discussed previously, one of the principles of biolaw and bioethics is the principle of autonomy. One of the ramifications of this principle in the doctor[6] patient relationship is informed consent. Every patient has the right to

[6] It includes not only the doctors but every health care provider involved in the patients care

be informed (Patak et al. 2009), so they can give consent. Therefore the doctor has a duty of disclosure, as explains Mills & Mulligan (2017, pp 133-134) "the doctors provision of information is essential to the patient's being able to make an accurate decision that reflects his or her own values and beliefs". Information is an essential part of the doctor-patient relationship, as "patients have the right to be informed about the care they receive, make educated decisions about their care, and have the right to be listened to by their providers"(Patak et al. 2009, p 1)

According to O'Mahony (2015) to the patient give a valid consent is necessary that they have the "capacity to make decisions" (p 54)," must not be under influence" (p 54) and the information given must be sufficient. Another consequence of autonomy in the relationship between doctor and patient is that the patient has the right to refuse treatment, or refusal of consent (Madden, 2016). Having failed in informing the essential and failure in getting the patient consent can result in liability (Madden 2016).

2.5. Medical Malpractice

Malpractice can be defined as (OED, para 1, a)[7] as a "treatment is given by a member of the medical profession that departs from a generally accepted standard of practice and results in injury to the patient, through negligence, ignorance, lack of skill, or malicious intent".

Medical malpractice is a general term that encompasses medical error, negligence and criminal conduct.

Medical error can be defined as "the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim" (Institute of Medicine 1999, p 21). Errors are

[7] https://oed.com/view/Entry/113038?redirectedFrom=malpractice#eid

preventable and can / can not cause harm to the patient (Institute of Medicine, 1999).

Medical negligence can happen when a person by action or omission, unintended, violated the duty of care and caused an injury in the other person (infra). It is different from an adverse event that can be defined as "any untoward medical occurrence in a subject to whom a medical product has been administered, including occurrences that do not necessarily have a causal relationship with the treatment"(Murdoch, 2006). Sohn (2013) explains that "punishing adverse events per se would have a chilling effect on treating complex conditions or performing difficult procedures"(p 3), and would hinder the care of more complex patients (Sohn, 2013).

2.5.1.Litigation/Liability

In the Irish legal system, every "citizen has the personal constitutional right to litigate O'Brien v. Keogh [1972][8], cited in Healy, 2006, p 20). Litigation can be understood as " A legal action by parties who are known as *litigants*"(Murdoch, 2006, p 662); or "civil action brought by a claimant against a defendant based on legal principles, asserting some right or legal entitlement"(Brown and Marriott, 2011, p 18). Liability can be defined as "A legal obligation or duty, or the amount owed."(Murdoch, 2006, p 662) , the liability arises when a person breaks the trust or a contract and performs a wrong; it can be civil or criminal(Murdoch, 2006).

In litigation there is a neutral third party, a judge, that will make a "binding determination" (Brown and Marriott, 2011, p 20). The part does not have much control of the process, it a process that is "extraordinarily limited" (Brown and Marriott, 2011, p 33), it is right based, it

[8] O'Brien v. Keogh [1972] I.R 144 at 155, per O'Dalaigh C.J (SC)

can be time-consuming or fast depending on the court (Brown and Marriott, 2011)

According to Sohn (2013), litigation, in the context of medical malpractice can affect the doctors behavior negatively, the author explains that it can affect the doctor-patient relationship, ending up in the doctor fearing the patients because of the fear of litigation and, it can also make the doctor act defensive and avoid services that have a higher risk (e.g. neurology). A more rational system would focus more on the goals of compensation and improvement, rather than on punishment for those who err (Sohn 2013, p 51).

2.5.1. 1.The Cost of Medical Malpractice

The States Claims Agency (SCA) is the name in which the National Treasury Management Agency (NTMA) perform the claims management, risk management, and legal costs management functions, including medical malpractice claims (NTMA, 2019). In their 2019 report, they declared that the Irish government already expend more than 2 billion euros in clinical claims[9], and only in 2018 they had the expenditure of 347 million euros. In the USA, a study from 2010 (Mello et al. 2010), found that more than 55 billion dollars, is the cost of medical malpractice claim system per year. A study from 2003 found out that medical malpractice litigation does not increase patient health care and safety, and it is an "a costly approach for identifying and correcting medical errors."(Employment Policy Foundation 2003).

[9] Clinical Claims are the claims managed under the Clinical Indemnity Scheme. Under this scheme the SCA " manages clinical negligence claims taken against healthcare enterprises, hospitals, and clinical, nursing and allied healthcare practitioners covered by the scheme"(NTMA, 2019, p 41)

2.5.2. Medical Negligence

2.5.2.1. Introduction

As stated before, the healthcare professional and the patient relationship deals with the human being in its most elemental and vulnerable state, an error committed by the healthcare provider can cost the health or even the life of the patient, however, hardly one of these errors will be intentional (Pattison 2006). The legal outcome of a negligent act is civil liability or in major cases, criminal liability. A situation that arises from "medical negligence is a tort action for damages for personal injuries" (O'Mahony, 2015, p 9). To the injured person's claims be successful, the relationship between the parties and the duty of care must be demonstrated (O'Mahony, 2015); there was a breach of the duty of care and that damage (injury) resulted from that breach (O'Mahony, 2015). For the medical negligence action be successful is necessary to prove that the "harm has been caused by a failure to provide the appropriate standard of care" (O'Mahony, 2015, p 11).

2.5.2.2. The Concept/Definition of Negligence

The Civil Liability (Amendment) Act 2017, defines clinical negligence as "anything done or omitted to be done in the provision of a health service by a health services provider in circumstances which could give rise to liability for damages for negligence in respect of personal injury or death"(s 10, 4).

According to Tully (Tully, 2014, p 3) "negligence is a breach of a legal duty to take care which results in damage to the plaintiff." To sum up, negligence happens when a person by action or omission, unintended, violated the duty of care and caused an injury in the other

person.

According to MacMahon and Binchy (2013), the four elements of negligence, and all the four apply to medical negligence cases (Healy 2006): a)Duty of care, b)Failure to conform to a required Standard of Care, c)Loss and damage, d)Causal link between the action and the damage (causation).

a) Duty of Care

According to the Healy (2006), the duty of care of the doctor starts "once he assumes responsibility for the care of another and once he undertakes, expressly or impliedly, to exercise medical care and kill on the patient's behalf." (p 271). From the hospital perspective, the duty of care starts when the person is accepted as a patient (Healy 2006).

Mills and Mulligan (2017), teaches the steps to assess if there was a duty of care by the Irish courts: 1. sufficient relationship of proximity between the parties, 2. The damage caused was reasonably foreseeable, 3. The imposed duty by the law was just and reasonable, 4. There's a strong public policy that would create an exception to the legal liability (p 198).

b) The Standard of Care -The Dunne test for medical negligence

The standard of care from the professional, according to Mills and Mulligan (2017, p 218) is the one "with the practice and standards of the profession and, by extension, with comparable individual within that profession".

In the Irish common law, the decision that sets the principles for the medical negligence cases is the *Dunne v National Maternity Hospita*l (1989), these principles state the standard of care in medical negligence cases (Mills and Mulligan 2017). Important to note that this test has not been applied to medical negligence cases for nurses (Mills and Mulligan 2017;

O'Mahony, 2015, p 12):

> The principles thus laid down related to the issued raised in this case can, in this manner, be summarised.
>
> 1. The true test for establishing negligence in diagnosis or treatment on the part of a medical practitioner is whether he has been proved to be guilty of such failure as no medical practitioner of equal specialist or general status and skill would be guilty of if acting with ordinary care.
>
> 2. If the allegation of negligence against a medical practitioner is based on proof that he deviated from a general and approved practise, that will not establish negligence unless it is also proved that the course he did take was one which no medical practitioner of like specialisation and skill would have followed had he been taking the ordinary care required from a person of his qualifications.
>
> 3. If a medical practitioner charged with negligence defends his conduct by establishing that he followed a practice which was general, and which was approved of by his colleagues of similar specialisation and skill, he cannot escape liability if in reply the plaintiff establishes that such practice has inherent defects which ought to be obvious to any person giving the matter due consideration.
>
> 4. An honest difference of opinion between doctors as to which is the better of two ways of treating a patient does not provide any ground for leaving a question to the jury as to whether a person who has followed one course rather than the other has been negligent.
>
> 5. It is not for a jury (or for a judge) to decide which of two alternative courses of treatment is in their (or his) opinion preferable, but their function is merely to decide whether the course of treatment followed, on the evidence, complied with careful conduct of a medical practitioner of like specialisation and skill to that professed by the defendant.
>
> 6. If there is an issue of fact, the determination of which is necessary for the decision as to

> whether a particular medical practice is or is not general and approved within the meaning of these principles, that issue must in a trial held with a jury be left to the determination of the jury. In order to make these general principles readily applicable to the facts

Mills and Mulligan (2017), bring attention to a situation where the standard of care could be lowered (p 232), where the physician was inexperienced; the physician practices alternative medicine; when the case happened the standard of care was lower; the situation involved an emergency.

c) Causal link

Mills and Mulligan (2017), teaches that causation is "the issue of whether the act of the defendant caused the plaintiff the damage complained of."(p 235). I short words, it can be deduced the causations is the link between the action (or omission) and the damage, harm, injured caused.

In Irish common law, there is a traditional test "but for" and it "is satisfied if the plaintiff can prove on the balance of probabilities that the defendant's negligence, she would not have suffered the injury (O'Mahony, 2015, pg13). .Another test is the" loss of a chance" (Healy 2009; O'Mahony 2015; Mills and Mulligan 2017) that it "the actions or omissions of a defendant cause the patient to lose a chance of recovery than he might otherwise have had" (Mills and Mulligan 2017, p237)

d) Damage

In the absence of damage, there is no compensation (Mills and Mulligan, 2017). Mills and Mulligan (2017) explained that to the damaged occur, it must be foreseeable, and the law

should recognise as being repairable by compensation.

2.6. Mediation and Medical Malpractice

As explained above, medical malpractice litigation is a costly process that involves the expenditure of millions of euros by the Irish government. In the first chapter was explained that one of the methods to manage, de-escalate and solve a conflict is mediation.

Mediation in Ireland is regulated by the Mediation Act 2017, and it can be defined as "a confidential, facilitative and voluntary process in which parties to a dispute, with the assistance of a mediator, attempt to reach a mutually acceptable agreement to resolve the disputes" (s 2, (1)). Is guided by the following principles: Voluntariness (s 6 (2)), Impartiality and neutrality of the mediator (s 8 (2)(b)), Self determination (s 6(9)), and confidentiality (s 6(6); s 7(d); s10)

Fear of litigation is one of the most common reasons for doctors do not apologise to the patients (Boothman et al. 2009; Sohn 2013). Mediation is a confidential, voluntary process provides an environment where the doctor can apologise without fearing liability.

Forehand (1999), however, points out some problems with mediation and medical malpractice:(p 922) :"(1) patients are not compensated as generously in mediation as they are in litigation, (2) patients will be intimidated into prematurely settling meritorious claims during mediation, and (3) mediation simply prolongs the dispute process by delaying the real resolution process-litigation."

The report of the Law Reform Commission (2010), in alternative dispute resolution, highlighted a suggestion that conciliation[10] would be a more appropriate method to medical

[10] Conciliation can be unsdertood as a process where a third impartial part, the conciliator is " more proactive and evaluative"(Brown and Marriot, 2011, p 156) and they maybe help the parties proposing some terms to the settlement (Brown and Marriot, 2011)

malpractice claims than mediation as the conciliator could make some recommendations that would make the parties more with the process of settling the agreement.

Yee (2006) analysing previous research compiled some advantages to mediation in medical malpractice conflicts: prevent litigation and is a time-effective resolution, the doctor-patient relationship is preserved; "mediation may be the better deterrent to future similar conduct" (p 422). Is a successful process, and the mediator, in comparison with juries are more fitting as explains(Yee 2006, p 419) "the facilitated resolution of a complex, multi-party dispute through the assistance of a trained mediator is oftentimes more efficient than the uncertainties of a trial resolved by a jury with no background or expertise in the tech". About the importance of the mediator and their role, Victor and Borisoff (1998) explains that they help to " deemphasise status and power difference between disputing parties, and stress the empowerment of both sides of the dispute in order to explore and articulate fully all goals, needs, and concerns" (p 21)

2.7.The New Zealand no-fault process

In New Zealand, rather the tort system for medical malpractice they have a no-fault system for personal injuries that includes medical injuries compensation. The system is funded tax, and it started in 1974 as a system to compensate for personal injuries, and still constitute a successful program(Duncan 2019).

Bismark and Paterson (2006), explains that this system "offers more-timely compensation to a greater number of injured patients and more-effective processes for complaint resolution and provider accountability. (p 278). In this system, the outcome of the injury dictates the compensation instead of fault, and the Health and Disability Commissioner and New

Zealand's medical council judges the doctors' conduct (Wallis, 2013). Not only this process helps to access compensation efficiently; it also can help to improve patient safety (Wallis, 2017). However, as Wallis (2017) observe "separating accountability from compensation does not make all that much difference to doctors." (p 39). Duncan (2019) explains that although it is a successful system in New Zealand, it probably wouldn't work in other countries as "it would require unusually strong public and political support" (p 351)

Chapter 3- Open Disclosure

3.1.Introduction

Communication is one of the most important elements in the relationship between doctors and patients (Ha et al. 2010). It is understood that although the healthcare system is safe (HSE, 2019), is a risk environment, it is "inherently dangerous"(Boothman et al. 2009). According to Health Service Executive (HSE, 2019), some factors influence this dynamic, like the vulnerability of the patient, the fallibility of the ones providing care and the complexity of the healthcare system (HSE, 2019). When there is an incident that caused harm to the patient, the relationship between the doctor and the patient will be damaged. If the patients feel that information is being hidden, they can get anxious, fearful, lose trust, and they will get more inclined to initiate legal action (Disclosure Working Group 2011).

The most vulnerable part of this relationship is the patient. When an unwanted incident happened to them, their integrity had been violated, consequently their dignity. As an autonomous person, the patient has the right to be informed about the incident and therefore be a part of the process of management of the incident. In the medical area, one of the ways of managing medical malpractice conflicts and increasing patient safety is through disclosure/ open disclosure programs (Hamm and Kraman, 2001)

According to Hamm and Kraman (2001) disclosure stands to the organisation as "ethical duty to fully inform the patient about the patient's care and treatment(p 20). The Australian Open Disclosure Framework (AODF) defines open disclosure as (ACSQHC,2013, p 11), "the open discussion of adverse events that result in harm to a patient while receiving health care

with the patient, their family and carers."The HSE (2019) defines it "as an open, consistent, compassionate and timely approach to communicating with patients and, where appropriate, their relevant person following patient safety incidents" (p 7).

It involves according to the HSE (2019) openness, transparency, honesty and timely communication; acknowledgement of the incident and its impact on the patients; an explanation of the incident; an apology; listening and hearing to the patient ; demonstrating compassion , empathy and kindness to all people involved and or afflicted by the incident (patient , relevant person and staff); the decision making is shared about treatment, ongoing care and the management of the incident; giving the opportunity to the patient and/ or relevant person to ask question and have it answered with honesty and factuality; providing support immediately or ongoing to the patient and/ or their relevant person, and the staff involved and or affected by the incident; reassurance of the learning outcomes in recurrence of the incident; and informing the measurements taken to prevent future occurrence.

As was discussed, from a humanitarian perspective, the principle of human dignity is the moral and legal interpretative guide throughout the relationship between doctor and patient. Open disclosure programs constitute a humanitarian way of communication and management of the conflicts that originated from the doctor-patient relationship.

The Irish policy of open disclosure promotes this humanitarian approach to the conflict, (HSE, 2019,p 6) as stated :

> The ethos of this policy is to ensure that the rights of all patients and staff involved in and/or affected by patient safety incidents are met and respected, that they are communicated within an honest, open, timely, compassionate and empathic manner and that they are treated with dignity and respect

> Open disclosure is a core professional requirement which is anchored in professional ethics. Communicating effectively with persons affected in a compassionate, empathic and thoughtful manner, especially when providing information about a patient safety incident, is a crucial part of the therapeutic relationship and if done well can mitigate anxiety and enhance trust in the staff, the organisation and the health care system.

To better understand the disclosure programs and why they are so important, below it will be reviewed some successful implementation.

3.2. The Veterans Affairs Medical Center in Lexington

In 1987, after paying more than 1.5 million as a result of losing two malpractice suits, The Veterans Affairs Medical Center in Lexington, Kentucky, United States of American (USA), management changed their approach to medical malpractices to a more proactive one. (Kraman and Hamm 1999). According to Kraman and Hamm (1999,p 963), this approach is:

> a humanistic risk management policy that includes early injury review, steadfast maintenance of the relationship between the hospital and the patient, proactive full disclosure to patients who have been injured because of accidents or medical negligence, and fair compensation for injuries.

In this approach, staff were encouraged to report mistakes to the risk management committee by the hospital. After reported, the committee investigated it to find the core cause of the error (Cohen 2000). As soon as the mistake was identified and it resulted in harm to the

patient, the committee would inform the patient or the person related to them(Kraman and Hamm 1999), by phone so they could have a face to face meeting with "the chief of staff, the facility attorney, the quality manager, the quality management nurse, and sometimes the facility director"(Kraman and Hamm 1999, p 967). In the meeting they would disclose the details of the incident to the patient, and, if the committee understood that the fault was that of the staff or hospital, an apology would be given, the fault would be admitted verbally or in writing if desired by the patient (Kraman, no date, cited in Cohen 2000). Assistance was provided, and they would stress that the institution and their staff would take action to prevent future similar incidents (Kraman and Hamm 1999). Restitution (medical or surgical), or monetary compensation would be offered in the meeting. Following the face to face meeting, they would assist with any additional information, the parties' attorneys would "work to reach an equitable settlement on the basis of reasonable calculation of loss."(Kraman and Hamm 1999, p 967).

Kraman and Hamm (1999), analysing the financial consequences of this approach between 1990 and 1996, found that it was paid an average of $ 190.113 per year in malpractice claims, a total of $1.330.790 for the period analysed. The hospital had 88 claims in that period paying an average of $ 15.622 per claim. Kraman and Hamm (1999) concluded that the "full disclosure" financial consequence was moderate.

According to Kraman (2001), the benefits of this approach for the patient were: "anger and outrage, destructive emotions in their own right, are dismissed or eliminated."(2001,p 255), a settlement was reached faster; the patient and medical facility maintained a good relationship. They experienced thought this program "that people judge hospital management and staff more by how responsible they act when they err rather than by the fact that an error was made" (Kraman 2001, p 255). The benefits for the hospital as reported by Kraman (2001),

were: the amount paid for settlement was reasonable, the openness in handling the malpractice "immunise the facility from malpractice attorneys and negative media publicity" (2001, p255); increase of self-report error from staff, increase of the detection of systems flaws and consequently fix.

Cohen (2000) makes some considerations about this approach adopted by the Veterans Affairs Medical Center in Lexington. According to him, the Veterans Hospitals differ from the private sector in how they handle their liability because as a government organisation, their malpractice claims are brought under a different set of legislation. The staff employed by the Veterans hospitals are not as personal exposed as the private sector professionals. The Lexington Veterans Affairs Medical Center had a posture of accepting responsibility for their mistakes, and they compensated the patient more equity (Cohen, 2000).

3.3. The Michigan Model

According to Boothman et al. (2009) to design an approach to manage medical malpractice claims, first is necessary to identify the root causes of the problem. In the proposed approach, actions were taken before the error even occurred. First the patients' expectations were managed, second the caregivers were resourced with mechanisms to assist the detection of the injury before it turned into a claim, and lastly, the organisation would recognise the value of the process of early detections and were supportive of the whole process (Boothman et al., 2009). After the error occurred, the organisation would identify and inform the patient so they could participate in the process, their needs would be prioritised, answers would be given, the expectations about the situation would be managed, explanations were given, and when a true mistake occurred, the organisation would acknowledge it and apologise for it, and

improvements would be made and communicated to the patient and family (Boothman et al., 2009)

Boothman et al. (2009), explains the reasons behind this approach that would decrease the possibility of litigation:

> If the patient's experience reasonably mirrors expectations, if the patient's need for information is met readily, if the patient is assisted in processing the information, and if the patient believes that the system has responded to his or her experience with improvements, the likelihood that the patient will feel the need for an advocate or seek satisfaction through the legal system diminishes significantly.

The University of Michigan Health System (UMHS), in Michigan, USA, had a shift in how they managed claims in 2001. They adopted a principled based approach based/ founded on proactivity, transparency and honesty (Boothman et al. 2012). Three principals were identified (Boothman et al., 2009, p 139): "1. compensate quickly and fairly when unreasonable medical care causes injury.2. Defend medically reasonable care vigorously.3. Reduce patient injuries (and therefore claims) by learning from patients' experiences". Boothman et al. (2009), explains that one of the challenges of this approach was to distingue "between reasonable and unreasonable care" (2009, p 139)

Kachalia et al. (2010) analysing the consequences of the disclosure program implementation (before and after) in the period of 1995 to 2007, found that the number of claims per month, in that period, lowered from 7.03 to 4.52 per month. After implementation, the number of lawsuits decreased from 38.7 per year to 17.0 per year (Kachalia et al. 2010). Before implementation, the time spent to resolve a claim was 1.36; it lowered to 0.95 (Kachalia et

al., 2010). The cost per lawsuit decreased from$405.921 to $228.308 after the implementation of the disclosure program.

Some consideration must be done about the Michigan Model, the University of Michigan is self-insurance since mid' 1980s; in the 1990s it was passed in the state of Michigan legislation that introduced a compulsory pre-suit period. Being a university hospital they were committed to being safe and having advanced care they attracted more patient, therefore, more risk (Boothman et al. 2012),

3.4.Sorry works!

Sorry works! is an organisation launched in 2005 in the USA, dedicated to promoting full disclosure and apologies in the medical malpractice cases (Wojcieszak et al., 2006),. They believe apologies with compensations can prompt the decline of medical malpractice lawsuits and legal costs. According to Wojcieszak et al. (2006), honesty is fundamental to prevent repeating errors and to lower medical.

Based on the disclosure program from the Veterans Affair Hospital in Lexington, Kentucky, they defend that the core cause of the adverse event that ends up in harm, injury, should be analysed to determine if "the standard of care was met"(p 345). Concluding that the standard of care was not met, the health service provider should, apologise, admit fault, give an explanation, discuss the measurements to fix the procedures to prevent the error being repeated, and "make a fair offer of up-front compensation as determined by an actuary or qualified party"(Wojcieszak et al., 2006, p 345). If it the standard of care was met, they defend that the heat provides should meet with the patient, give an explanation and an apology, but instead of admitting and compensating they should express empathy, and work

towards proving their innocence (Wojcieszak et al., 2006)

According to the Sorry Works! movement what makes disclosure works are up- from compensation. Wojcieszak et al. (2006) explains that "without compensation, patients and families might view an apology as flippant or not meaningful and become even angrier and more likely to pursue litigation "(p 345)

3.5. The Australian Open Disclosure

Open disclosure in Australia started being adopted in 2003. In 2012 they reviewed their framework, and in 2013 they published their currently open disclosure framework.

According to ACSQHC (2013), open disclosure involves the following elements : an apology or expression of regret, an explanation of the facts, give the patient and family space so they can describe their experience, talk about the possible consequences and the steps to be taken to manage the incident and to prevent it from happening again (ACSQHC, 2013). It is explained that open disclosure is not to provide information one-way; it is an exchange of information between two parties throughout meetings in a certain time period (ACSQHC, 2013).

The AODF (ACSQHC , 2013) is guided by eight principles: open and timely communication Acknowledgement, apology or expression of regret, supporting, and meeting the needs and expectations of patients, their family and carers supporting, and meeting the needs and expectations of those providing health care integrated clinical risk management and systems improvement good governance confidentiality.

3.6. The HSE Open Disclosure Policy

3.6.1. Introduction

In 2007 the Commission on Patient Safety and Quality Assurance were initiated, and in 2008, they published their report "Building a Culture of Patient Safety"(Duffy 2016). One of their recommendations was the establishment of an open disclosure culture for "adverse events" (Duffy 2016) and legislation to provide legal protection to it. In 2013 the HSE released their national open disclosure policy. In 2015 the Legal Services Regulation Act 2015, brought some provisions to help the management of clinical claims. In 2017, in the Civil Liability (Amendment) Act 2017 were included some provisions about open disclosure. In 2018 The CervicalCheck scandal broke prompting changes in the open disclosure policy in 2019 and discussions about the patient safety bill and mandatory open disclosure.

3.6.2. The Pilot Program

From 2010 to 2012 the HSE and the SCA in partnership instituted the open disclosure pilot program in two hospitals in Ireland, the Mater Misericordiae University Hospital in Dublin and Cork University Hospital (Pillinger, 2016).

The evaluation of the National Open Disclosure Pilot report (Pillinger, 2016) after the end of the pilot program was noted the following findings: there were a value and contribution of the leadership (in this case the clinical directors) in increasing the agreement/ recognition of the open disclosure in the organisations and staff (Pillinger 2016). The training sessions and awareness training sessions was an important component of the implementation of the pilot program with most of the participants rating it very useful (Pillinger 2016). One of the points that helped the successful implementation was 'staff support', so the staff could "feel safe

and supported pre, during and past disclosure"(Pillinger 2016, p 25). Another finding was that open disclosure should be integrated into the incident report and management as "effectively integrating open disclosure in incidents management at all levels is crucial for culture change and learning from incidents" (Pillinger, 2016, p 27).

About the timing of the disclosure, it was reported that an early stage disclosure and an early apology was "generally accepted as being important to preventing a situation from worsening, and in some cases to preventing a small error leading to further complications at a later stage"(Pillinger, 2016, p 35). It was noted the importance of documenting the disclosure, in special to work towards preventing future error (Pillinger 2016). One of the feedbacks they reported was the positive impact that open disclosure had on patient safety (Pillinger 2016).

Some barriers to the open disclosure were described ,(Pillinger 2016) most of the participants experience some of the following: not enough training, the personal feeling experienced by the clinicians, not enough clarity about some aspects of the open disclosure, the expectations of the staff and patient being different; the environment getting more hostile resulting in the involvement of the media impacting the staff morale; staff having their levels and resources reduced and consequently higher risk of errors; fear of litigation (Pillinger, 2016).

The critical points for the implementation of the open disclosure included (Pillinger 2016): organisational culture and environment support, leadership, adequate resources, provision of good training, engagement of the staff, building a culture of supporting and encouraging staff to implement open disclosure.

The benefits of open disclosure pilot to the patients were: recovered and closing, increasing in satisfaction, increase in trust and confidence in consequence of openness and transparency resulting in a better relationship between the organisation, patient and doctor, the understanding of the patients' needs and perceptions was increased (Pillinger 2016). For the

organisations: improvement of staff morale, creation of open and transparent culture, investigation and identification of the system flaws and timely response to incidents were encouraged, improvement of awareness and understanding of errors and quality improvement (Pillinger 2016). And for the staff, the culture of honesty and transparency was encouraged, willingness to learn from incidents, training resulted in clarity and confidence about open disclosure, improvement of communication and transparency, prevention of future incidents, improvement of trust between patient-doctor, healing and recovered was facilitated when the disclosure by the management was compassionate, honest and integrate (Pillinger 2016)

3.6.3.The Legal Services Regulation Act 2015

In 2015 the Legal Services Regulation Act 2015, included some provisions to help the management of clinical negligence cases. Clinical Negligence means "anything done or omitted to be done in the provision of health service by a health service provider in circumstances which could give rise to liability for damages for negligence in respect of personal injury or death" (219, part 2A, s 32A. (1). In these situations they established three provisions: a pre-action protocol (219, part 2, s 32B); an apology would not constitute an admission of fault or invalidate insurance (219, part 2, s 32 D) and the period to make a clinical claim increased from two to three years (s221) from the date of the incident of the date of the acknowledgement of the incident(221, (1), (a)).

3.6.4. Civil Liability (Amendment) Act 2017

The Civil Liability (Amendment) Act 2017 introduced the Periodic Payment Orders and open

disclosure provisions. They defined apology as an "expression of sympathy or regret"(s 7 (b)). An apology and information exchanged in the open disclosure meeting do not constitute fault or liability, and it does not invalidate insurance, and it is not acceptable in the proceedings (s 10, (1) (2)). The process can be summarised as: When a patient incident occurs, open disclosure by the health provider (s 12) to the patient or relevant person or both (12, (a), (b), (c)) will occur as soon as possible (s 14(1)(a)). Before it happens, the health provider has to determine the appropriate time for the meeting (s 15 1, (a)), determine when it must be made (s 15, 1, (b)), determine if an apology is appropriate (c), try providing the information as clear as possible (b). A meeting will be arranged (s16) with the patient and/ or the relevant person (s16, 1, a), the information will be provided (s16, 2, (a)) orally and written ((b),(c),(d)), in the manner described in (s 15, 3). The open disclosure meeting is voluntary, the refusal by the patient or relevant person in participating ill result in nothing; however the refusal should be recorded (s17).

The importance of open disclosure was explaining on the debates of the civil liability amendment debates, Deputy Helen McEntee, Minister Of State at the Department[11] :

> Patient safety is fundamental to the delivery of quality health care and to public confidence in the health system, and open disclosure is an integral element of patient safety incident management and learning. Open disclosure is about an open, honest and consistent approach to communicating with patients and families when things go wrong in health care. It includes keeping the patient informed, providing feedback on investigations and the steps taken to prevent a recurrence of the incident, and it may include, depending on the particular circumstances involved, an apology for what happened. For those reasons, open disclosure is important for building patient and public trust in the health system, and it is therefore vital

[11] https://www.oireachtas.ie/en/debates/debate/seanad/2017-04-05/7/

that it should be supported.

3.6.5. The CervicalCheck Scandal 2018

In 2018, Vicky Phelan, a terminally ill woman, won her case against the HSE in the high court being awarded e 2.5 million euros, she was given an incorrect result of her smear test and wasn't informed about it. After Mrs Phelan another two women went to the media to help to get awareness about the situation Emma Mihc Mhathuna (now deceased) settled her case in 7.5 million euros and as part of her settlement was the admission of liability by the HSE, and Ruth Morrissey, that had her smear test reported incorrectly twice was awarded in 2019 2.1 million euros, but the SCA decided to appeal this decision.(Hennessy 2019)

These cases lead to an external audit in the CervicalCheck screening program that unfolded the non-disclosure of incorrect smear test results for several women. An internal audit in 2010 identified the false negatives; however, as it was uncovered, they were not informed about their inclusion in the audit nor about the false negatives (Hennessy 2019).

In 2018 a scoping inquiry was started by dr. Gabriel Scally and his team, it was reported the reaction of the victims about the process of non- disclosure of the audit results as noted:

> there was an overwhelming feeling arising from all of the meetings and communications that the issue of non-disclosure was felt very intensely, and often angrily, by many women. It wasn't just the non-disclosure, but the rushed nature of the disclosure that did take place after the publicity surrounding Vicky Phelan's court case that affected them adversely. The characterisation at the meetings of the manner in which women and families were told of their situation varied from unsatisfactory, to inappropriate, to damaging, hurtful and offensive (p 19)

They related the decision from the internal audits that the one who should be notified about the women's smear results to the "treating clinician" and so the decision of disclosure it (Scally 2018). It sent letters about 207 women, three were sent to their GP and the other 204 to the treating hospital clinicians, from the 204, disclosure occurred in 43 cases, from them 27 were apologised, but only six were recorded. About the impact of the non-disclosure and the trust in the cervical check program, it was described that (Scally, 2018)they do not want the programme abolished or damaged; rather, they want to see it renewed and reinforced in ways in which they can have confidence and trust (Scally 2018).They want a program that will deliver patient-centred care and put the rights of women at the forefront of delivery.

The audit found some major flaws in the 2013 disclosure program and they recommended that the HSE/SCA open disclosure policy should have been revised to acknowledge the patients rights to "full knowledge about their healthcare" (Scally, 2018,p 99), the right to be informed of "any failings in that care process, however and whenever they may arise (Scally, 2018, p99); the process of reviewing the incident should have a patient advocate as a member, non- disclosure should be an exception "limited number of well-defined and explicit circumstances, such as incapacity" (Scally, 2018, p 99); training and education to in open disclosure should be implemented - they suggested a training in open disclosure to be required as a condition of employment, open disclosure should include audits and evaluation, an annual report should be presented publicly (Scally, 2018).

3.6.6. Mandatory Open Disclosure

One consequence of the Cervical Check screening scandal was the proposition of the

mandatory open disclosure to be included in the patient safety bill. The general scheme of the patient safety bill proposes mandatory open disclosure only in “Serious patient safety incidents” (Department of Health, 2018, p10). The serious patient incident is defined as “any unintended or unexpected incident or harm that occurred in the provision of health service”. In addition, they proposed to as an offence as they are “failing to discharge their duty” (Department of Health, 2018, p 3;Scally 2018)

Chapter 4- Apologies and Medical Malpractice

4.1. Apologies and Open Disclosure

According to the Canadian Patient Safety Institute (Taylor, 2007)"Apology is perceived by patients and families affected by adverse events as essential "(p 6) and a crucial component for the disclosure procedure effectiveness (Taylor, 2007). However, as they explain, "most organisations and professional bodies suggest or require that an apology not be made" (p 27) and just an expression of regret can be perceived differently resulting in litigation (Taylor, 2007). According to the AODF (2013), for an apology be successful it must be sincere, and the effectiveness is in the way it is delivered (ACSQHC 2013). An apology itself in this type of conflict would be insufficient, and additional actions and information are required to the open disclosure to be effective (ACSQHC, 2012).

To better understand the role of an apology in disclosure programs, it was asked the opinion of two professionals: Doug Wojcieszak, the founder of SorryWorks! And Richard Boothman, the architect behind the Michigan Model. The interviewees were approached by email, and a phone call was agreed. It was conducted an informal interview, semi-structured by Skype and WhatsApp, that were recorded with the approval of the participants. During the interview it was asked three questions- that were previously sent by email: what were their projects and why it is so effective/important; in their opinion: is an apology an important step in the disclosure programs and why?; and why disclosure programs fail? The first question for the purposes of this section it will not be discussed, but it can be seen in the appendix

Wojcieszak, while answering the question about apologies, explained that an apology is an important step in the disclosure programs, and it is what the families, the doctor and nurses

want , he explained that “If someone hurt, if someone causes you harm, it cost you money or actual time or injured you in some way, I really want to hear gosh, I am sorry I made a mistake, forgive me, you know, people want to hear that” and emphasized that it is what people want to. He explained that when doctors and nurses do it, it shows that they are “concerned and caring”. He explained that “There’s a lot of confusion about what apology exact means, and even what is supposed to do, and for the longest time at least in the states, doctors wouldn’t even say sorry, I mean they wouldn’t just talk, they would just run away and hide” he said that this happened on his brother’s and nephew’s case, that the doctor would “not returning emails or phone calls just literally running fences, running away”. He explained that the way the doctors and nurses handle it is changing as they “are more likely to say sorry”, but that they sometimes do not know how to apologise. He also explained that an apology is no only saying sorry, it needs to be more than just those words.

About the question ‘why disclosure programs fail’, he said that he had never heard about a disclosure program failing, but they can fail to sustain or fail to get launched or when “you don’t have active training or leadership was not entirely supportive, they don’t make everything that is necessary to make it happen”, he explained that it takes effort to put everything together, and theat training, and discussing the expectations with the staff when they are hired is necessary. He explained that “you don’t expect everybody to get it right the first time” but is a process that takes time

Boothman, while answering the question about apology, explained that you can use sorry for a lot of reasons, that apologies mean “an expression of remorse when we know we could have been, should have got better in that we caused harm”, but he noted that although an apology is “extremely important” it is not a cure for all malpractice cases. He explained the relationship between doctor and patient is one of the most intimate ones , that it is “a

relationship of such trust sometimes blind trust we are often giving our bodies or giving our loved ones over to people we don't know (...) they are going to do their best in an inherently risky environment" and he said that in that context

> when something does go wrong, and historically patients have been stonewalled, we have not told what had happened, the sense of betrayal is enormous, so the act of an apology of a very sincere expression of remorse accompanied by a statement of what really happened has an unbelievable deflating impact on the anger that has built up in the sense of betrayal[12]

To demonstrate how an apology could be powerfull he described a case[13] that he had seen about a resident that mistakenly overdose a patient with heparin. The management found out a small printing problem in the label and within 24 hours corrected the error. He concluded by saying that "when we give people a chance, they really understand and I think this is why an apology is so important, you start with this deeply intimate relationship and when things go wrong people feel betrayed, and a genuine apology can start healing both sides"

About why disclosure program fails Boothman explained that he looked into several health system and concluded that "the single biggest reason is that they see it as a risk management strategy and not something deeper" and continued "the other ones they are not durable because they cherry-pick or they are very selective about the cases that they feel comfortable apologising to usually is so very small cases or very obvious cases" and elucidated that the ones successful were capable of normalising that as part of their culture . He pointed out some barriers to disclosure programs first human nature the way the insurance industry sell their products and how lawyers are taught to see the worse case possible

[12] Appendix
[13] Appendix

4.2.Apology and Medical Malpractice Conflicts

To try to understand more about the use of apologies in medical malpractice conflicts, in this section, it will be previous research about the use of apology in these types of conflicts. This analysis is important to help to ascertain the value of an apology,

Robbennolt (2009), examining the literature established that the patient expect to understand what happened , the prevention of future errors, the acknowledgement of the error, they expect to be informed about the error about what, why and how it occurred and how they will be affected by it , the prevention of future harm, to receive an apology with an expression of regret, that the communication happens without they being the one to prompting it .

The physicians worry about the warm caused, their reputation and the consequences, fearing loss of trust and respect feeling "distress, guilt and loss of self-confidence" (Robbennolt, 2009, p 377), fear of a lawsuit. Robbolnnot (2009)found that the reasons why physician does not apologise are because of the legal liability and litigation , another is the culture in the medical field, and the expectancy of perfection is another barrier for the physician apology.

About the relationship between apology and litigation , Robbennolt (2009) found that previous research concluded that the reasons patient litigate, to prevent that the same thing happens in the future, because of the poor explanation given, failure in communication and in the honestly of the physician, failure in informing the error and seek revenge as well., and she found that Apologies help to settle claims

Wu et al. (2009), conducting a study about the disclosure of medical error reported the following findings : A full apology and acknowledgement of responsibility were associated to "only a slight reduction in intention to sue". (p 1016). However a full apology and acknowledgement of responsibility were related to " better ratings and greater trust in the

physician" (Wu et al , 2009, 1015) the perception of the patient "of what was said appeared to be more important than what was actually said"(Wu et al , 2009, p 1015) and the perception and trust in the physician were strongly related to the perception of what is said. Acknowledgement of responsibility without an apology "yielded no such benefit and may have even resulted in more negative judgments"(Wu et al , 2009, p 1015)An increase of lawsuits could be suggested by their study when disclosed an unsuspected error "by making more patients aware they have suffered preventable harm" (Wu et al., 2009, p 1016). And when disclosing to those that knew about the error "does not change the absolute risk that any given patient will sue"(Wu et al., 2009, p 1016).

Raper (2011), analysing the use of apology in the medical setting, apology laws and patient safety in the United States concluded that an apology barely helps the goal of making the patient safer. Explaining that the modern health system is "highly complex" (Raper, 2009, p 316) and imperfect, there is no part for the apology though they are "morally praiseworthy."

Ho and Liu (2010) exploring the impact of apologies law on medical malpractice in the USA found that in the short - term apologies laws decreased the average settlement payment and increased the number of cases solved involving permanent injuries. The time that takes to reach a settlement was reduced, and in the long term "could have been fewer cases overall" (Ho and Liu , 2010, p 26)

Chapter 5- Discussions

Conflicts can be simple or complex, depending on their context. To solve it or manage, it is necessary to understand its core causes (Jeong 2008). Conflict management is essential for all conflicts(Victor and Borisoff, 1998). There are several methods to help manage it or solve, like negotiation, mediation, arbitration, and litigation (Goldberg et al., 2007; Jeong, 2010c); the method chosen will depend on the conflict circumstances.

Medical Malpractice conflicts are complex because it involves dealing with human beings in their most intimate form. This is due to the nature of the doctor-patient relationship, a relationship based on trust, knowledge, loyalty and regard (Chipidza et al. 2015; Ridd et al. 2009). When an error occurs in this scenario, the relationship breaks and distrust and disbelief arises.

The healthcare system, although it is safe (HSE, 2019), is an environment that represents risk and danger(Boothman et al., 2009). From a humanitarian and legal perspective, this system should be guided by the Principle of Human Dignity, resulting in the healthcare provider acting reasonable, understanding that the patient is a human being, a person that deserves respect and is entitled to rights (Andorno 2011). Therefore the patient should be seen as an autonomous being, and as part of this intricate relationship, the most vulnerable side. Because patients have autonomy and at the same time are vulnerable a good communication is essential (Simpson et al., 1991; Ha et al., 2010)

It was noted while reviewing the literature that failure in disclosure essential information and getting the patient consent could result in liability (Madden 2016)

In this innately risky environment, when an error occurs, and a conflict arises, different methods can be used to manage it or solve it. But before reviewing them is necessary to

understand what each part expects.

While analysing the literature and previous research was found that, in summary, patients expect to be informed about the error, have an explanation of what and why it happened, they expect the error recognised, the prevention of future error, to receive an apology , and that communication will be done without them starting it (Robbennolt 2009). The doctors worry about the consequences of the harm caused, they fear the loss of trust, respect, fear of lawsuits and bad media (Pillinger, 2016), although they want to apologise[14].

As it can be seen that each party has different perception/ expectations about the conflict, and a method to manage it or solved should be chosen; preferably a process that will fulfil the patients' and the doctors' expectations. One of the common factors in their expectations is an apology. As it was stated, this research was conducted to try answering the following questions: is there a value of an apology in the medical malpractice conflicts and does it worth to delivery an apology in medical malpractice conflicts? To try answering these questions is necessary to understand what is an apology, where to use it, and the consequences and some factors that can influence. To try reaching this objective literature review was done, data from different sources were presented, and now it is necessary to analyse all the finding so a conclusion can be reached.

Apologies can be considered an essential part of conflict resolution and should be acknowledged (O'Hara and Yarn 2002). It can help to solve, manage a dispute restoring trust or the relationship itself(Goldberg et al., 2007). To Apologise is an act that is familiar to us (O'Hara and Yarn 2002; Smith 2008); it seems like a simple act, but it is a complex process. The meaning of an apology varies from context and the perceptions of its participants. While analysing the literature, it was possible to highlight some elements of this process; to

[14] Section 4.1

apologise involves an expression of regret, acknowledgement of an offence, acknowledgement of responsibility, offer of reparation, and, an explanation, justification of an offence; at least one of these elements or all. It involves at least two sides, and each party has its own perspectives and perception about the apology (Goldberg et al., 2007; Lazare 2004; Taft 2000)

Doctors fear litigation (Sohn, 2013) and avoid apologising because it could possibly be used as an admission of fault. One of the findings of this research was that in Ireland, apologies are protected by law. According to the Legal Services Regulation Act 2015 and the Civil Liability (Amendment) Act 2017, apologies in medical malpractice conflict does not constitute an admission of fault, does not invalidate insurance, and the information exchanged in the context of the Civil Liability (Amendment) Act 2017 are protected.

When an error occurs, and conflict arises, there are different methods to solve it, in the legal area litigation is one of them. In medical malpractice litigation, part of the claims are from negligence, and it is necessary to prove some of the legal criteria were met (supra). While reviewing the literature was noted that medical malpractice litigation is costly and lead to some negative consequences to doctors, as they can start avoiding working in some areas that are considered high risk and start fearing the patients(Sohn, 2013).

When analysing it alone, it can be concluded that litigation constitutes a right that any citizen has however for being costly, sometimes time-consuming and an adversarial method that the parties do not have much control in its outcomes, it should be avoided. Notwithstanding this fact in medical malpractice conflicts, it is a method that does not help to improve patient safety but results in doctors fearing litigation. It seems like a method that should be used as a last resort in medical malpractice conflicts.

Another method used to manage or solve a conflict is mediation. Mediation is a confidential

and voluntary process that provides a friendly environment where an apology can be delivered without the fear of admitting fault and any information being used in litigation. It was noted some disadvantages, and it was suggested that conciliation would be a better process for these conflicts. While analysing the advantages and the counter-arguments, was taken into consideration the principles that guide the mediation. It can be concluded that mediation provides an excellent method of conflict resolution because is a friendly, voluntary, confidential process where the parties have more autonomy. However, the parties should be informed about the possible consequences and reassured that mediation is a voluntary process, where they are the only one with the power to settle it (self-determination). Moreover, the mediator provides a good aid to the conflict (Yee, 2006;Victor and Borisoff 1998). In conclusion, mediation can be an excellent method to help manage or solve medical malpractice conflicts and provides a unique environment to deliver an apology.

One method that is used by risk management to manage or solve medical malpractice claims is called open disclosure or disclosure programs. As stated, all the patients have the right to be informed about their treatment and consequently have the right to be informed about any error that happened. Open disclosure, in summary, is an ethical, humanitarian way of disclosing an incident that caused harm to the patient. It is a process that is guided by openness, transparency and honesty. When previously disclosure programs and their finds were examined, it was noted that open disclosure programs could help to reduce the amount expend with settlements, the number of malpractice claims and the time spent to resolution.

From the literature review and data gathered it could be deduced that the process of disclosure consists in giving the patient timely communication about the incident, in a preferable face- to- face meeting, delivering all the information known about it and engaging the patient in the process of managing the incident. It also involves listening to the patient

and/or family about their experience with the incident, and answering all their questions in a transparent and honest way, offering a sincere apology and a reasonable compensation; giving the patient and/ or family all the support necessary and follow-ups, assuring that everything will be done to prevent the same error from happening in the future.

In Ireland, the open disclosure programs started when a pilot program was launched in two different hospitals that lead, in 2013, to the national open disclosure policy. In 2015 and 2017, two acts were enacted that could help potentially with the process (supra). However, in 2018 the CervicalCheck program scandal was unfolded, and it was discovered that some exam results that had been wrongly delivered as negative, in truth were positive. It was found that no disclosure happened to several patients and the action of not disclosing this information result in an enormous scandal.

Before analysing the use of apologies in disclosure programs is necessary to understand why they fail. Finding why they fail can help to understand how medical malpractice conflicts can be managed and/or solved. It was analysed the finds of the HSE/SCA pilot program report and was asked the opinion of two professional. In the report was stated that the barriers to open disclosure were: lack of training, the personal feelings of the doctors, lack of support from the leadership, a hostile environment for open disclosure, and bad media.

While talking with one of the interviewees, it was explained that disclosure programs fail to get launched or to be supported because of the lack of training and support of the leadership. The other interviewee explained that the main reason why disclosure programs fail is because they are seen only as a risk management strategy and not something more profound. Other factors that influence the failure of open disclosure programs were noted: the organisation picking cases they were comfortable disclosing or that they would have to disclosure and human nature. It was pointed out that success was achieved when disclosure was turned into

part of the organisation culture. It can be deducted that proper training, support from the leadership and efforts to change the organisation culture-shifting from non-disclosure to disclosure are factors that influence the success of disclosure programs.

An apology is a common factor in disclosure program being described as "an essential part of it" (Taylor,2007). While analysing disclosure program and apology, it was described as acting that patients, families, doctors and nurses want to. It could be concluded that it is a social need, however sometimes to doctors is not a clear action[15]. A sincere apology was described as an aid to help reduce the feeling of betrayal and help to heal the parties.

One argument that can be done about apologies and disclosure program is that the second cannot prevent the first being used as an admission of fault. At least in Ireland, this argument does not proceed because apologies in disclosure programs are protected since 2017, and they are protected in clinical claims since 2015.

Open disclosure can be an excellent method in managing medical malpractice claims, with evidence of being successful implement (e.g. The Lexington Veterans Hospital, and the Michigan Model). Open disclosure not only is a suitable method from a conflict management perspective but from a legal standpoint consist in exercising respect for the person that had their integrity and dignity violated, respecting their right of being informed, the right of being autonomous. Therefore, it is a program that enables the right of the patient of being informed about all the facts about their care, and being involved in the process of management of any conflict that arises in that environment.

However, some consideration about open disclosure in Ireland should be done. Open disclosure is a relatively new program in Ireland. Their pilot started in 2010, and the national policy was released in 2013 and reviewed in 2019. Therefore is still in the process of

[15] section 4.1. supra

implementation. An analysis of the impact of open disclosure in the number of claims, patient safety, time to process the claim, and the cost is needed to be done. A study about the psychological and social aspects of open disclosure inside and outside of the health system environment is necessary, because not only the doctors should be informed and educated about open disclosure but the patient as well as they are a party in this process.

One recommendation that can be done concerning the HSE disclosure program is that disclosure should occur to all the cases when an error occurs. It should be understood that the patient has the right to know when an error occurred even when nobody has a fault on it. And as one of the interviewees explained, a factor that influences the failure of open disclosure is one's discretion in choosing the case to disclosure.

Analysing the value of an action, especially one as subjective as an apology is not easy. There is no right or wrong; what can be deduced is that there are some patterns of conduct that are more accepted and successful than others. An apology as was explained is a fact, is a familiar act; it could be considered a need. It can be concluded, after analysing the data, reviewing the literature and talking with two professional, there is a good amount of evidence that indicates that delivering an apology in the context of medical malpractice does worth.

About the value of an apology, there is evidence that an apology helps to de-escalate the conflicts, repair trust, or the relationship itself. There is evidence that it helps to reduce the number of claims, the amount paid for settlement, and reduce litigation. However, an observation should be done. Apologies by itself probably won't solve the conflict, it is seen as a conflict management tool or a human thing to do, they should be included inside a process.

Conclusion

This dissertation aimed to answer the questions: is there a value in an apology in medical malpractice conflicts, and does it worth delivering an apology in medical malpractice conflicts? It was analysed the meaning of an apology, and its elements, previously researched was reviewed, the nature of doctor-patient relationship explained, the function of the principle of human dignity in healthcare explored. It was analysed the use of mediation, litigation and open disclosure programs, and the use of an apology in those process. Two interviews were conducted to help the analysis and collecting data. After analysing and discussing all the finds, it was concluded that there is a value in apologising in medical malpractices conflicts.

Reflections

Doing this dissertation felt like assembling a thousand-piece mono-colour puzzle. It required an enormous amount of time that it was not provided, and required patience and focus. Although apology is an interesting topic to research, there is not a lot of works that evaluate it profoundly, what required a greater amount of time trying to find good research papers or books that could help the argumentation in this dissertation.

Another factor that influenced the doing of this dissertation was that in Ireland, open disclosure is a relatively new approach to the management of medical malpractice claims, thus not enough data was available. The States claim agency was contacted, and information was requested, however, the reports that they indicated me to look did not follow a pattern, and therefore some information was not good enough to use as evidence

One interesting fact that I personally experienced was, as an international student, my network in Ireland is very restricted, and from my previous experiences specialists, and any organizations hardly ever answered to my emails. However, to my surprise, all the three specialists that I contacted answered, although one of them could not help, and one of the two organizations I contacted answered me. It was a very nice experience doing the interviews and talk to them. While talking with one of the interviewees, i realized that the work I was doing was in the right direction.

Overall, although it was a very time-consuming process that required more that it was possible to provide, it was a good experience for learning

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Appendix

Interviews Transcription[16]

First interview- Doug W.

it is, it is important, you know is what families want,and also doctors and nurses [...not audible] If someone hurt,if someone causes you harm, it cost you money or actual your time or injured you in some way, I really want to hear gosh, I am sorry I made a mistake, forgive me, you know ,people want to hear that stuff and, and it means something to a lot of people, so it is important and you probably [not audible] okay good, I think we illuminated this on the paper, a lot of the things in that. There's a lot of confusion about what apology exact means, and even what it suposed to do, and for the longests time at leats in the states, doctors wouldnt even say sorry, I mean they wouldnt just talk ,they would just run away and hide that was certainly it was my brothers case, nephew's case I mean back them just literally, you know not returning emails or phone calls just literally running fences, running away we've changed some of that ,they like you know, doctors and nurses are more likely to say sorry, and we'll go to apologize but they don't always know what that means and sometimes they think you know how would you just say sorry well okay that's that's fine but if if you injured somebody if you hurt them cripple after bit they're dead and then they leave I have family but this, they forgot how they're going to take the next steps there's no money and

[16] The audio was unploaded on moodle

other things that needs to cover the table then it needs to be more than just words and sorry, it used to be I'm sorry I screwed up and and here's how we're going to try to this whole's possible, that to sometime solution nurses they get can do is like well it was a you know it was a bad outcome we're not sure what happens, I'm not wearing aan apologize, you shouldnt apologize you should empatize, just it just happened so difficult tonight someone you're sorry that their grandma tonigh[audio not good] inversely adverse event is just bad it's just a known complication of without an error and doctors will get kind of incredulous and say what you're expecting me to apologize for all there's that no, again I expect you apologize for something you didn't cause, it was an unknown complication to the procedure complete still need the optaze,you see again optize off sooner home I'm sorry, oh and we picked up on that the paper,[….]

why disclosure programs fail?

for you well you know I've never as I wrote in my response I've never seen on Oh lawsuits you drive across where they sometimes they fail this sustained or fail to get launched and you don't have act training or leadership was not entirely supportive of it so I mean there's plenty of work you know, I got involved on myself where you know a hospital or insurance now let's do those no just they don't do all that needs to be done to make it happen it's way you know yet talk to my fears well here I go yeah yeah that didn't work oh did not work or did you fail to work you failed you know staff that are trained we got on the ball and stay after gonna keep educating wouldn't do that because , and then nurses aand doctors are hired and of the organization they need to be brought it up and then in a word this is an expectation of you working at this hospital or a nursing home whatever it is that's right yeah that's freshly but that probably hey that's just the growing pains of a new process getting the health care

you don't expect everybody to get it right the first time typically happened if there were that easy it'd have been a long a long time ago so will persist it until anchor

Second Interview - Richard B.

so let's define our terms firt, at leats in english we use the word I'm sorry for wide range of reason right yeah I can say to you sorry this program is not working very well gthat doesn't that doesn't mean it's an apology so I had to make fiction at the University and tell to ourselves right from the beginning it's not so much apologies that drive this it's sincerity and authenticity we had to be completely honest so so I want to make sure that you and I are on the same page of how is this for the kind of the context of what I'm about to tell you the word apology means an expression of remorse when we know we could have been should have got better in that we caused harm and it's an expression of remarse so now why is that important it is extremely important now it's not a panacea for all of the malpractice practice issue and it doesn't fix everything but the relationship between caregiver and patient is almost the most intimate relationship in this kind , we have a dayghet in the fourth year of training as an obstratician gynecologys [...] and your daughter called in the second year of school and she said I don't think I can do this and I said why and she said I had my first clinical experience I saw 15 patients today they were all complete strangers i didnt know a single person and here were these people taking their clothes off and letting me put my hands and telling me their most inimity things on their lives and she said the resposanbility on on my shoulders is awesome and she said I don't know if I can handle that it is and she said I never appreciated one of what an amazing and poignant relationship that really is and I have always known that so when I represent doctors this is unusual in all of personal injury litigation because it begins with such a relationship of such trust sometimes blind trust we are often giving our bodies or

giving our loved ones over to people we dont know at all and press that they are going to do their best in an inherently risky endeavor you cannot give an antibiotic c to a child risk free I've had two cases of children with miserable deaths just for getting an antibiotic for an ear infection,anybody did anything wrong so with that reality when something does go wrong and historically patients have been stonewalled we have not told what had happened the sense of betrayal is enormous so the act of an apology of a very sincere expression of remorse accompanied by a statement of what really happened has an unbelievable deflating impact on the anger that has built up in the sense of betrayal I have seen some of the most remarkable human responses that you could ever imagine i give you one exemplo we had a we had a lady who had a neurosurgical procedure in her at in her brain and about four or five hours after the procedure she showed signs of us broke and the I the plan was to get a CT scan of her brain as quickly as possible and if she had bleeding at the brain we would take her to the operating room but if she had a clot which was causing the stroke we would give her an anticoagulant called heparin so that was the plan and sure enough that looked like a clot so they delivered 3.000 units of heparrin and it seemed to break up the clot but then she had hourendous bleed in her brain and she was no longer solvedble so severe that she …. was so the family was called she was on life support and the attending physician came in to tell her that tell the family that he was terribly sorry but heparin is a dangerous drung and this could had happened in the absence of negligence well he discovvered while he was talking to the family is that the labeling of heparin has been deceptive and known to be a problem for years on the label of heparin is in big numbers in this case each file at 1,000 but in small print it said times 10 the physicians that night delivered 30,000 units not three while the attending physician was telling the family how sorry he felt that this patient was going to die the resint who actually administered the drug came to me with these files in his hand and said and he was

crying and he said I killed this lady i delivered ten times the dose would we let him talk to the familly and I said to the attending physician I have no idea how this family is going to react if they react badly we've got to get this resident out of there he went in and told this family and they were dumbstruck they were silent for the longest time and the patient's sister crossed the floor and embrace that resident he said to him we have watched you in really care she said never forget my sister but don't you dare quit because you're going to do a lot for a lot of people in your career and don't you let this mistake make you quit the practice of medice I have never seen anything so generous and so amazing in my life to that apology it was very hard felt of course and i said [?more importantly within 24 hours we had identified what had happened we were sloppy with the use of heparin we had heparin is that if this resident had to request the heparin from the pharmacy he woudl have gotten the proper dose but we would have loose , anyway to complete the story within 24 hours we fixed that problem i dont thiink any other patient would have an heparine overdose because of the sloppiness we had that led to that problem, this is why the system , this aproach is so improtant but then apology , that I discovered in my 17 years of michigan no more than five people tried to take advantage of us everybory was so generous and so when we give people a chance they really understand and and i think this is way an apology is so important that you start with this deeply intimate relationship and when things go wrong people feel betrayad and a genuine apology can start healing bothe sides

yeah yeah I'm here can you hear me can you hear me yeah okay so my last

question is why the disclosure programs fail

yeah[Music] i am so glad that you aske that question very so people ask it i have looked at many of the heatl system that tried and fail and i think that t on the beggining of our conversation i told you how important is to undertsnd the real goal is to build an accountable clinical culture to say to physician youre establish this relationshi, everybory sticks their neck out in this incredable dangerous activiti our goal is to continuosly imptove, the health system that had been suscessful undestand that the other ones they are not durable because they cherry pick or they are very selective about the cases that they feel confortable apologising to usually is so very small cases or very obvious cases so endedn up [] anyway it is mormalizing the ones that are sucessfull and the ones that are capable of normalise this as part of their culture and theyliterally gets to the point to say that is not our program this is how we behive this is what it means our care our organization so i retared of the university of michigan in august of last year without one with no concerns whatsoever that we are going to blackslot? Not i left very good people in my place but because which i did but because medical staaff specially really embraced this and we proved to them we reassure them that the finantial sky woulnt fall in this was only a [] in our patient care and they did believe i dont think they will never go back

The biggest impediments are first of alll human nature i really think we are wired for [] i think we are wired to fight or flight and when something bad hapens the human nature is to run away or to get defensive the insurese industry and the legal profession have sort of exploited that so im my experience the insurece people sayd every patient representes a catastrofe and that's not true but that the way they sell insurance youneed to pay for insurance or otherwise your face finantial ruin well thats not that only exaggerates that concern and

lawyers are trained to see the worst case as a lawayer thats our training I think that has made things worse so we have a whole generation and healthcare providers have never known that it's okay to be honest with their patients in this situation but hey really wanna be because the people that go to health care are that people tahta find meaning for themselves in healing people it its a interesting group of people that I have dealt with my carrer