Apology for the Unexpected Death of a Child in a Health Care Facility

A Prescription for Improvement

by Frank Gomberg

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Dedication

I would like to dedicate this paper to my mentors Professor Martin Teplitsky (formerly of Osgoode Hall Law School), Judge Hugh Locke (now retired, formerly of the Ontario Superior Court), Kenneth E. Howie, Q.C., and Lawrence H. Mandel, Q.C. (both of Thomson, Rogers, Lawyers, Toronto, Ontario). These teachers contributed immeasurably to my legal career. Without their unwavering support, I would never have been a competent litigation lawyer, let alone a full-time mediator. I am forever indebted to these four "wise men" for forgiving my many mistakes. None of them ever embarrassed or humiliated me. I now belatedly and unequivocally apologize to each of them for the errors I committed and for the aggravation I caused each of them. Each has inspired me. Each treated me with genuine affection and respect when I was a very young, inexperienced lawyer—when there was nothing in it for them. Each has been an exemplar of integrity and the best that the law has to offer. It is a privilege for me to acknowledge them here.

Further Dedication and Acknowledgement

Since the original publication of this paper (on April 15, 2011) I have met and been inspired by another doctor who has taught me much about compassion and humanity. I met Dr. Stephen Fremes, a wonderfully gifted cardiac surgeon on February 10, 2012 at Sunnybrook Hospital. I'd had a "heart attack" on February 9. Dr. Fremes performed a quintuple bypass on me on February 13, 2012. Without his surgical brilliance, I would not be mediating nor would I be writing any papers at all. He and his wife, Jill have been big supporters in the 7 years between then and now. I am lucky to have such great friends.

In addition, I wish to acknowledge the passing of two of my much beloved mentors. Martin Teplitsky Q.C. died on July 14, 2016. The Honourable Judge Hugh R. Locke died on September 25, 2017. I have lost two irreplaceable friends. The profession has lost two exemplars of decency and civility. We are all poorer without them. Their legacies live on!

F.K.G.
Toronto, Ontario
May 15, 2019

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Dr. Ronald Laxer has been more than an extremely close friend since we were nursery school classmates at Montreal's Talmud Torah over 52 years ago. Ron is probably the world's pre-eminent paediatric rheumatologist, a truly exceptional scholar, teacher and clinician. Ron was Vice-President of Education and Quality at The Hospital For Sick Children, Toronto. His advice about incorporating medical journal articles into this paper and his assistance in locating these materials went far beyond what a friend should ever expect of a friend.

Dr. T. James Cairns, formerly Deputy Chief Coroner for Ontario was unknown to me prior to the Shore inquest. His integrity and strength of character in difficult times for him and for me, have been a true inspiration.

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To my new friends, Dr. Philip Hébert and Dr. Izzeldin Abuelaish all that I can say is thank you for your valuable time and for your humanity. You met with me—a total stranger—in order to educate me on ethics and apology. Both of you have contributed to this being a much better and more polished paper than it otherwise would have been. I can never repay Philip and Izzeldin for their kindness and generosity of time and spirit. A simple heartfelt thank you will have to suffice.

I also want to acknowledge the unwavering support of my favourite doctor, my father, L. Charles Gomberg, M.D., F.R.C.P. (C.). My father is and always has been a tower of strength. He is still doctoring and skiing at age 85. He suggested that I investigate The Tuskegee "Bad Blood" experiment. The idea was an excellent one and led me to view President Clinton's apology to the victims of this horrible experiment. This apology brought me to tears. It must rank as one of the great apologies of all time.

F.K.G.
Toronto, Ontario
April 15, 2011

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Preface

The doctor who ***wants*** to get in trouble after an incident of actual malpractice can do so easily. All he has to do is avoid the patient, blame the patient for the bad result, refuse to talk to the family, refuse to apologize, refuse to listen in humility to patient castigation, and then to send his bill as usual. The doctor who wants to guarantee a breakdown in the relationship does not have to do ***all*** of the foregoing, just a few will suffice. The doctor who does not want to be sued will avoid these traps and will face the patient with humble sympathy and courage for the truth.*

A stiff apology is a second insult...The injured party does not want to be compensated because he has been wronged; he wants to be healed because he has been hurt.

~ G. K. Chesterton

(ii)

Professor Kenney Hegland describes this abandonment of apologies as starting as early as law school, and he offers the following anecdote;

> *In my first year Contracts class, I wished to review various doctrines we had recently studied. I put the following:*
>
> *In a long term installment contract, Seller promises Buyer to deliver widgets at the rate of 1000 a month. The first two deliveries are perfect. However, in the third month Seller delivers only 999 widgets. Buyer becomes so incensed with this that he rejects the delivery, cancels the remaining deliveries and refuses to pay for the widgets already delivered.*
>
> *After stating the problem, I asked "If you were Seller, what would you say?" What I was looking for was a discussion of the various common law theories which would force the buyer to pay for the widgets delivered and those which would throw buyer into breach for cancelling the remaining deliveries. In short, I wanted the class to come up with the legal doctrines which would allow Seller to crush Buyer.*
>
> *After asking the question, I looked around the room for a volunteer. As is so often the case with the first year students, I found that they were all either writing in their notebooks or inspecting their shoes. There was, however, one eager face, that of an eight year son of one of my students. It seems that he was suffering through Contracts due to his mother's sin of failing to find a sitter. Suddenly he raised his hand. Such behavior, even from an eight year old, must be rewarded.*
>
> *"Ok," I said, "What would you say if you were the seller?"*
>
> *"I'd say 'I'm sorry'".* *

* See Ann J. Kellett, "Healing Angry Wounds: The Roles of Apology and Mediation in Disputes Between Physicians and Patients", (1987) Missouri Journal of Dispute Resolution 111 at p. 124 citing R. Blum, The Management of the Doctor-Patient Relationship 253.

***** See Professor Elizabeth Nowicki quoting Professor Kenney Hegland in "Apologies and Good Lawyering" at www.ssrn.com/abstract=1430212. Site last visited February 24, 2011 (original footnote deleted).

1. INTRODUCTION

Like love, apology is in the air.[1] It is ubiquitous and omnipresent. In many respects, it is the "flavour of the month". Philandering politicians do it;[2] athletes do it;[3] popes do it;[4] rock stars do it;[5] and so do cops,[6] major food,[7] pharmaceutical[8] and oil companies.[9] Sociologists write about it;[10] so do psychiatrists,[11] lawyers,[12] law professors,[13] ethicists,[14] and self-help gurus.[15] Almost everyone has apologized in his life, not only in North America and in western Europe but in lands far away. Numerous comparative studies have been undertaken contrasting apology styles and methodologies in different countries

1 See Love is in The Air lyrics by John Paul Young at www.romantic-lyrics.com/ll14.shtml. Site last visited February 15, 2011.

2 See a chronology of President Bill Clinton's many apologies arising out of his sexual relationship with intern Monica Lewinsky summarized at www.articles.cnn.com/1999-02-12/politics/apology_1_accountability-demands-consequences-remorse-big-mistake?_S=PM:ALLPOLITICS. Site last visited February 15, 2011.

See "Edwards admits affair in Statement" at www.firstread.msnbc.msn.com/_news/2008/08/08/4435196-edwards-admits-affair-in-statement. Site last visited February 15, 2011.

It is noteworthy that Senator John Edwards' initial apology was grossly deficient for a number of reasons, not the least of which was the fact that when later faced with the imminent publication of a tell-all book by his former aide Andrew Young, Edwards conceded in January 2010 what he had steadfastly denied to that point—his paternity of his mistress Riele Hunter's daughter. This apology in instalments is hardly convincing and is universally frowned upon by apology theorists.

See www.voices.washingtonpost.com/44/2010/01/john-edwards-admits-paternity.html. Site last visited February 15, 2011.

3 See Kobe Bryant's apology for sexually inappropriate behaviour towards a young woman which ultimately led to an abortive sexual assault charge against him "Kobe Bryant's Apology" at www.sports.espn.go.com/nba/news/story?id=1872928. Site last visited February 15, 2011.

See also Marion Jones' apology for false statements and illegal steroid use at www.americanrhetoric.com/speeches/marionjonesapologyforsteroiduse.htm. Site last visited February 15, 2011.

See also Tiger Woods' apology for his many extramarital sexual affairs delivered on February 19, 2010 at www.youtube.com/watch?v=OuJ5p2NF35o and his further apology for spitting on a golf course delivered on February 14, 2011 at www.skynews.com.au/sport/article.aspx?id=577876&vId-2183312. Both sites last visited February 15, 2011.

See also Sean Avery's apology for referring to Dion Phaneuf's girlfriend actress Elisha Cuthbert as "sloppy seconds" at www.cbc.ca/sports/hockey/story/2008/12/03/avery-timeline.html. See also Detroit Tigers star Miguel Cabrera's apology for drunk driving and for asking the police "Do you know who I am?", The Toronto Star, Friday, February 18, 2011 at p. S8.

4 See Pope Benedict's apology for unspeakable sexual abuse at blogs.reuters.com/faithworld/2010/09/18/pope-apologizes-for-unspeakable-crimes-of-sexual-abuse/ and Pope John Paul II's apology for past errors, faults and immoral acts of individuals (and not the church itself) at www.religioustolerance.org/popeapo2.htm. This apology is deficient as are all apologies where the titular head of an institution apologizes for acts other than for misdeeds of the institution which the apologizer heads. Both sites last visited February 15, 2011.

5 See Chris Brown's apology to Rihanna at today.msnbc.msn.com/id/32013728/ns/today—entertainment and psychiatrist Dr. Gail Saltz's commentary on the sincerity of Brown's apology. Site last visited February 15, 2011.

6 See "Cop apologizes for 'sluts' remark at law school", The Toronto Star, Friday, February 18, 2011 at p. A2. This apology strikes close to home as the offending remarks were made by Toronto Police Constable Michael Sanguinetti at a safety forum at Osgoode Hall Law School—where I am both a student and a teacher. As the father of a 20 year old daughter who on February 11, 2011 acted in a University of Guelph production of The Vagina Monologues (which decries this kind of misogynistic link between style of dress and sexual assault), I am appalled at this type of comment.

7 See Michael McCain's apology for the Maple Leaf Foods listeria contamination at www.youtube.com/watch?v=CgK3o3AJM2U. Site last visited February 15, 2011.

8 See Chicago Tylenol Murders at en.wikipedia.org/wiki/1982_Chicago_Tylenol_Murders for Johnson and Johnson's handling of the crisis caused by the cyanide poisoning of its Extra Strength Tylenol capsules. Site last visited February 15, 2011.

9 See BP's apology for the Gulf Spill (Tony Hayward apologizes) at www.smartplanet.com/technology/blog/thinking-tech/bp-releases-apology-ad-phony-or-heartfelt/4331/. Site last visited February 15, 2011.

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

11 Aaron Lazare. *On Apology* (Oxford: Oxford University Press, 2004) and Roy Schafer, "Cordelia, Lear And Forgiveness", (2005) 53 Journal of The American Psychiatric Association 389.

12 See, for example, Abigail Penzell, "Apology in the Context of Wrongful Conviction: Why The System Should Say It's Sorry", (2007) 9 Cardozo Journal of Conflict Resolution 145; and Marshall H. Tanick and Teresa Ayling, "Alternative Dispute Resolution By Apology: Settlement By Saying I'm Sorry", (1996) The Hennepin Lawyer, 22.

See also Leslie H. Macleod, "A Time For Apologies: The Legal and Ethical Implications of Apologies in Civil Cases", Cornwall Public Inquiry, Phase 2 Research and Policy Paper; Final Paper April 12, 2008, www.atttorneygeneral.jus.gov.on.ca/inquiries/cornwall/en/report/research_papers/Phase_2_RP/3_Macleod_Apologies. Site last visited February 24, 2011.

13 See, for example, Professor Prue Vines, "Apologising to Avoid Liability: Cynical Civility or Practical Morality?", (2005) 27 Sydney Law Review 483; Professor Jennifer K. Robbennolt, "Apologies and Legal Settlement: An Empirical Examination", (2003-2004) 102 Michigan Law Review 460 and Professor Donna L. Pavlic, "Apology and Mediation: The Horse and Carriage of the Twenty-First Century", (2002-2003) 18 Ohio State Journal of Dispute Resolution 829.

14 See Lee Taft, "Apology Subverted: The Commodification of Apology", (2000) 109 Yale Law Journal 1135, "Apology and Medical Mistake: Opportunity or Foil?", (2005) 14 Loyola University Chicago Institute for Health Law, Annals of Health Law 55 and "On Bended Knee (With Fingers Crossed)", (2005-2006) 55 DePaul Law Review 601.

15 See Ken Blanchard and Margaret McBride. *The One Minute Apology* (New York: William Morrow, 2003) and Beverly Engel. *The Power of Apology: Healing Steps to Transform All Your Relationships* (New York: John Wiley and Sons, Inc., 2001).

and cultures.[16] Indeed, in China one can hire a professional apology firm to deliver a customized apology.[17]

How then can I contribute to scholarship on this intricate and multi-faceted subject?

I propose to analyze/assess apology theory and practice through the prism of 32 years of experience in personal injury litigation: the first 20 of these years as a litigation lawyer (1979-1999), and the last 12 as a full-time mediator (1999-2011). I believe that with the benefit of my varied experience as focussed through the scope of academic writing, I can add something valuable to the discourse on apology. My objective is to do this in the context of healthcare malpractice litigation and specifically, lawsuits arising from the deaths of children in healthcare facilities: deaths alleged to have been caused or contributed to by medical or nursing malpractice. I believe that the cauldron of emotion generated by such child deaths makes this particular contextual study of apology worthwhile; for if one can distill the essence of good apology in these horrific situations, one can craft a template for success for apologies in all aspects of life.

The three child fatality cases that I have selected to study are cases involving three distinct scenarios: i) the undoubted negligence of two nurses compounded by distortion and obfuscation;[18] ii) clear physician negligence in the context of an implanted cardiac defibrillator which failed to defibrillate;[19] and iii) surgical "non-negligence" masquerading as negligence after a 15 year old boy who had damaged his spleen in a bicycling accident died roughly three weeks later from a massive splenic bleed.[20] It is hoped that this study will promote the development of a more productive apology culture, so that healthcare apologizers can apologize more effectively, and their "apologizees"[21] may benefit from these improved and more meaningful apologies.

In addition to my analysis, I hope that the three cases that I have included will be used as pedagogical modules in mediation and risk management courses, in medical schools and in other programs in order to stimulate discussion of the manner in which doctors and nurses may ethically respond to crises. I have made the exemplar cases fulsome in detail so that they may be employed as stand-alone exercises. I expect that these three case studies will contribute to the improvement of apology in Canada. Ultimately, it is hoped that potential medical and hospital apologizers will embrace the conclusions in this paper. I further hope that the three case studies will be used as teaching tools by The Canadian Medical Protective Association—The CMPA, (the Canadian defence group

16 See Max Bolstad, "Learning From Japan: The Case For Increased Use of Apology in Mediation", (2000) 48 Cleveland State Law Review 545; Ilhyung Lee, "The Law and Culture of The Apology In Korean Dispute Settlement (with Japan and The United States in Mind)", (2005) 27 Michigan Journal of International Law 1; Mitchell A. Stephens, "I'm Sorry: Exploring The Reasons Behind The Differing Roles of Apology in American and Japanese Civil Cases", (2008-2009) 14 Widener Law Review 185; Naomi Sugimoto. *Japanese Apology Across Disciplines* (New York: Nova Science Publishers, Inc., 2010); and Hiroshi Wagatsuma and Arthur Rosett, "The Implications of Apology: Law and Culture in Japan and The United States", (1986) 20 Law and Society Review 461.

17 As Aaron Lazare so eloquently put it
Another indicator of the growing international importance of apologies is the fact that China now boasts of several apology companies, as well as apology "call-in" shows on state radio. The Tianjin Apology and Gift Centre, part of a psychological stress reduction centre, has a staff of 20 who write letters, deliver gifts, and offer explanations. The employees are middle-aged, educated, well-spoken men and women who have significant life experience, often as lawyers, teachers, and social workers. Most of the clients are involved in family or business disputes or are estranged lovers. This method of apology in China, through paid surrogates, illustrates not only the importance of apology in other cultures but also how delivering apologies differs according to culture. It seems to me unlikely that such a business would thrive in the United States, where the offended party expects to receive apology directly from the offender or at least from a significant third party.
Supra note 11 at pages 7-8 (Lazare's footnotes deleted).

18 The Lisa Shore case. See www.lisashore.com. Site last visited February 26, 2011. See also Sharon Shore. *No Moral Conscience: The Hospital For Sick Children and the Death of Lisa Shore* (Toronto, Canada: Self-published, 2005).

19 I was the lawyer who represented the family of the deceased, Janice T. Blake. I have changed all names in the case to maintain confidentiality.

20 Again, I represented the family of the deceased, Danny Smith. I have once again changed all names in the case to maintain confidentiality.

21 The word "apologizee" does not appear in the dictionary and is my own construct. I use it as an antonym to "apologizer" (U.S.) or "apologiser" (Britain) as I think it more succinctly connotes the recipient of the apology than do terms such as "victim" or "offended party".

which defends and indemnifies physicians) and Health Insurance Reciprocal of Canada—HIROC, (the Canadian defence group which defends and indemnifies hospital personnel including hospital-based nurses).

It is my thesis that apologies are just as necessary in non-negligent health facility based child death scenarios as they are in those fact situations where negligence is crystal clear or at least provable to the civil standard. I posit that the human condition is such that regardless of negligence, when a child dies in a healthcare setting, there is a need for reconciliation and understanding between the professional healthcare provider (the apologizer) and the family (the apologizee). Part of this dynamic relates to society's view of the god-like qualities associated with healthcare providers (where power resides) and the perceived dependence and indeed neediness of patients (where there is an absence of power).

This paper will attempt to elucidate what informs the connection between apologizer and apologizee and how we as lawyers and mediators should attempt to foster apology and expand its use, notwithstanding the potential for abuse by disingenuous, "commodity"[22] based apologies.

Just as doctors often swear the Hippocratic Oath upon graduation from medical school, so too should lawyers and mediators "do no harm".[23] If we embrace this standard by implementing some of the suggestions that I offer in this paper, then we will make healthcare based child-death litigation in Ontario more compassionate and humane. This is a worthwhile goal for all who are involved in this field, including mediators, plaintiffs' lawyers, defendants' lawyers, doctors, nurses, errors and omissions insurers, and, in Canada, The CMPA and HIROC. I hope to contribute to the worthwhile goal of diminishing the "scorched earth" approach to these cases, and perhaps to humanize the conflict resolution model which is available to litigants embroiled in this type of litigation.

2. PSYCHOLOGICAL DYNAMICS ARISING FROM THE WRONGFUL DEATH OF A CHILD

Before turning to the constituent components of an effective apology, and the necessity for inclusion of these components in the apology in order to maximize the apology's healing potential, it is useful to place the law pertaining to wrongful death, and specifically the wrongful deaths of children, in some historical context. In doing this, a brief review of the literature pertaining to the psychological effects of the death of a child on his or her family members is also necessary.

Awards for wrongful death were established at least as early as Biblical times. This long history is a reflection of the value that we place on the physical integrity of the person and on maintaining order in a civil society. If injury or death is inflicted by one person on another, and if that injury or death goes uncompensated, the absence of punitive sequelae has significant adverse ramifications for maintaining an ordered, civilized society. Though "an eye for an eye" is a crude "compensation" scheme, it does serve to deter negligence by warning a potential tortfeasor that if he doesn't take care, society will inflict the identical injury on him that he has

22 See Lee Taft, "Apology Subverted: The Commodification of Apology", (2000) 109 Yale Law Journal 1135.

23 The Hippocratic Oath does not specifically state "do no harm". The original version states "I will abstain from whatever is deleterious and mischievous." The so-called modern version reads "I will abstain from whatever is harmful or mischievous" (my emphasis). It is noteworthy that the original version uses the conjunctive and the modern version, the disjunctive. Be that as it may, the phrase "do no harm" is commonly attributed to the Hippocratic Oath. See www.nktiuro.tripod.com/hippocra.htm for various iterations of the Hippocratic Oath. Site last visited February 15, 2011.

inflicted on his victim. The eye for an eye maxim is known as *Lex Talionis* which is defined in Black's Law Dictionary as:

> The law of retaliation: which requires the infliction upon a wrongdoer of the same injury which he has caused to another....Expressed in Mosaic law by the formula "an eye for an eye; a tooth for a tooth".[24]

The first articulation of the *Lex Talionis* principle was in Exodus 21:23-25. This Biblical passage reads:

...life for life, eye for eye, tooth for tooth, hand for hand, foot for foot, burn for burn, wound for wound, bruise for bruise.[25]

The Sephardic Institute's analysis references two further places in the Old Testament where *Lex Talionis* is also articulated.

> The "eye for eye" formulation occurs two additional times in the Torah. Following the case of the blasphemer, in a passage that is linked to the previous subject in an unusual manner, it states: "If anyone maims his fellow, as he has done so shall it be done to him—fracture for fracture, eye for eye, tooth for tooth. As he has maimed a man so shall it be rendered unto him" (Lev. 24:19-20). And in the passage dealing with false witnesses, it states: Do to him as he had schemed to do to his brother... Your eye shall have no pity—life for life, eye for eye, tooth for tooth, hand for hand, foot for foot" (Deut. 19:19, 21).[26]

It is hardly surprising that our civil justice system has evolved over the centuries and that we now award money to victims and their family members as a form of compensation, rather than inflict injuries or put perpetrators to death. This evolution in the law of compensation reflects a more sophisticated and developed victim-centred approach, but arguably fails to recognize some of the more basic needs of victims and their surviving family members in wrongful death litigation and specifically, wrongful death litigation arising from the deaths of children: the need to be heard; to be understood; to be empathized with; and the need not to be re-victimized by the very process designed to compensate. The pristine simplicity of *Lex Talionis* required no victim participation, and indeed assured the victim and her family members a kind of moral equivalency or fundamental fairness. Once the victim lost his eye or his life at the hands of a "tortfeasor", the legal recourse was swift and highly predictable.

Personal injury litigation as of 2011 in Ontario has distanced victim and tortfeasor (largely through the interposition of liability insurance) and has failed to consider the emotional impact of injury, either on a victim's sense of bodily and psychological integrity or on that of his survivors in the wrongful death context. Shuffling money from the tortfeasor—or more likely from his liability insurer—to the victim's family members in a wrongful child death case fails to integrate concepts of recognition of harm and apology into the process. This unfortunate failure is an area where mediation and other alternative dispute resolution processes hold out unique promise as vitally important components of "healing". I submit that apology is a critically important part of the "compensation package".

Arguably, the most assaultive of all injuries is death and of all deaths, the most tragic are those of children.

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24 *Black's Law Dictionary*, Revised Fourth Edition, (St. Paul, Minnesota: West Publishing, 1968).

25 Sephardic Institute, **"**Parashat Mishpatim, Part III on 'An Eye for an Eye**"'**, www.judaicseminar.org/bible/mishpatim3.pdf (Brooklyn, New York, 2009) at page 1. Site last visited February 17, 2011.

26 Ibid.

The death of a child is an horrific re-ordering of the natural sequence of life's events. Parents are supposed to pre-decease their children. Anything else is outside the parameters of what we normally conceptualize.

The civil litigation process in Ontario is ill-equipped to recognize and appropriately respond to the horror of the wrongful deaths of children. The binary "win-lose" paradigm is clearly not conducive to reflect society's value of the life of a child, and in the long march to the courtroom, the emotional needs of the surviving family members are at best ignored and at worst violated.

As the ethicist Lee Taft has said:

> Tort claimants are people whose lives have been turned upside down, people upon whom "the terrors of death have fallen," people overwhelmed by horror. It is important to remember that there are dimensions to a tort victim's suffering that make it different from the suffering each of us endures as a part of human experience—ordinary suffering that is interwoven in earth-side living. The parent who loses his or her child because another fails to obey a traffic signal suffers differently from the parent whose child dies from illness. Both grieve, but the grief of the tort claimant is compounded with powerful and complex emotions because of the relationship of their loss to another's wrongful act.[27]

In this paper, I will discuss how apology in the context of a civil claim for the wrongful death of a child in a healthcare facility can and should hold the promise of making things better for the child's surviving family members. This conception that things can be made better does not arise from a naive belief on my part that anything good can ever emerge from a child's wrongful death, but is more a reflection upon apology as a restorative tool in the "wrongdoer's" armamentarium. Apology therefore falls into the category of "do no harm" and perhaps, if done effectively, it may do some good.

In her watershed work *On Death and Dying*,[28] the psychiatrist and thanatologist Dr. Elisabeth Kübler-Ross formally sets out the five stages that the dying person must move through in order to have a "healthy" death. These stages are:

i. denial
ii. anger
iii. bargaining
iv. depression
v. acceptance

In her subsequent book *On Grief and Grieving*,[29] Dr. Kübler-Ross clarifies that the five stages apply not only to the dying person, but to the grieving family members as well:

> Denial in grief has been misinterpreted over the years. When the stage of denial was first introduced in *On Death and Dying* it focused on the person who was dying. In this book, *On Grief*

27 Lee Taft, "On Bended Knee (With Fingers Crossed)", (2005-2006) 55 DePaul Law Review 601 at p. 612 (footnotes omitted).

28 Elisabeth Kübler-Ross. *On Death and Dying*, (New York: Scribner, First Paperback Edition, 2003).

29 Elisabeth Kübler-Ross and David Kessler. *On Grief and Grieving,* (New York: Scribner, First Paperback Edition, 2007).

and Grieving, the person who may be in denial is grieving the loss of a loved one. In a person who is dying, denial may look like disbelief. They may be going about life and denying that a terminal illness exists. For a person who has lost a loved one, however, the denial is more symbolic than literal.[30]

As Kübler-Ross says:

> You may also be angry with yourself that you couldn't *stop* it from happening. Not that you had the power, but you had the will. The will to save a life is not the power to stop a death. But most of all you may be angry at this unexpected, undeserved, and unwanted situation in which you find yourself. Someone once shared, "I'm angry that I have to keep living in a world where I can't find her, call her, or see her. I can't find the person I loved or needed anywhere. She is not really where her body is now. The heavenly bodies elude me. The all-ness or one-ness of her spiritual existence escapes me. I am lost and full of rage".[31]

She goes on to state:

> Acceptance is often confused with the notion of being all right or okay with what has happened. This is not the case. Most people don't ever feel okay or all right about the loss of a loved one. This stage is about accepting the reality that our loved one is physically gone and recognizing that this new reality is the permanent reality. We will never like this reality or make it okay, but eventually we accept it. We learn to live with it. It is the new norm with which we must learn to live. This is where our final healing and adjustment can take a firm hold despite the fact that the healing often looks and feels like an unattainable state.[32]

Kübler-Ross talks about sitting down with dying patients and having them share their experiences with her and with her medical students. Though there is an obvious difference between talking to a dying person, and a healthcare professional communicating with bereaved family members and apologizing, there are some useful parallels:

> If we ask ourselves what is so helpful or so meaningful that such a high percentage of terminally ill patients are willing to share this experience with us, we have to look at the answers they give when we ask them for the reasons of their acceptance. Many patients feel utterly hopeless, useless, and unable to find any meaning in their existence at this stage. They wait for doctors' rounds, for an X-ray perhaps, for the nurse who brings the medication, and the days and nights seem monotonous and endless. Then, into this dragging monotony a visitor comes who stirs them up, who is curious as a human being, who wonders about their reactions, their strengths, their hopes and frustrations. Someone actually pulls a chair up and sits down. Someone actually listens and

30 Ibid at p. 8.

31 Ibid at p. 12.

32 Ibid at pp. 24-25.

> does not hurry by. Someone does not talk in euphemisms but concretely, in straightforward, simple language about the very things that are uppermost in their mind—pushed down occasionally but always coming up again.[33]

Kübler-Ross then remarks that "This shows how meaningful such relationships can become and how little expressions of care can become the most important communications".[34]

If this is the case between a psychiatrist and a dying patient, similar regard for and attention to bereaved family members as part of the apology process bodes well for a negotiated settlement.

Apology done appropriately may at least send victims home feeling that their concerns and emotions have been considered in a meaningful and non-patronizing way. In this limited sense, apology holds the promise of transformation.

Kübler-Ross's analysis of the control that litigation brings to victims' shattered lives may also inform why, in order for apology to be effective, it must be well planned, well executed and conducted with absolute sensitivity. Victims may not want to surrender the litigation by way of a settlement, as in a way this seems like a further loss of their loved one.

> Control covers painful feelings such as sadness, hurt and anger. Many of us would prefer to fight it out rather than feel grief, loss, and seemingly inconsolable pain.
>
> But control feels empty and harsh as it covers up the more vulnerable sensations underneath. Control gives the illusion of safety and helps us think we are holding everything together, but an illusion is all it is. And breaking it is a daunting task. In the movie *Broadcast News*, Holly Hunter played a very controlling news producer. In one scene she is confronted about her controlling behaviour by her boss, who says sarcastically, "It must be great to always be right". Her unexpected answer "No it's hell".[35]

Apologizers in the healthcare milieu must have some awareness of the literature on death, dying, grief and grieving. In addition, there must be an advertent, conscious focus on the proposition that the survivors will have gone through the five stages of grief and they will likely be cycling through them again at the time of the apology. As Kübler-Ross said:

> People often think of the stages as lasting weeks or months. They forget that the stages are responses to feelings that can last for minutes or hours as we flip in and out of one and then the other. We do not enter and leave each individual stage in a linear fashion. We may feel one, then another, and back again to the first one.[36]

This reality poses a threat to the process but also presents tremendous opportunity to apologizers—opportunity borne from knowledge of the stages of grief and how they can be accessed to benefit everyone.

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33 *On Death and Dying* at p. 260.

34 Ibid at p. 261.

35 Elisabeth Kübler-Ross and David Kessler, *On Grief and Grieving* at p. 95.

36 Ibid at p. 18.

3. THE CONSTITUENT COMPONENTS OF AN APOLOGY

There has long been considerable debate over whether people are born with various kinds of expertise, or whether they can learn whatever is necessary to become competent at the enterprise in question. Indeed much has been written about the "born not made" dichotomy.[37] I am firmly of the view that though apologizing comes naturally to some, and is harder for others, the apology skill set is highly learnable. A lot turns on effective apology in the context of a child death in the healthcare setting. In Ontario, the death may give rise to a coroner's investigation, a coroner's inquest, disciplinary proceedings in the regulated healthcare provider's college, civil litigation and perhaps even criminal charges. Much of this could, at least in theory, be obviated by a well-timed, sincere, holistic, connected, humane apology. What then constitutes this model of perfection, this gold standard of apology?

To begin this analysis, I will briefly review the requisite components as described by five established apology authorities. Sociology professor Nicholas Tavuchis of the University of Manitoba was the first to focus on apology as a sociological phenomenon. Tavuchis offers that "apology has two fundamental requirements: the offender has to be sorry and has to say so. These are the essential elements of an authentic apology".[38] He then goes on to address the other features of apology which according to him are superfluous or inessential.

> Other features, for example, offers of reparation, self-castigation, shame, embarrassment, or promises to reform, may accompany an apology, but they are inessential because, I submit, they are implicit in the state of "being sorry". Moreover, unless carefully tendered, such professions can easily drown out the voice of sorrow and compromise the unconditionality required of forgiveness. Whatever else is said or conveyed, an apology must express sorrow. If the injured party believes that the offender is genuinely sorry, additional reassurances are superfluous. In some arcane way, then, one's future actions come to be seen as immanent in the evanescent speech that expresses one's present sorrow and regret.[39]

The second major student of apology was a psychiatrist at Harvard Medical School, Dr. Aaron Lazare. Dr. Lazare believes that the apology process has four constituent parts:

1) the acknowledgement of the offense;
2) the explanation;
3) various attitudes and behaviors including remorse, shame, humility, and sincerity; and
4) reparations. The importance of each part—even the necessity of each part—varies from apology to apology depending on the situation.[40]

Lazare further subdivides "acknowledging the offence" into its components.

37 See by way of example James L. Fisher and James V. Koch. *Born, Not Made, The Entrepreneurial Personality* (Westport, Connecticut: Greenwood Publishing Group, 2008) and Everett Lockhart, "Leaders are born not made..." at blogs/computerworld.com/node/3914. Site last visited February 17, 2011.

38 Nicholas Tavuchis. *Mea Culpa: A Sociology of Apology and Reconciliation* (Stanford: Stanford University Press, 1991) at p. 36.

39 Ibid.

40 Aaron Lazare. *On Apology* (Oxford: Oxford University Press, 2004) at p. 35.

He says:

> The most essential part of an effective apology is acknowledging the offense. Clearly, without such a foundation, the apology process cannot even begin. As self-evident as that statement may seem, we should not assume that acknowledging an offense is a simple task. The reason that this part of the apology can be so challenging is that the acknowledgment may involve as many as four parts: 1) correctly identifying the party or parties responsible for the grievance, as well as the party or parties to whom the apology is owed; 2) acknowledging the offending behaviors in adequate detail; 3) recognizing the impact these behaviors had on the victims(s); and 4) confirming that the grievance was a violation of the social or moral contract between the parties. An effective apology requires that the parties reach agreement on all four parts, although it is common for one or more of the parts to be implicit—that is, not verbally stated. In a simple apology between two people, for example, the offender does not have to state in so many words that the party to whom he is apologizing is the offended party. An inability to reach agreement on these matters is, in my view, the most common cause of failed apologies....
>
> Even when the offense seems obvious the offender still needs to explore what the offense means to the offended party. For example, if I accidentally break your vase, I need to understand the value you attach to it, and how you feel about my handling it without your permission. Similarly, if I embarrass you in front of others, I need to understand your sensitivity to my words and your relationship to the people who witnessed your embarrassment. In both cases, the possibility of offering a meaningful apology may depend on how well I grasp the full nature of the offense from your perspective.
>
> An example of the importance of acknowledging the correct offense in a simple personal apology occurred during some rather vigorous roughhousing between my six-year old grandson and myself. In the middle of our play, I squirted instant whipped cream on his cheek near his mouth. He began to cry and told me he was angry with me. I responded immediately that I was very sorry. He answered that it was too late to say "sorry". An hour later while he was playing in my office, I turned to him and repeated how sorry I was for squirting the whipped cream, explicitly naming the offense for the first time. To my surprise, he told me he liked my squirting the whipped cream. It was fun. What he was upset about was bumping his head against the sofa, an event of which I was unaware and for which he blamed me. I could then make a heartfelt apology (a massage and a kiss on the head) for having inadvertently caused his collision with the sofa. (In truth, I had not felt terribly remorseful about the whipped cream.) After he seemed comforted, I asked if he forgave me. "Yes," he said. I asked him why he forgave me.

> He responded, "because you kissed my head and because I know you will make pancakes for breakfast." For all its apparent insignificance, I believe this encounter with a six-year old child provides an excellent illustration of the importance of identifying the offense. If the goal is an effective apology that restores a damaged relationship, the best way to begin is by accurately understanding how the offended parties feel they were wronged.[41]

John Kador, an accomplished business writer, talks about the five "R" dimensions of apology:

- Recognition
- Responsibility
- Remorse
- Restitution
- Repetition[42]

He then discusses what must be included in each dimension of apology. For details of the constituent components of apology as articulated by Kador, see column three of the chart at page 15 of this paper.

William Benoit, a communications professor, discusses accounts and image restoration in his excellent book.[43] He delves into image restoration strategies in the context of damage control.

Benoit cites scores of examples of attempted image restoration including the Exxon Valdez oil spill,[44] the Union Carbide Bhopal disaster,[45] President Nixon's Cambodia address,[46] Senator Edward Kennedy's Chappaquidick address,[47] Clarence Darrow's speech defending himself on jury tampering charges[48] and tennis star Billie Jean King's defensive discourse arguing that she was not an "active lesbian".[49] Benoit's writing is valuable as it focuses more on the apologizer and less on the apologizee. In this way, it is easy to see why the various "accounts, excuses and apologies" left much to be desired in each of the cases referred to above. For our purposes, Benoit cites Goffman's work and in particular Goffman's articulation that the apology is a symbolic splitting of the self into two parts, the bad and the good, and requires five elements in order to be effective:

> An apology consists of a symbolic splitting of the self into two parts: the bad self, who committed the undesirable act, and the good self, who deplores that act. A complete apology has five elements: expression of regret, acknowledgment of expected behavior and sympathy for the reproach, repudiation of the behavior and the "self" committing it, promise to behave correctly in the future, and atonement and compensation.[50]

41 Ibid at pp. 75-77.

42 John Kador. *Effective Apology: Mending Fences, Building Bridges, And Restoring Trust* (San Francisco: Berrett-Koehler Publishers Inc., 2009) at p. 47.

43 William L. Benoit. *Accounts, Excuses and Apologies: A Theory of Image Restoration Strategies* (Albany: State University of New York Press, 1995).

44 Ibid at pp. 119-131.

45 Ibid at pp. 133-141.

46 Ibid at pp. 143-155.

47 Ibid at p. 18 and p. 21.

48 Ibid at p. 28.

49 Ibid at p. 16

50 Ibid at p. 35.

Nick Smith, formerly an unhappy litigation lawyer, and currently a much happier philosophy professor, identifies what he describes as the twelve elements of a categorical apology. These are:

1) Corroborated factual record
2) Acceptance of Blame
3) Possession of Appropriate Standing
4) Identification of Each Harm
5) Identification of the Moral Principles Underlying Each Harm
6) Shared Commitment to Moral Principles Underlying Each Harm
7) Recognition of Victim as Moral Interlocutor
8) Categorical Regret
9) Performance of the Apology
10) Reform and Redress
11) Intentions for Apologizing
12) Emotions[51]

As Smith was a litigator at a mega law firm in New York, and a former law clerk to Judge Nygaard of the United States Court of Appeals for the Third Circuit,[52] his practical "real world" insights are particularly valuable to those of us who mediate and litigate wrongful child death cases. His comments about the eleventh and twelfth categories (Intentions and Emotions) are particularly salient:

> 11. Intentions for Apologizing: The categorical apology also requires certain mental states. Rather than promoting the apologizer's purely self-serving objectives, the offender intends the apology to advance the victim's well-being and affirm the breached value.
>
> 12. Emotions: As a result of her wrongdoing, the apologizer will experience an appropriate degree and duration of sorrow and guilt as well as empathy and sympathy for the victim. I leave further questions regarding what constitutes the appropriate qualitative and quantitative emotional components of categorical apologies to be determined in consideration of cultural practices and individual expectations.[53]

With these structural underpinnings identified by the five apology architects discussed above, it is now appropriate to turn to three case studies of apology subverted. I do this in order to demonstrate that to implement the academically identified elements of apology is infinitely more difficult than to identify them. For quick reference and easy comparison I set out the five taxonomies of apology as described above (Tavuchis; Lazare; Kador; Benoit and Smith) in chart form. It is hoped that this one stop visual matrix will assist apologizers in the healthcare setting to give better apologies.

51 Nick Smith. *I Was Wrong: The Meanings of Apologies* (Cambridge: Cambridge University Press, 2008) at pp. 140-142.

52 Ibid, Front page description of the book and its author.

53 Ibid at page 142.

TAVUCHIS	LAZARE	KADOR	BENOIT (GOFFMAN)	SMITH
1. Offers of reparation **2. Self-castigation** **3. Shame** **4. Embarrassment** **5. Promises to reform**	**1. Acknowledge the offence** a. correctly identifying the party or parties responsible for the grievance, as well as the party or parties to whom the apology is owed b. acknowledging the offending behaviours in adequate detail c. recognizing the impact these behaviours had on the victim(s) d. confirming that the grievance was a violation of the social or moral contract between parties **2. Explanation** **3. Attitudes and behaviours including remorse, shame, humility and sincerity** **4. Reparations**	**1. Recognition** a. What am I apologizing for? b. What was the impact of my behaviour on the victim? c. What social norm or value did I violate? d. Am I apologizing to the right person? e. Do I have cause to apologize? f. Do I have standing to apologize? g. Should apologies include explanations? **2. Responsibility** a. Do not be defensive b. Do not evade or blame the victim c. Focus on victim's needs not offender's redemption d. Offender must look into his heart and reckon what he finds there e. Offender values relationship and wants to rebuild it on terms agreeable to the victim f. Offender rejects self-excuse and accepts undiluted responsibility **3. Remorse** a. Signals offender's contrition b. She wrongly hurt someone and if she could she would undo what she did c. Offender feels guilt, distress or shame for the action and will not repeat it d. Contrast between remorse and regret. **4. Restitution** a. Attempt to practically restore relationship to what it was before offender broke it. b. Offender must concretely express contrition c. Offender can't talk his way out of a situation he acted his way into d. Victim must: • be made whole insofar as that is possible • see offender make a sacrifice • see offender commit to relationship **5. Repetition** a. Assures the victim that the offender will not repeat the offence b. Requires a genuine change in the offender for if he won't change then the apology is valueless	**1. Expression of regret** **2. Acknowledgement of expected behaviour and sympathy for the reproach** **3. Repudiation of the behaviour and the "self" committing it** **4. Promise to behave correctly in the future** **5. Atonement and compensation**	**1. Corroborated factual blame** **2. Acceptance of blame** **3. Possession of appropriate standing** **4. Identification of each harm** **5. Identification of the moral principles underlying each harm** **6. Shared commitment to moral principles inderlying each harm** **7. Recognition of victim as moral interlocutor** **8. Categorical regret** **9. Performance of the apology** **10. Reform and redress** **11. Intentions for apologizing** **12. Emotions**

4. THREE FACT PATTERNS: A TRILOGY OF TRAGEDY

I) LISA SHORE AND THE MISSING HEART-LUNG MONITOR

On February 24, 2000 a coroner's jury comprised of three women and two men, rendered an unprecedented verdict in the annals of Canadian health law. The jurors unanimously concluded that 10 year old Lisa Shore had died between 6:20 a.m. and 7:00 a.m. on October 22, 1998 at the world renowned Hospital for Sick Children (HSC) in Toronto, and that homicide was the means of death.[54]

It is no understatement to say that the jury's verdict shook the venerable HSC to its core. HSC had unleashed a public relations disaster upon itself by virtue of the way it had behaved from October 22, 1998 (when Lisa died) until February 24, 2000 (the date of the homicide verdict). One would have thought that the homicide verdict (which was largely self-inflicted) would have provoked much more apologetic behaviour on the part of HSC. This would have been therapeutic for all. Unfortunately, HSC continued to support its nurses in the public eye and in their hearings at the College of Nurses; and it failed to ever proffer a meaningful, heartfelt apology to the Shores.

The devastating jury verdict triggered a cascade of negativity for the liable parties and the victims alike: it generated disciplinary proceedings before Ontario's College of Nurses for Lisa's two treating nurses and for HSC's Chief of Nursing; the two treating nurses were charged with criminal negligence causing death;[55] Sharon Shore was delayed in her call to the Ontario bar;[56] and HSC was the recipient of reams of negative radio, television, print and internet publicity. This was adverse publicity which certainly damaged HSC's heretofore unblemished and well-earned reputation and no doubt impacted on its recruitment and fund raising efforts. What then was the genesis of this unmitigated disaster for everyone involved, and what can be learned as a pedagogical exercise in

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54 See Verdict of Coroner's jury, Ontario Ministry of the Solicitor General, Office of the Chief Coroner, February 24, 2000.

See also Harold Levy and Jennifer Quinn, "Lisa's death called homicide: Parents call for police investigation and public inquiry", The Toronto Star, Friday, February 25, 2000 at p. A1.

See also Nicholas Van Rijn, "Homicide verdict unusual in Ontario", The Toronto Star, Friday, February 25, 2000 at p. A3.

See also Jennifer Quinn, "Hospital 'failed Lisa'", The Toronto Star, Friday, February 25, 2000 at p. A1; "Unusual Inquest a low point for Sick Kids: Hearing into death of Lisa Shore was tense, adversarial", The Toronto Star, Friday, February 25, 2000 at p. B1 and "Lisa Shore didn't have to die", The Toronto Star (editorial), Friday, February 25, 2000 at p. A24.

See also "A homicide at Sick Kids hospital", Maclean's, March 6, 2000 at p. 19.

See also Mark Gollom, "Coroner's inquest rules girl 10, a homicide victim", The National Post, Friday, February 25, 2000 at p. A1.

See also "Hospital Death 'Homicide'", The Toronto Sun, Friday, February 25, 2000 at p. 1 and Natalie Southworth and Susan Bourette, "Sick Kids death ruled a homicide", The Globe and Mail, Friday, February 25, 2000 at p. A1 and John Barber, "Sick Kids saga grows ever more disturbing", The Globe and Mail, Friday, February 25, 2000 at p. A16.

See also "Hospital Homicide", The Toronto Sun (editorial), Saturday, February 26, 2000 at p. 14 and "Sick Kids Mistreats Grieving Parents", The Toronto Star (editorial) Friday, April 6, 2001 at p. A24.

See also Tanya Ho, "Girl's death at hospital a homicide", The Gazette, Montreal, Friday, February 25, 2000 at p. A8.

See also Kathleen Griffin, "Sick Kids death deemed homicide", Markham Economist and Sun, Saturday, February 26, 2000 at p. 1.

See also Jim Coyle, "At Sick Kids a day to be struggled through", The Toronto Star, Saturday, February 26, 2000 at p. A6.

See also Harold Levy, "Juror supports probe", The Toronto Star, Sunday, February 27, 2000 at p. A5.

55 See Graeme Smith, "Two nurses face charges of criminal negligence; Death of girl the result of drug interaction that led to cardiac and respiratory arrest", The Globe and Mail, Thursday, October 25, 2001 at p. A21.

See also Jonathan Jenkins, "Two nurses 'shocked' charges are looming in death", The Toronto Sun, Thursday, October 25, 2001 at p. 10.

See also Nancy Carr, "Two nurses charged in death of girl at Sick Kids", The National Post, Friday, October 26, 2001 at p. A10.

See also Jonathan Jenkins, "Surrender: 2 nurses turn themselves in on negligence rap", The Toronto Sun, Friday, October 26, 2001 at p. 7.

See also Harold Levy, Kerry Gillespie and Catherine Porter, "Hospital nurses to face criminal charges", The Toronto Star, Thursday, October 25, 2001 at p. A1. The headline at p. A30 "Police search hospital, coroner's officer" must have sent chills down the spines of the HSC administration!

56 See *Law Society of Upper Canada v Sharon Ellen Shore*, 2006 ONLSHP 55(CanLII), Law Society Hearing Panel.

See also Hearing Panel's Costs decision in Shore's favour 2007 ONLSHP 47 (Can LII); Law Society's Appeal to Appeal Panel successful and Shore's award of costs reversed 2008 ONLSAP6 Can LII; Shore's Judicial Review dismissed by Divisional Court 2009 Can LII 18300, 2009 Carswell Ont 2151, 250 O.A.C. 331, 96 O.R. (3d) 450

Shore's leave to appeal application to the Court of Appeal was dismissed on October 19, 2009 almost 11 years to the day after Lisa's death. See www.ontariocourts.on.ca/coa/en/leave/2009.htm#refused. Site last visited February 22, 2011.

terms of the possibility for apology to diminish the horrendous pain of a child's unanticipated death?

Lisa was born on November 20, 1987. She broke her right leg playing at the playground on February 11, 1998. Thereafter, she suffered excruciating pain in the injured leg. This pain was later diagnosed to be complex regional pain syndrome (CRPS), a non-life-threatening condition. Lisa was twice treated at Boston Children's Hospital, because the doctors at HSC thought her pain to be mostly psychosomatic.

Lisa's pain was so severe on October 21, 1998 that her mother, Sharon, brought her to the HSC emergency department. Lisa remained in the emergency department until 1:20 a.m. on October 22, 1998, at which time she was admitted to the orthopaedic floor. Upon transfer, monitoring orders were entered in the hospital's "kidcom" computer system. It was at this point in the chain of events that the critical failure occurred: the nurses who were responsible for Lisa on the floor to which she was transferred failed to open or to access or read these orders.[57] Consequently, Lisa was not attached to an electronic monitor to measure her heart rate and respiratory rate. The deterioration in Lisa's vital signs which preceded her death was not responded to by the nurses, nor did the machine's alarms ever sound.

The two treating nurses reluctantly conceded through their lawyer at the inquest that if there was a monitor attached to Lisa (which Sharon Shore vehemently denied), then this monitor was not turned on and that's why the alarms didn't sound as Lisa's vital signs diminished, leading inexorably to her death.

This agreement was announced to a packed coroner's court on January 17, 2000 by Ontario Deputy Chief Coroner, T. James Cairns, M.D. as follows:

> So for the purposes of the inquest, with that further evidence, with an analysis by a number of experts and with the agreement of all counsel, you can accept for the purposes of this inquest that if a monitor was in Lisa's room at 7:00 a.m., now it's up to you to decide later, but if a monitor was in Lisa's room at that time, then if it was in the room it either was not attached to Lisa and was turned off, or if it was attached to Lisa, it was turned off and the theory that was being put forth that electrical activity from the heart, while not being productive electrical activity that would help her to have a heartbeat, may have in some way confused the monitor to think that she was alive when she wasn't alive, that is not an issue that needs to be addressed.
>
> Everyone has accepted that if the monitor was in the room either attached or unattached to Lisa, it was in the off position and therefore that theory of the complex issues that were arising on the day that we stopped the inquest have now been addressed. I would just ask, Counsel, have I fairly represented the views that you all came to?
>
> **MR. GOMBERG:** Yes, on behalf of the Shore family, I'm Frank Gomberg, I agree with that.

57 See Harold Levy, "Records withheld, inquest jury told: Sick Kids failed to disclose doctor's orders, coroner says", The Toronto Star, Thursday, January 20, 2000 at p. D3 and Kerry Gillespie, "Girl's doctor says 'orders not followed'", The Toronto Star, Tuesday, November 9, 1999 at p. B1.

See also Dick Chapman, "MD's orders 'lost': Lisa, 10 not monitored hourly, inquest told", The Toronto Sun, Tuesday, November 9, 1999 at p. 7.

MR. HAWKINS: Yes, that's acceptable.

MR. KRKACHOVSKI: On behalf of G.E. Marquette, yes, Mr. Coroner.

MS. POSNO: That's fine.

THE CORONER: I hope my Counsel isn't going to disagree with me.

MR. BROWN: No.[58]

The two treating nurses later testified that Lisa had been attached to a monitor but the breathing part of the monitor was intentionally turned off by the more senior of the two nurses after three loud false alarms. In other words, rather than replacing the allegedly defective monitor, the senior nurse testified that she simply turned the breathing part of the monitor off. Neither Sharon Shore nor any of the other parents on the ward ever heard these three "phantom" alarms.

The coroner's jury clearly rejected the suggestion that these alarms had ever sounded. Even if the alarms had sounded, and in consequence the respiratory part of the monitor was turned off by the more senior nurse, the nurses and HSC had no explanation for why the cardiac component of the monitor never alarmed when Lisa's heart rate dropped. Their testimony was that they had not turned the cardiac component off, as it was mechanically impossible to do that. The obvious conclusion was that there was no monitor ever attached to Lisa and thus no alarms had ever sounded.

Rather than concede the fact that no monitor was ever used (which would have required a concomitant admission that the nursing care rendered to Lisa had been grossly negligent), HSC's lawyer called an HSC-employed biomedical engineer on November 9, 1999 to testify that the cardiac part of the monitor could be fooled into concluding that a child's stopped heart was still beating. If true, this would have been an explanation for why the cardiac part of the monitor never alarmed. This suggestion was made with no notice to the presiding coroner or to any of the participating lawyers. It led to a two month adjournment of the inquest. Upon resuming the inquest, HSC recanted this ghost heartbeat suggestion by way of the January 17, 2000 agreement announced by Dr. Cairns and previously referred to. Instead of any apology up to and including the resumption of the inquest on January 17, 2000, HSC took a pummeling in court and in the press. This is how it played out in open court on November 9, 1999 leading to the adjournment until the January 17, 2000 recantation.

THE CORONER: Mr. Gomberg?

MR. GOMBERG: Deputy Chief Coroner, I say this with the greatest of respect: this is outrageous. This is a theory that nobody has ever heard anything about. There are no expert reports that have been served on anyone, this is a Coroner's Inquest, so we have some latitude. To come up with the theory that nobody, including the Chief Coroner's Office, the Deputy Chief Coroner or the Crown Attorney, my friend Ms. Posno or I have heard anything about in the middle of a Coroner's Inquest, for an experienced litigation lawyer like my friend, is outrageous....he now calls a witness to give evidence that her heart, though

58 Excerpt from the Transcript of the Testimony of Stephan Bauer at the Inquest Into The Death of Lisa Shore taken January 17, 2000 at pp. 3-4.

it wasn't beating, was giving off some signals and that that explains why the Corometric, the heart part, didn't operate, is outrageous. This is the fourth or fifth inquest I've done in the last two years; I've never heard of anything like this. It is outrageous. We have written answers from the hospital to questions that were posed that say we don't know why that monitor didn't work. And, now, in the middle of a Coroner's Inquest, he comes up with a theory, it's outrageous. Those are my submissions.[59]

The argument in open court in the absence of the jury, but in the presence of a dumbfounded media contingent (clearly hostile to HSC) continued:

> **MR. GOMBERG:** Can I say something please? Mr. Hawkins, we're in a courtroom, and that doesn't mean that we're in Alice in Wonderland or in fantasy land. Mr. Hawkins has pulled a sleazy, cheap trick. Now, Mr. Hawkins is telling you things that are not true, because we had a meeting at the Hospital for Sick Children and had an opportunity to talk to the doctors, and I'm talking about Dr. Roy, who is the head of anaesthesiology, I'm talking about Dr. Reeder, who is the head of nursing and I'm talking about the head of surgery, Dr. Wedge, who as I understand it, is one of the chief doctors in the hospital. Not once did anybody ever say anything about this. Mr. Hawkins is not telling the truth.
>
> **MR. HAWKINS:** I object most strongly to that.
>
> **MR. GOMBERG:** You can object all you like.
>
> MR. HAWKINS: Mr. Bauer has clearly indicated that he was first shown last Wednesday these wave forms. As of Friday, he ran these wave forms through the computer, and that's what he has produced here today.
>
> **MR. GOMBERG:** Well, what are you talking about meetings that we had?[60]

Dr. Cairns summarized the situation much more succinctly:

> We can argue this issue appropriately with proper production of material in advance, but I don't see how we can possibly pursue this particular item with this particular witness at this particular time, since we have had no production. I would want this reduced to writing and I would want to be able to get independent experts to review this, if that is a line that you're intending to take along. I must say, I, personally, unless you've got a different explanation, I consider this an **ambush** of the process.[61] (Emphasis added by author.)

The two month adjournment (November 12, 1999-January 17, 2000) would not have been necessary had this ghost heartbeat construct not been concocted. HSC could have avoided the following headlines in the local and national newspapers:

59 Transcript of Legal Argument at the Inquest Into The Death of Lisa Shore taken November 9, 1999 at pp. 2-3.

60 Ibid at pp. 8-9.

61 Ibid at p. 12.

"Confusion Delays Inquest"[62]
"Lawyer calls testimony 'outrageous'"[63]
"Status of cardiac monitor at question in girl's death"[64]
"Girl's death not due to monitor, lawyer says"[65]
"Hospital covering for nurses: mother"[66]
"Coroner fumes over ambush"[67]

When it dropped the "ghost heartbeats" theory on January 17, 2000, HSC was reeling from its self-inflicted wounds. It is easy to infer that the jurors were unimpressed. On February 3, 2000 juror Lawrence Dhillon, on the pretext of asking a question of clarification of a nursing educator who was testifying (which inquest jurors are permitted to do), asked the following:

BY JUROR #4:

Q. The testimony that we've heard by the nurses telling us what was done, what we find wasn't done–––

A. Mm–hmm.

Q.–––filling in flow sheets with parts of what should have been filled in, we've heard of instances supposedly where people have lied to one another, improper forms being made or errors being made in certain documents. And I'm not sure, Dr., if I'm allowed to ask this but to me this sounds like a coverup.

A. I mean, I–––

Q. We've been given a smokescreen.

A. Mm–hmm.

Q. Now, I'm not asking you to answer it, but my thought is

THE CORONER: I don't think this witness, in her capacity, is able to answer that question.

BY JUROR #4:

Q. I do have one other comment. I realize Sick Children's Hospital is well known and unblemished, basically, and I hope that this situation is just an isolated case and it covers the whole iceberg and not just the tip.

A. I assure you this has been unlike anything I've ever experienced in my career. If that gives you any assurance or reassurance, it's been extremely distressing for all of us and unusual, never seen it before, unheard of, distressing, extremely tragic, extremely unfortunate. I wish we could all roll back the hands of time and fix something to prevent this.[68]

62 Dick Chapman, "Confusion delays inquest: Sick Kids Cover-up, Lawyer", The Toronto Sun, Saturday, November 13, 1999 at p. 23.

63 Natalie Southworth, "Lawyer call testimony 'outrageous'. Inquest into girl's death erupts at suggestion alarm may have been faulty", The Globe and Mail, Wednesday, November 10, 1999 at p. A9.

64 Kerry Gillespie, "Status of cardiac monitor at question in girl's death", The Toronto Star, Saturday, November 13, 1999 at p. B4.

65 Natalie Southworth, "Girl's death not due to monitor, lawyer says: Inquest told machine does not malfunction", The Globe and Mail, Saturday, November 13, 1999 at p. A12.

66 Rick Vanderlinde, "Hospital covering for nurses: mother", The Liberal, Thursday, November 18, 1999, at p. 1.

67 Dick Chapman, "Coroner fumes over ambush", The Toronto Sun, Wednesday, November 10, 1999 at p. 10.

68 Transcript of the Testimony of Mary Douglas at the Inquest Into The Death of Lisa Shore taken February 3, 2000 at pp. 25-26.

Unfortunately for HSC, the front page of the next day's newspaper added water to an already foundering ship. The headline screamed "Sick Kids cover-up charged: Inquest juror points finger at Toronto Hospital".[69] Where was the apology? It seemed that the apology was lost in cyberspace—just as the kidcom orders had been lost in cyberspace.

When it seemed that things couldn't possibly get worse for HSC, they did. An audiotape describing the conditions of all patients on the ward, including Lisa, was erased and consequently never furnished to the coroner.[70] The missing emergency orders were not located by HSC management until January 26, 1999 (because the administration couldn't figure out how to retrieve the orders from the computer system) even though one of the nurses had printed them up on October 27, 1999 (five days after Lisa's death) and retained them until she brought them to court at my request on January 28, 2000.[71] She apparently succeeded in locating the orders in the computer system, whereas the HSC administration including its computer experts had failed in its search.

On January 27, 2000, all of these calamitous revelations were compounded even further: observations by the jurors led them to believe that at least one of the nurses in the body of the courtroom was signaling answers to one of the two culpable nurses as she testified:

THE CORONER: Just before we begin again, at the break the Coroner's Constable has brought to my attention that the jury have indicated to the Coroner's Constable that they have concerns that this witness, while answering questions, that it appears to them that certain members of the audience, and it's their impression, is assisting the witness with answers by certain body movements.

I would remind the audience that this witness is on the witness stand, and even the appearance of prompting an answer is inappropriate. And if it continues, I will have to do something about it. The indication through the Coroner's Constable is that before the witness answers a question, it is the jury's impression that there is a nodding of heads or shaking of heads before the answer is given.

> That is entirely inappropriate if it's going on. Whether it's being done intentionally or not, I am not in a position to say, but it's inappropriate and I would like to see it cease immediately, otherwise other steps will be taken.[72]

This was anathema to the position of HSC—because if the jury thinks something is happening, then it's happening. It hardly improved matters that both *The Globe and Mail* and *The Toronto Star* on January 28, 2000 each cited the concern of the jurors that a negligent nurse was being coached while testifying under oath.[73]

69 See Harold Levy, "Sick Kids cover-up charged: Inquest juror points finger at Toronto hospital", The Toronto Star, Friday, February 4, 2000 at p. A1.

70 See Dick Chapman, "Inquest told of crucial tape", The Toronto Sun, Tuesday, February 8, 2000 at p. 1 and Harold Levy, "Nurse Back on Stand in Girl's Inquest: Sick Kids witness had not told jury of taped record", The Toronto Star, Tuesday, February 8, 2000 at p. B3.

71 See Harold Levy, "Nurse found doctor's 'missing' orders: made printout of hospital's computer file, inquest told", The Toronto Star, Monday, January 31, 2000 at p. B5.

72 Excerpt from the Transcript of the Testimony of Ruth Doerksen at the Inquest Into The Death of Lisa Shore, taken January 27, 2000 at pp. 136-137.

73 See Harold Levy, "Hospital Contradicted at Inquest", The Toronto Star, Friday, January 28, 2000 at p. B3. See also Lila Sarick, "Timing of evidence at inquest criticized: some facts about girl's death at Sick Kids should have been revealed earlier, coroner says", The Globe and Mail, Friday, January 28, 2000 at p. A18.

The final indignity to HSC consisted of the already mentioned devastating post-verdict editorials harshly condemning the hospital. The titles to the editorials were ominous: "*Hospital Homicide*", "*Lisa Shore didn't have to die*" and "*Sick Kids Mistreats Grieving Parents*".[74]

What then, could have obviated most, if not all of these cataclysmic events? I submit that a proper apology was necessary, but one was never offered. A visually simple chronology of events highlights opportunities when apologetic intervention would likely have achieved a desirable goal. It was surprising and disappointing that with all of the administrative, public relations, medical, technological and intellectual brainpower at HSC, the apologetic comments that were eventually proffered were too contrived and too deficient to constitute anything more than non-apologies or pseudo-apologies (for reasons to be discussed later in this paper), and consequently served only to insult the surviving family members.

Date	
October 22, 1998	Lisa's death at HSC
September 30, 1999	Civil case settled before mediator, retired Court of Appeal Justice W.D Griffiths
November 8, 1999	Coroner's Inquest begins
November 12, 1999	Coroner's Inquest adjourns over "ghost heartbeats"
January 17, 2000	Inquest resumes when HSC abandons "ghost heartbeats" position
February 24, 2000	Inquest verdict rocks HSC

74 Supra note 54.

It is noteworthy that the civil litigation had been settled at mediation in order to obviate any suggestion that the Shores' quest for answers and for **justice** was monetarily motivated. As such, apology was certainly available to HSC between Lisa's death on October 22, 1998 and the mediation; at the mediation on September 30, 1999; or during the Inquest (November 8, 1999-February 24, 2000). Indeed the lengthy adjournment due to the suggestion of ghost heartbeats, presented an excellent opportunity for apology: the tort damages had already been paid, HSC knew it was going to abandon the ghost heartbeats strategy upon resumption of the inquest, and an apology would have been inadmissible at the inquest. There was no apparent legal or factual reason that no apology was forthcoming at that time. The only apology ever made to the Shores up to the conclusion of the inquest was delivered by Dr. Jean Reeder, Chief of Nursing from the witness box on February 8, 2000. This is what Dr. Reeder said **when questioned by her lawyer**:

> **Q.** I understand, Dr. Reeder, that there is something you would like to say on behalf of the Hospital to the family?
>
> **A.** I would. Mr. and Mrs. Shore and your family members, I have sat here throughout the inquest, we've met on two previous occasions, and on behalf of our institution, let me say how terribly sorry we all are, because we failed you as an institution. We are terribly sorry.[75]

This apology was delivered in an emotionless, impersonal way, in a sterile courtroom in downtown Toronto. I have included the actual audio of this apology in the late Dr. Reeder's voice as the transcript doesn't reflect her lack of emotion. Dr. Reeder was present at the September 30, 1999 mediation with her lawyer and a HIROC

75 Excerpt from the Transcript of the Testimony of Dr. Jean Reeder at The Inquest Into The Death of Lisa Shore taken February 8, 2000 at p. 5.

representative. No one from the medical or nursing staffs or from the HSC administration attended the mediation. No apology was offered at mediation. Opportunity missed.

After this pseudo or non-apology by Dr. Reeder from the witness box on February 8, 2000, the next pseudo or non-apology was offered by Dr. Alan Goldbloom, HSC Senior Vice-President at HSC's post-inquest press conference on February 24, 2000. Significantly, the Shores were not invited to this event. The following are excerpts from this oral apology:

> We are very deeply saddened by the tragedy of Lisa Shore's death. Clearly The Hospital for Sick Children failed Lisa Shore and failed the Shore family. We will live with this forever. We are profoundly sorry for what has happened. We are determined to do everything humanly possible to ensure that such a tragedy never happens again.
>
> .....
>
> Finally, I want to say to the members of the Shore family that no words could possibly express how sorry and devastated all of us are by this tragedy. The people who devote their careers to this institution are here to help children and to support families. When we fail to do that it is devastating for all of us. We offer them our deepest sympathies. We apologize for the mistakes that have been made. We are terribly sorry. We will all live with this forever.
>
> .....
>
> Our apology and our regret over this tragic death are very sincere. I understand how the Shore family must feel. I understand their anger. They have suffered a loss that is unspeakable. Their grief must be unspeakable. Nothing can change what has happened. We continue to offer our apologies and we continue to feel in this hospital that we have let the family down.[76]

Two additional truncated and remarkably similar (no doubt co-ordinated) non-apologies had been previously delivered as follows:

> This was a very sad event and we offer sincere condolences to the entire Shore family.[77]
>
> Lisa's death is a very sad thing. The Hospital offers its sincere condolences to the entire Shore family.[78]

A further non-apology was issued by Michael Strofolino, President and CEO of HSC in a press release on March 6, 2000, dealing with the nurses reporting themselves to the Ontario College of Nurses. As Strofolino put it:

> We apologize again to the Shore family for the pain we have caused them. They can be sure that the College will review the nursing issues in detail.[79]

By issuing this apology to the press, Strofolino gave the

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76 Dr. Alan Goldbloom, Senior Vice-President, HSC, Press Conference at HSC on February 24, 2000 (video of 22 minute press conference in the possession of the author).

77 HSC Risk Manager Marion Stevens' letter of March 3, 1999 to Coroner Dr. Morton Reingold (in possession of the author).

78 HSC lawyer Patrick Hawkins' letter of March 12, 1999 to Mr. Frank Gomberg (in possession of the author).

79 Michael Strofolino, President and CEO, HSC. Text of HSC Press Conference March 6, 2000.

impression of being less concerned about the family than he was about the public perception of HSC. In retrospect, it is clear that this apology was merely an attempt to avoid the further adverse publicity which was about to be unleashed upon the nurses and HSC by Sharon Shore's imminent formal letters of complaint about the nurses to the Ontario College of Nurses.[80]

The final purported apology occurred at my law office on March 7, 2000. Michael Strofolino, Sharon and Bill Shore and I were the only ones present. In this further deficient apology Strofolino refused to accede to the Shores' request that HSC fire the two culprit nurses—an act which was critical as part of reparation and promise to reform (Tavuchis); acknowledging the offence and effecting reparation (Lazare); showing remorse, making restitution and foregoing repetition (Kador); repudiation of bad behaviour (bad actors), promise to behave correctly in the future and atonement and compensation (Goffman-Benoit); and the corroboration of factual blame, acceptance of blame, identification of harm, and reform and redress (Smith). Indeed Strofolino's demeanour was defiant, and although some of what he said was intended to be conciliatory, the message was that HSC's non-co-operation wasn't really its fault; because initially the death was a coroner's case and more recently the nurses were involved in disciplinary proceedings. This refusal to take responsibility flies in the face of all apology theories and ignores the reality that the inquest coroner, the inquest jury, the media and any other fair-minded courtroom observers had concluded that the nursing care rendered to Lisa was abysmally deficient and the HSC investigation to determine what had happened was equally deficient. Opportunity lost.

80 When the nurses found out about Sharon Shore's imminent formal letters of complaint, they attempted to pre-emptively report themselves to make themselves look better. The attempt failed, just as Dr. Reeder's apology from the witness box had failed. See Harold Levy, "Apology Rejected", The Toronto Star, Wednesday, February 9, 2000 at p. A1 and Dick Chapman, "Apology at Inquest", The Toronto Sun, Wednesday, February 9, 2000 at p. 18.

II) JANICE T. BLAKE AND THE DEFIBRILLATOR WHICH DIDN'T DEFIBRILLATE

Janice T. Blake was just 15 years old when she died on March 1, 2002. She had grown up in an intact family. She was survived by her father, Aurel (58 years old), her mother, Susan (52 years old) and her younger brother, Jason (12 years old).

Janice was generally healthy until she was about 13 years old. While playing soccer she fell flat on her face. She was taken to the urban children's hospital and admitted for two weeks. The paediatric cardiologist diagnosed Janice with arrhythmogenic right ventricular dysplasia. Janice was treated with a medication called amiodarone. About two and a half years after beginning her medication, when Janice was about 15 years old, she was re-admitted to the urban children's hospital. Because she had suffered recurrent episodes of ventricular tachycardia, her medication was changed to atenolol and sotalol. It was also recommended that a defibrillator be implanted into Janice's chest. This would shock Janice's heart in order to regularize her heartbeat when her heart went into ventricular tachycardia.

Janice was admitted to the urban children's hospital on December 31, 2001. This was for implantation of the automatic implantable cardioverter defibrillator (AICD). The surgery went well, and after a two week hospital stay, Janice went home.

Unfortunately, Janice kept getting painful shocks from the AICD. About two weeks after discharge, Janice was again admitted to the hospital to have the source of the shocks investigated. Two weeks later she was again investigated for the recurring shocks. Though painful, these shocks were not life threatening. As a result of the

repeated visits to the urban children's hospital for the shocks to her heart, the treating cardiologist opted to change the management of Janice's ventricular tachycardia. Instead of shocking her heart when it went into ventricular tachycardia, the decision was made to have the AICD go into overdrive pacing. A month before her death, Janice's AICD was re-programmed to go into overdrive pacing first. If that didn't work, then Janice was to get another sequence of overdrive pacing to address the ventricular tachycardia. If that didn't work, then Janice was to receive up to six shocks. When Janice had last been in the cardiology lab for a check up of the AICD, the six shocks had been temporarily removed from the AICD. Instead of replacing the six shocks, the cardiologist and the technician in the lab had in error re-inserted only one shock. The problem with overdriving pacing is that it can induce ventricular fibrillation, a highly lethal condition.

When Janice's heart went into ventricular tachycardia on March 1, 2002, the AICD tried overdrive pacing. When that didn't work, a second overdrive pacing sequence was initiated. This second overdrive pacing sequence caused ventricular fibrillation. The way to treat ventricular fibrillation is by shocks. The AICD shocked Janice's heart once. This didn't restore a normal rhythm. There were supposed to be five more shocks programmed in the AICD, but they'd been removed (in the hospital lab) and not replaced about five weeks earlier. Janice couldn't be revived. The coroner's analysis was as follows:

> In January 2002 Janice received shocks from the device indicating ICD discharges; she was able to sense these shocks at the time they were delivered. Analyses of the ICD recordings revealed episodes of ventricular tachycardia that had responded to the shocks. On January 25, 2002 further investigations were performed in the cardiac catheterization laboratory, specifically to induce ventricular tachycardia and test other dysrhythmia (overdrive pacing) algorithms. During this electrophysiological testing the ICD, that is **normally programmed to deliver six maximal shocks for ventricular fibrillation (VF), was reprogrammed to deliver only one maximal shock.** This change was made to permit the external delivery of countershocks (for VF), as necessary, without interference from the ICD. External defibrillator pads were placed at the time of this testing and reprogramming. Following this testing, however, the ICD was not reprogrammed to deliver repeated maximal shocks (six) and was left to only deliver one maximal shock for ventricular fibrillation.

Follow-up at the cardiology clinic at the urban children's hospital after the reprogramming of the pacemaker in the catheterization laboratory failed to uncover that the number of ventricular fibrillation therapies had been left at one single maximal shock.

Following Janice's sudden death on March 1, 2002 an autopsy was ordered and subsequently performed. As an arrhythmogenic death was suspected the ICD was interrogated prior to the performance of the complete autopsy. The following information was discovered at the time of the interrogation:

- Janice suffered an episode of monomorphic

ventricular tachycardia on March 1, 2002 (as she had suffered in the past).

- The first therapy from the device (for ventricular tachycardia) was overdrive pacing (as expected based on programming of the device).
- This therapy was unsuccessful and a second overdrive pacing sequence was initiated (in keeping with the programming of the device).
- If this second overdrive pacing sequence had failed and Janice had remained in VT she would have received up to four cardioversion (shock) therapies. The second overdrive pacing sequence, however, accelerated her VT into a rate and rhythm that could be considered in the ventricular fibrillation (VF) zone.
- The ICD, having detected ventricular fibrillation, switched to a VF therapy algorithm. The ICD then delivered one maximal shock which was not successful in converting the dysrhythmia to a perfusing rhythm.
- The ICD then failed to deliver any further shocks (as it had been programmed on January 25, 2002 to only deliver one shock for VF).
- An external shock was subsequently delivered by paramedics but was unsuccessful. Subsequent ventricular pacing from the ICD was not successful.

The incorrect re-programming of the AICD and the failure to detect the error, though clearly inadvertent, bespoke negligence. Had the AICD been properly programmed to provide a further 5 shocks instead of 1 shock, Janice would have had a far greater chance of survival.

The urban children's hospital subsequently developed a procedure to deal with post-programming assessments of the devices. This procedure included a sign-off by an electrophysiologist for any implanted device that includes re-programming the device. This sign-off was to occur in all cases before the patient was discharged. Hopefully this would prevent such disasters from recurring.

The civil case settled without commencement of a lawsuit exactly one year after Janice's death. Three months before the settlement, the doctor and his lawyer met with the family and with me. Though there was no formal apology, I am convinced that the family meeting with the doctor was a catalyst for the settlement. Indeed the settlement that was achieved was funded both by HIROC and by The CMPA and reflected the fact that the re-programming error was both a physician and a technician (hospital) problem.

It is important to consider the positive effect that the meeting with the doctor had on the resolution of the civil claim. Although that meeting was clearly salutary and contributed to an efficient and bloodless legal outcome, consider how much more meaningful a heartfelt apology would likely have been to the bereft family. Opportunity missed.

III) DANNY SMITH AND THE SPLENECTOMY NOT DONE

Danny Smith was born on May 10, 1988. On April 28, 2003 at about 2:00 p.m. Danny was riding his bicycle. Danny was not quite 15 years old and he was a good cyclist. Because Danny was safety conscious, he was wearing a bicycle helmet and arm and leg protection. While going over a jump in a skate park, Danny catapulted into the air, doing a belly flop on the handlebars of the bike. He ruptured his spleen. Danny was taken by ambulance to the local hospital where it was felt that a splenectomy (removal of the spleen) would be the treatment of choice. The general surgeon at the local hospital checked with the urban children's hospital (80 miles away) to determine the current definitive treatment for paediatric splenic rupture. The urban children's hospital recommended that Danny be transferred by ambulance to the city for definitive management of his splenic injury. The local hospital complied and Danny was transferred early in the morning hours of April 29, 2003. He was admitted to the trauma ward of the urban children's hospital for strict bed rest and for close observation under the care of Dr. Sam Greene, a fully qualified paediatric general surgeon. Danny remained an in-patient at the urban children's hospital for six days. On May 5, 2003, he was discharged home on restricted activities with no contact sports or gym activities until a scheduled follow-up at the urban children's hospital in four weeks. No follow-up care was prescribed to take place at the local hospital or at Danny's family doctor's office.

Danny remained home from school for two weeks. On May 23, 2003, 18 days after discharge, he went to work at the local McDonald's. Two hours after arriving at work, Danny telephoned his father Jim, and said he wasn't feeling well. Jim went to pick Danny up at the McDonald's. He found Danny dead in the street. It was May 23, 2003, 25 days after the original injury and 18 days after discharge from the urban children's hospital. The autopsy concluded that Danny had died as a result of internal exsanguination (massive bleeding) from a ruptured spleen.

It was noteworthy that Danny's haemoglobin counts were as follows:

April 28, 2003, 6:30 p.m. (at the local hospital)	114
April 29, 2003 (at the urban the children's hospital)	100
April 30, 2003 (at the urban children's hospital) a.m. p.m.	97 90
May 1, 2003 (at the urban children's hospital)	90
May 2, 2003 (at the urban children's hospital)	87
May 3, 2003 (at the urban children's hospital)	no haemoglobin done
May 4, 2003 (at the urban children's hospital)	no haemoglobin done
May 5, 2003 (at the urban children's hospital) discharged	no haemoglobin done

As the time period for starting a lawsuit was quickly running out, I sued Dr. Greene. I contemporaneously retained a general surgeon to offer me an opinion on whether Dr. Greene had been negligent. This opinion concluded:

The post-mortem examination done on May 24, 2003, reported that the abdominal cavity contained 3 litres of partly clotted blood including large chunks of blood clots. The stomach contents and intestines were normal. The spleen weighed 390 grams and the spleen was firmly adherent to the undersurface of the left hemidiaphragm by dense fibrous adhesions. On pulling back the diaphragm there was abundant dark reddish blood clots. **Cause of death was intra abdominal bleed due to ruptured spleen.**

Delayed rupture of the spleen is a rare but reported complication of injuries to the spleen. Ruptured spleens especially in children and teenagers are now observed in hospitals and

treated conservatively. In most cases the spleen heals and there is no need for surgery. **The important thing is for the patient to rest on restricted activities with no contact sports or any heavy physical activity.** Reassessment is within a month to six weeks after the injury and includes the CT scan to see whether there is a successful healing of the ruptured spleen….

Dr. Sam Greene met the standard of care in admitting Danny to the urban children's hospital on April 29, 2003 and taking care of him while he was in the hospital. He stabilized and did not need any surgery. His haemoglobin became stable and he was on oral feeds and was discharged in stable condition. The urban children's hospital also met the standard of care in Danny's case. He was admitted to the hospital, he was observed carefully in an expert fashion and when he was discharged he was in stable condition. **He was advised not to do any physical work and to rest.** However on May 23, 2003 Danny developed a delayed rupture of his spleen after working at McDonald's and was not able to be resuscitated. (All emphasized sentences added by medical-legal consultant in original report.)

In conclusion, Dr. Sam Greene and the urban children's hospital met the standard of care in managing Danny's medical condition.

Sincerely,
Jacques Plante, M.D., F.R.C.S. (C), F.A.C.S.

I couldn't believe that Dr. Plante wasn't supportive of this malpractice claim. This was particularly so since a friend of mine (a highly qualified, experienced, ethical emergentologist) had told me that the decision to discharge Danny from the urban children's hospital with no haemoglobins to be taken by his family doctor or at the local hospital shrieked negligence. Unhappy with the first opinion, which I (mistakenly) believed to be wrong, I retained one of the most eminent paediatric general surgeons in Canada. His opinion was also fully supportive of the care Danny had received. I quote liberally from this second opinion because it forms the basis for my discussion of the apology which was necessary in this case, notwithstanding the absence of negligence.

> Danny's mother kept him at home for the next two weeks. On May 23rd he returned to school. He had a part-time job at McDonald's which he went to after school. He phoned his father around suppertime stating he did not feel well and asked him to pick him up. He was found by a pedestrian lying on the sidewalk, responding to verbal questions stating that he had pain in his abdomen. When the ambulance crew arrived they could feel a carotid pulse, a number of attempts were made to start an intravenous. He was intubated and transferred to the local hospital arriving there at 6:52. He had no vital signs at the time of his arrival and despite vigorous resuscitation attempts was pronounced dead at 7:11 pm on May 23rd.
>
> Post mortem examination was done on May 24th and showed 3 litres of partly clotted blood and some large chunks of blood clot in his abdomen.

His spleen was somewhat enlarged and showed a laceration and pulverization of the upper portion with some old and new hematoma and blood clot. It was felt that he had died from rupture of the superior portion of the spleen and hemorrhagic shock.

Isolated splenic trauma, particularly in the pediatric age group, has been managed by non-operative means for many years. The usual indication for doing a laparotomy is an unstable patient who does not respond to fluid resuscitation or who has other associated intra-abdominal injuries or other major injuries that require an anesthetic. Danny's vital signs, especially his blood pressure, were always very stable from the time he arrived in the Emergency Department at the local hospital and through his stay at the urban children's hospital. At no time was there any indication that he required operative intervention. Many individuals with splenic injuries will initially drop their hemoglobin over the first 24-48 hours then it usually will stabilize and gradually start to climb again over the next several weeks. This boy's hemoglobin was 114 at the time of his admission at the local hospital, down to around a 100 [sic] the day after and then down to about 90 and stayed there over the next three days. Some of the drop is initially from continuing oozing and some is hemodilution from receiving intravenous fluids. Values on the 1st, 2nd and 3rd of May between 94 and 87 would all be considered within the same range and within lab variability. Standard care guidelines which have been approved by the American Pediatric Surgical Association for splenic injuries would suggest a hospital stay between four and five days for the type of injury that Danny had with activity restriction for five or six weeks.

His management and care throughout his stay at the urban children's hospital met the standard of care used by all children's hospitals throughout North America and certainly have met the guidelines suggested by the major trauma associations and the American Pediatric Surgical Association and the Canadian Association of Pediatric Surgeons.

Danny was at home for 18 days after his discharge before his sudden demise. He unfortunately had a delayed splenic rupture which is extremely rare and not really predictable. Most incidences of this occurrence probably happen within the first week or two after injury. There was no indication to do routine blood work on him since his hemoglobin had stabilized in hospital and this is not a procedure that any of us would do after we discharged patients unless there was some clinical indication that the patient was having ongoing bleeding which Danny did not show. They are usually advised if they feel unwell, have abdominal pain or light-headed that they should go to a hospital immediately and let them know that they have had a splenic injury. There was no recorded documentation in the data I reviewed about his condition during these 18 days as to

pain or feeling unwell. Possibly there might have been a precipitating episode such as a minor fall or blow to his abdomen that could have caused this delayed bleed. It is also possible that this was a spontaneous occurrence. As mentioned above, there is usually a period where the individual feels some increasing pain, may feel faint and light-headed but if they get to a hospital facility fairly quickly they can often be resuscitated and have the spleen removed.

This is an extremely unfortunate occurrence that happened to this young man but I feel his management initially at the local hospital and thereafter at the urban children's hospital certainly met the standards of care expected and it would not be routine practice to continue to do hemoglobins in an otherwise stable patient. I think that Danny had stopped bleeding by the time he left the urban children's hospital and was not bleeding over the next several weeks. I suspect he probably had a fairly sudden delayed bleed sometime on May 23rd which was quite massive and led to his demise.

Yours sincerely,
Douglas Harvey, M.D., FRCSC
Professor of Surgery and Pediatrics
Richard Duff Children's Hospital

As Dr. Greene had not been negligent, a fault-admitting apology would have been inappropriate. It would, however, have been gracious and humane for Dr. Greene to have met with the Smiths to empathize with their devastating loss and to tell them that Danny's death was highly unexpected. Dr. Greene could have advised that delayed splenic rupture was extremely rare and completely unforeseeable. He could have told the Smiths that had there been any hint of a delayed bleed, a splenectomy would have been done. All of this would have forged a connection between Dr. Greene and the Smiths and would have advanced their healing. Opportunity missed.

5. ERRORS AND ADVERSE EVENTS

In a very emotionally moving essay[81] which falls within the relatively new genre of medical literature,[82] Dr. Marc Rothman, an intern at the Yale School of Medicine, describes a trip he made (on his own time, on the weekend) from his apartment to the hospital. He went to apologize to Morgan Davis, a 40 year old black man who weighed 380 pounds, had asthma, high blood pressure, coronary artery disease, gout, depression, sleep apnea and dermatitis. Davis lived in a homeless shelter. When he had seen Dr. Rothman in the hospital (two days earlier), Morgan was complaining of frequent urination—four times a night. This was a serious problem for Morgan Davis, as when he ran to the toilet, he might not get there in time. In addition, while Davis was at the toilet, other residents could steal his "stuff".

81 Marc D. Rothman, "The Apology", (2007) 80 Yale Journal of Biology and Medicine 77.

82 See for example a number of fascinating fiction and non-fiction writing on medicine and its impact on people suffering devastating loss including Jerome Groopman, *How Doctors Think,* Jerome Groopman, *The Measure of Our Days*, Jerome Groopman, *The Anatomy of Hope: How People Prevail in the Face of Illness,* Atul Gawande, *Complications: A Surgeon's Notes on an Imperfect Science,* Atul Gawande, *Better: A Surgeon's Notes on Performance,* Lisa Belkin, *First Do No Harm,* Abraham Verghese, *The Tennis Partner,* Abraham Verghese, *My Own Country, A Doctor's Story,* Abraham Verghese, *Cutting for Stone,* Vincent Lam, *Bloodletting and Miraculous Cures* and Oliver Sacks, *Migraine,* Oliver Sacks, *The Mind's Eye,* Oliver Sacks, *Musicophilia,* Oliver Sacks, *Awakenings* and Oliver Sacks, *The Man Who Mistook His Wife For a Hat and Other Clinical Tales*. What seems clear is that the drama and pressure of those who practice medicine and surgery place these practitioners at the heart wrenching interface of life and death. Out of these often terrible tragedies emerge stories of hope, renewal, courage and triumph of the human spirit.

Dr. Rothman prescribed Hytrin for Morgan's benign prostatic hypertrophy. Morgan was in a rush to leave with his prescription as his sister was waiting for him outside in her car; and Dr. Rothman was in a rush to see his next patient. Dr. Rothman hit the button on the computer and Hytrin popped up. He then prescribed one of the pre-set doses—10 milligrams—one pill each night before bed. When Dr. Rothman finished work that day, he looked at his notes. He saw his mistake. The dose for Morgan was supposed to be Hytrin 1 milligram. Instead it was 10 milligrams, which as Dr. Rothman put it "would topple a California redwood tree".[83]

Dr. Rothman immediately called the pharmacy. The prescription had been filled; 10 milligrams. Dr. Rothman called the homeless shelter. Morgan wasn't there. Dr. Rothman called Morgan's sister. She couldn't reach him but she confirmed she'd taken him to the pharmacy to pick up the prescription. Morgan was staying with a friend who didn't have a telephone. Morgan's sister told Dr. Rothman she'd go to the friend's house to advise Morgan of the problem. When Dr. Rothman called Morgan's sister back the next day, she told him that Morgan was in the hospital. As Dr. Rothman put it:

> Her words slammed into me like an avalanche moving downhill at 100 miles an hour. My head split open like a hollow eggshell, and my spine bent over until it snapped. The pain shot through me from the phone to the floor like a bolt of lightning.[84]

Dr. Rothman was shaken to his personal and professional core. How had this happened? What to do? Dr. Rothman obtained Morgan's hospital telephone number from his sister. He picks up the story in a poignant, lyrical and profoundly human way:

> I hung up (from the sister) feeling a bit reassured. Despite the pain, Morgan was alive. But suddenly the floor gave way beneath me, and I tumbled down into a deep, dark chasm with no bottom. I looked up but could scarcely see my apartment above me. The regular sounds of my life were barely audible from this desolate, isolated place. I closed my eyes and in the darkness saw Morgan. He was in pain, writhing, afraid. He was smothered in a web of intravenous lines, heart monitors, and face masks. He was being poked and prodded by some other intern, asked the same 20 questions another 50 times.
>
> My time with Morgan in the clinic replayed itself in slow motion. The decimal point that was not there. The pointing and clicking of the mouse in my hand. Morgan taking the script and rushing out the door. Now he was in the hospital, and it was my fault. I stared at my wife in the kitchen and reminded myself that doing the right thing is sometimes hard. I picked up the telephone again and dialed the hospital number. A deep voice answered.
>
> "Hello?"
>
> "Mr. Davis, it that you? It's Dr. Rothman calling."
>
> "Oh, Dr. Rothman! I got your message, but it was too late!" He spoke quickly, excitedly, and I found myself staring into space, completely absorbed by his words.

83 Marc D. Rothman, "The Apology", (2007) 80 Yale Journal of Biology and Medicine 77 at p. 78.

84 Ibid at page 80.

"I got home and drank that pill just like you said, Doc, before I went to sleep, and it made me dizzy. But the next morning when I woke up, I felt real, real bad, so I took another pill, and then I almost fell down the stairs! I had to crawl to my bed and lay down, but I was nauseous. Then I was gettin' these chest pains, so my cousin told me to call the ambulance, and now I'm back here in the hospital again. Oh, it was just terrible, Doc."

He took another pill in the morning? I was confused. Why would he do that? And was he having chest pain now?

"Oh, yes, and I been short of breath, too, just like the other times I been in the hospital, Dr. Rothman." Oh my God, I muttered, did I trigger a heart attack?

"Have they done any tests yet?"

"They wanted to do something on Monday, Doc, but they say I'm too big for the machine, so they might send me to Boston or something. But I won't be taking that medicine again, that's for sure!"

"I'm so sorry this happened, Morgan. The dose of Hytrin I gave you was too high. I tried to reach you at the shelter, but I guess it was too late." He reminded me he had left the shelter and started talking about his friend and the new place where he was living.

I remember that he didn't sound angry. He should be furious, I thought to myself. Wouldn't I be? Why wasn't he mad? Had he not heard me? Had I been vague? Didn't I use words like "my mistake" and "wrong"? Had I fudged and emphasized how rushed we were, or did I imply that the pharmacy was somehow at fault? Had I truly owned up to the error?

The moral imperative to be honest with patients about an error is clear. Patients want to know the truth and hate being lied to most of all. Still, it's hard to use the first person. "The dosage was incorrect" and "I prescribed the wrong dose" sound the same, but they are not. The difference between "A mistake was made" and "I made a mistake" is subtle but important. Admitting a mistake in the first person is a thousand times harder. "I" wrote the wrong dose. "I" made the mistake. "I" am sorry.

> Morgan seemed pleased to know I would visit him over the weekend. Saturday was my day off, but I would go to the hospital anyway. I needed to see my patient, to check on his condition, and apologize to him face to face.[85]

Dr. Rothman describes what in medical jargon is called an error. Dr. Philip Hébert, a biomedical ethicist, describes adverse events and errors in his excellent book *Doing Right.*[86] As Dr. Hébert puts it:

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85 Ibid at pp. 80-81.

86 Philip Hébert. *Doing Right* (Oxford: Oxford University Press, 2009).

An error in healthcare may be broadly defined as any outcome or process that you would have preferred not to have occurred—as when one says afterwards, 'Oh, that was a mistake.' Errors are not always harmful—they may be interrupted before affecting anyone. For example, writing the wrong dose on a prescription may be an error but not cause the patient harm if the pharmacist catches the mistake before the patient received the medication. Errors also usually entail some moral responsibility because one could have done otherwise—acted 'better' or 'differently'—in the circumstances. (If you couldn't or wouldn't, reasonably, have done differently, then there is no 'mistake', only an unfortunate event.) By contrast, adverse events in medicine are incidents caused by a medical intervention that are harmful to patients or that threaten to harm (set back the interests of) patients. About one-third to half of adverse events are considered preventable and so can be designated as errors. (An adverse event would be a rash following the first-time administration of penicillin to a patient; it would be an error if the same outcome happened due to an inadvertent second-time use of penicillin in the same patient.)[87]

Dr. Hébert's description of errors is technically correct, but for the purposes of this paper, I am concerned not with harmless errors but only with harmful ones. Had Dr. Rothman gotten to Morgan before he consumed the Hytrin, then that would have been an error without a healthcare or outcome consequence; although it might have shaken Morgan's confidence in Dr. Rothman. These errors are interesting and have generated much debate about whether they should even generate apologies.

The philosophical and moral dimension to this is hard to miss. If Dr. Rothman had gotten to Morgan before he filled the prescription, then Dr. Rothman in theory could have told Morgan anything he wanted to. To quote an aphorism, "no harm, no foul". Had the pharmacy filled the script and had Dr. Rothman gotten to Morgan before he actually ingested the Hytrin, the situation is more difficult; for now Dr. Rothman has to tell Morgan why he shouldn't consume medication which is in Morgan's possession. Since lying is clearly unethical and morally indefensible, it becomes much more difficult to handle the situation in an appropriate way without telling Morgan the unvarnished truth.

> Conventional wisdom suggests that when a patient is harmed by medical error, full disclosure—including acceptance of responsibility, an apology, and an explanation—will result in the best outcomes for both patient and physician. We found that full disclosure incorporating these elements and assurance of efforts to prevent recurrence resulted in more positive outcomes in terms of patient satisfaction, trust, and emotional response and decreased the likelihood of changing physicians. The effect of disclosure on the likelihood of seeking legal advice was more complex, suggesting strong situational influences in this area. Both the clinical outcome of the error and the specifics of the error situation influenced how people respond to medical errors. We conclude that full disclosure fulfills patients' expectations and may help sustain or strengthen

87 Ibid at pp. 177-178.

the patient-physician relationship, but it may not prevent litigation under some circumstances.[88]

In the hypothetical error scenarios presented in this study, how apparent an error would be to the parent influenced whether pediatricians would disclose this error, how much information they would provide about the events that led to the error, whether an apology would be offered, and how much detail they would offer regarding prevention of the error in the future. Framing the decision to disclose an error based on whether the patient or family is aware of the error is in conflict with standards established by the Joint Commission on Accreditation of Healthcare Organizations and raises challenging ethical questions regarding truth-telling in medicine. A similar effect has been described in a large sample of surgeons and medical specialists, suggesting that this practice may be common across medical specialties (footnotes omitted).[89]

As Loren and his co-authors conclude:

> ...the relationship among a pediatrician, a child, and a family is steeped in trust, a commodity that can be significantly diminished by the occurrence of a medical error. In this context, disclosing a medical error to a child and family can be remarkably challenging. Nevertheless, parents have clearly articulated a desire to be told about errors in the medical care of their children. This study demonstrated marked variation in when and how pediatricians might disclose medical errors and found that they may be less likely to disclose an error that was less apparent to the family.[90]

What emerges as an unequivocal principle is that patients want apologies and they want humane, truthful apologies. The apology must be timely, delivered in a connected, compassionate way and must not shirk responsibility or attempt to re-direct or misdirect it. Anything less introduces a qualification (a "but") into the language of apology which is akin to dropping an atomic bomb into a lake where people are fishing. Obviously, there's no fishing to be done when all the fish are dead.

As Dr. McCord and his colleagues stated:

> ...participants preferred not to dwell on the anger. Rather, they preferred apologies in which the physician takes ownership for the problem. For example, "I apologize for your long wait," is preferred over "I'm sorry you've been kept waiting". The latter response may come across as "passing the buck"—no personal responsibility is taken, while "I apologize for your long wait" may connote more personal responsibility. Although an explanation alone did not appear as satisfying to participants, an apology combined with an explanation was the overall preferred response.

88 Kathleen M. Mazor et al, "Health Plan Members' Views About Disclosure of Medical Errors", (2004) 140 Annals of Internal Medicine 409 at p. 417.

89 David J. Loren et al, "Medical Error Disclosure Among Pediatricians", (2008) 162 Archives of Pediatric Adolescent Medicine 922 at p. 925.

90 Ibid at p. 926.

> The acknowledgment "I can see that you are upset" was the least preferred response.[91]

The nursing profession's stance on disclosure and apology at least in theory is identical to that of the medical profession. As nurses Smith, Twedell and Pfrimmer have stated:

> Adverse events are emotionally distressful for patients and families, as they can experience loss of trust and heightened anxiety related to concern about future events. Emotional support of patients and family members is crucial initially and going forward.
>
> Apology plays an important role in the disclosure process. An apology does not imply guilt. It is an important part of the healing process for both patients and caregivers. An apology can reduce the emotion of an event and restore focus on future care and resolution (footnote omitted). Liebman and Hyman distinguish between an apology of sympathy and an apology of responsibility. An apology of sympathy is essentially saying "I'm sorry this happened to you", whereas an apology of responsibility is saying "I'm sorry we did this to you". There is widespread endorsement of apology of responsibility when the adverse event is clearly caused by unambiguous error or system failure (footnote omitted).[92]

Clearly, the method of communicating an apology, the sincerity, the words used, the environment, the speaker's tone, dress, demeanour and the pace in which the apology is delivered will inform the effectiveness of the apology.

> To our knowledge, this is the first study to investigate the importance of how patients interpret the physician's communication about an adverse event. The video vignette methodology we used allowed us to control what was actually said, observing how participants interpreted this and how both of these factors related to their evaluation of the physician.
>
> Our results support those from earlier studies suggesting that full disclosure of an adverse event leads to greater trust and more positive regard by patients and family members. This was particularly true when the physician acknowledged responsibility for the adverse event. Interestingly, acceptance of responsibility without an accompanying apology yielded no such benefit and may even have resulted in more negative judgments. This is similar to Schwappach's finding that equivocal statements acknowledging an error had no effect or even increased the probability of negative ratings. Our findings complement those of previous studies in that we obtained a community sample rather than health plan members.

A surprising finding was that the *perception* of what is said was more strongly associated with how physicians were perceived and trusted

91 Ronald S. McCord et al, "Responding Effectively to Patient Anger Directed at the Physician", (2002) 34 Family Medicine 331 at p. 335.

92 Elaine Smith et al, "Nursing's Role in Disclosure and Apology", (2010) 41 The Journal of Continuing Education in Nursing 342.

than what was actually said. This finding has face validity, but there have been few studies of how handling of an incident affects patients' evaluations. One interpretation is that just because we think we've conveyed a message does not mean that it will be heard and understood. In communicating, the sender encodes meaning in his or her words and the receiver decodes the meaning. Ambiguous wording from the sender or preoccupation of the receiver increases the chances of translation error. In addition, multiple factors affect how patients evaluate physicians.

If it is difficult to modify patient perceptions based on language, what can physicians do? One piece of advice is that once you have decided to disclose an error, you should make sure that the patient knows you really mean it. For a discussion that includes explaining, apologizing and accepting responsibility, this may involve repeating the message and aligning other channels of communication (e.g., posture, demeanor) to be congruent with the expression of regret, contrition and empathy. It is also important that physicians ask questions to help ensure the message is getting through. As in aviation, use of a "read back," where the receiver is required to verbally repeat the sender's message before taking any action, may be a useful way for physicians to test patient comprehension. There is a need for further research on the disclosure process (footnotes omitted).[93]

93 Albert Wu et al, "Disclosing Medical Errors to Patients: It's Not What You Say, It's What They Hear", (2009) Journal of General Internal Medicine 1012.

Though it is beyond the parameters of this paper, it is noteworthy that there is a movement in medical education towards incorporating apology as a separate competency to be taught to physicians in their residency training.

> If apologies are an emerging clinical skill, then identification of medical error should become a core competency in residency training. We would not allow our residents to insert a central line without demonstrating competence first, and we should not allow them to apologize before teaching them what medical error is and what it is not, and how to say I am sorry. Needless harm may ensue in either instance. Indeed, in the description of their safe-practice guidelines on disclosure of error, the National Quality Forum acknowledges that training of healthcare workers is needed to achieve effective disclosure.

Physicians are not very good at many of the skills they spend years learning, like making diagnoses or assessing the prognosis of dying patients. Studies using autopsies as the gold standard show that even in the modern area [sic-era], the cause of death identified clinically and the pathological diagnosis after death differ almost half the time. Is there any reason to assume that physicians will be better at identifying medical error, especially in the absence of formal training?

We agree completely that the potential positive impact of apologies for patients, families, and healthcare workers is great and that apologizing

is very important in the healing process. We concur with the thoughts of Dr. Lucian Leape, who noted, "The only treatment, the only way trust can be restored and the patient begin to heal, is for the caregiver to acknowledge the error, take responsibility—and apologize." But if apology is an "emerging clinical skill in medicine," graduate medical education must approach this skill as it has approached other clinical skills. It must be taught in an evidence-based manner, and expert faculty must role model this skill for residents the way an expert clinical cardiologist might teach cardiac auscultation. Identifying medical error and apologizing for it is, in many ways, fundamentally different from other skills we teach residents. All other clinical skills are focused on patient care, which is in turn, about "the treatment of health problems and the promotion of health". The recognition and disclosure of medical error and apologizing for it are, perhaps broadly defined, aspects of good patient care, but they are not intrinsically about treatment and promotion of health. Given these differences, we suggest that this be recognized as a separate competency, thereby stressing its importance in the evolving culture of medicine. If residency training is to fully involve itself in the culture of patient safety, the skills needed to define, recognize, disclose and apologize for medical error must be taught, and curriculum development must be focused on this as a distinct competency.[94]

94 Colleen Christmas and Roy C. Ziegelstein, "The Seventh Competency", (2009) 21 Teaching and Learning in Medicine 159 at pp. 160-161.

What then constitutes good apology and how can we isolate the components of good apology in the context of the practice of medicine? It is submitted that just as good medicine weaves art and science into a coherent tapestry, so good apology is both art and science. The sciences of communications, linguistics, risk management and medicine must be integrated with the arts of human relations, empathy, sympathy and the ability to internalize the horror of the losses described by Kübler-Ross and others in their examinations of death, dying and survivorship.

Dr. Richard Roberts holds both a medical degree and a law degree. In his excellent article "*The Art of Apologizing: When and How to Seek Forgiveness*",[95] he articulates what I believe is the crux of the issue:

> Even when the care is blameless, a caring professional will show empathy when a patient has an undesired or unanticipated result or appears unhappy or offended....[96]
>
> An apology acknowledges responsibility and reflects remorse. It should be offered when an error has occurred and harm or potential harm has resulted.[97]

Dr. Roberts' so-called Apology Zone is worth reproducing as it starkly prescribes when an apology should be proffered.

> THE APOLOGY ZONE
>
> An error is defined as the failure of a planned action to be completed as intended (i.e., error of

95 Richard G. Roberts, "The Art of Apologizing: When and How to Seek Forgiveness", (2007) Family Practice Management 44.

96 Ibid.

97 Ibid at p. 45.

execution) or the use of a wrong plan to achieve an aim (i.e., error of planning).

An adverse event is an injury caused by medical management rather that the underlying condition of the patient. An adverse event attributable to error is a "preventable adverse event."

When errors and adverse events intersect, you have entered an "apology zone" and an apology might be appropriate.

Negligent adverse events represent a subset of preventable adverse events that satisfy legal criteria used in determining negligence (i.e., whether the care provided failed to meet the standard of care reasonably expected of an average physician in the same or similar circumstance).[98]

It is submitted that all of the medical, legal, sociological and philosophical literature about apology becomes sharply focussed when we address the issue of apology for causing a death. This is even more so when it is a child's death and the death was, in legal terminology, caused or contributed to by a member of the healthcare team. I am not speaking of negligently caused deaths but of iatrogenic deaths or deaths where medical care was administered or not administered and as such had some temporal connection with the death. Negligent deaths in the tortious context are a small subset of all paediatric deaths from adverse events. Errors are a subset of adverse events and all errors are not necessarily negligent errors. Surely whether the paediatric death was caused by negligence (Lisa Shore, Janice T. Blake) or adverse event (Danny Smith) there is still a moral and ethical duty to apologize. A few of the reasons for this are as follows:

> When a patient dies the trauma is obviously even more severe and may be particularly severe after a potentially avoidable death. Lehman *et al* studied people 4-7 years after they had lost a spouse or child in an accident. Many continued to ruminate about the accident and what could have been done to prevent it, and they appeared unable to accept, resolve, or find any meaning in the loss. Relatives of patients whose death was sudden or unexpected may therefore find the loss particularly difficult to bear. If the loss was avoidable in the sense that poor treatment played a part in the death, their relatives may face an unusually traumatic and prolonged bereavement. They may ruminate endlessly on the death and find it hard to accept the loss.[99]

I submit that if one defines "patient" very narrowly, then the practitioner who treated a child who has died may argue that the physician-patient relationship is terminated by the death. However, surely this is too narrow a perspective and fails to take into account the psychological and psychiatric sequelae which are to be suffered by the survivors. The doctor who was primarily responsible for the actions or decisions which led to the child's death owes the survivors a duty as a physician and as a human being: that duty is to do what he or she can to minimize the horrible suffering that is certain to ensue. I

98 Ibid at p. 47.

99 C. A. Vincent and A. Coulter, "Patient Safety: What about the Patient?", (2002) 11 Quality Safety Health Care 76 at p. 78.

submit that to fail in this regard is to abrogate the physician's solemn commitment to the principles espoused in the Hippocratic Oath.

Before turning briefly to the Shore, Blake and Smith cases, it is worthwhile to review the Micalizzi case and the heartbreak and horror that it spawned.

Justin was a healthy, active 11 year old who enjoyed bowling and playing basketball. He came home from school one day with ankle pain and a fever. Over the next 2 days he saw three different doctors and he was eventually taken to hospital for surgery to incise and drain his swollen ankle. By 8:00 a.m. on the day after his surgery, Justin was dead.

Justin's parents were bewildered by his highly unexpected death, but they were left to grieve this unexpected death on their own. The medical profession heaped insult onto injury by not explaining what had happened, what had gone so terribly wrong.[100]

As Justin's mother said approximately 8 years after his death:

> ...I am still waiting for, and still need that conversation. Not receiving an apology and explanation from someone caring for your child when something goes wrong is incomparable to any form of inhumanity in medicine or in society. It is simply not right. Justin was our child and we were owed an explanation and an apology. We didn't expect anyone to say "I'm sorry that I screwed up", but perhaps simply "I am so very, very sorry that your son has died in our care. I will do everything in my power to help you and your family heal and explain to you everything that I honestly know about the event.
>
> Justin's surgeon would have been my hero if he said that to us but instead they said "these things happen in medicine" and we were expected to accept that. As a parent, I couldn't.[101]

As a result of Justin's unexplained and unapologized-for death, his mother founded the Justin's Hope Project Task Force for Global Health.[102] In this capacity, she has contributed to scholarship on what "can be done to promote recovery from catastrophic loss for the family of the injured patient and for the health care providers intimately involved?"[103] Dale Ann Micalizzi describes the scene immediately after Justin's cardiac arrest in the operating room:

> My son was on a stretcher in the hall being wheeled away by the trauma team to the ambulance, after his cardiac arrest in the operating room. They would not let us ride along. I had broken my promise not to leave him already. My husband's promise that he would be fine was also broken. Our pain and guilt over these broken promises have eased only minimally over the ensuing years. The surgeon walked us to our car in silence. If he said anything, we have no idea what it was. Our world had crashed, and we could not listen

100 Marie M. Bismark, "The Power of Apology", (2009) 122 The New Zealand Medical Journal 96.

101 Ibid.

102 Barbara W. Brandom et al, "What Happens When Things Go Wrong?", (2011) Pediatric Anesthesia 1.

103 Ibid.

to outsiders yet. This may be why physicians often think that parents do not hear what they are saying: because the parents cannot, not because they do not want to, they just are not physically and emotionally capable in that moment. Our other children and family joined us at the hospital upon advice from the chaplain, as there was little life left for our son. Two ministers held our hands and prayed with us in a tiny room. I was heaving over a garbage can, unable to control the turmoil in my stomach. The pain of seeing my child in this condition was unfathomable. I left his room as the team attempted to revive him over and over again. I could not watch. I rocked back and forth while kneeling down outside his room. I remember a group of residents being briefed on the case, and one of them wanting to comfort me, but sadly turning away. I remember his dark hair and eyes looking down at me. Many years later, tears stream down my face, as if this happened yesterday.[104]

As Micalizzi and her co-authors state it:

> Families want honest answers from the physicians involved in their loved one's care. They want to know what went wrong, why it happened, and what is going to be done to prevent it from happening again. These are also the questions asked by root cause analysis (RCA). Most families want an unrehearsed authentic apology, but for many the apology is not as important as the honest disclosure, which they need. The number one complaint of many families is the difficulty they encountered in obtaining a copy of their child's medical records. It often takes years for parents to piece together what was done for their child and how things progressed. They may meet roadblocks and excuse every step of the way.
>
> Families react differently to trauma and may have different needs in the aftermath of an injury, depending upon their cultural background. Many patients and families (particularly the parents of children who have died or suffered permanent disability) wonder whether they are in some way to blame for the harm that occurred. The thought that this catastrophe could have been prevented if we, the family had done something differently may nag parents and siblings for years. Apology from the doctors may provide important confirmation to the family that the health system had more responsibility for the injury than did the patient or the family. By truthfully acknowledging the extent to which the outcome was a result of their actions and/or of broader aspects of the delivery of health care, health practitioners can lift the burden of uncertainty and guilt from the shoulders of the family and provide an understanding of how and why things went wrong (footnotes omitted).[105]

104 Ibid at p. 2.

105 Ibid at p. 2.

Dale Ann Micalizzi never got the apology or the explanation that she so desperately needed. Neither did the Shore family, Janice T. Blake's surviving family members or Danny Smith's surviving family members. The treating health practitioners in my trilogy would have benefited from advice from Marc Rothman or Philip Hébert. The surviving families would have benefited as well. Dr. Hébert believes that:

> There has been an attitudinal shift towards truth-telling in medicine in the last 40 years. Honesty and transparency are extensions of this, particularly in pre-event disclosure. This manifests itself in the medical profession being quite good at dealing with informed consent—a pre-event issue. The medical profession is not nearly as good at post-event disclosure—responding with honesty and transparency when things go wrong.[106]

I asked Dr. Hébert why doctors are bad at apology and explanation when unexpected deaths occur. His answer was:

> Doctors are perfectionists. They don't like acknowledging their fallibility. To do so is like swallowing a watermelon whole—it sticks in your throat.[107]

Dr. Hébert offered how HSC ought to have dealt with the Shore family. He unhesitatingly and forcefully articulated the following:

> HSC ought to have met with the family straight away. Lisa's death was the ethical equivalent of a medical emergency. There are few ethical emergencies in medicine. This was one of them. Lying about mistakes as was done in the Shore matter is almost as bad as the actual mistakes. In Shore, HSC was not prepared in a systemic way to deal with error. The hospital didn't know how to analyze error or to determine culpability. There was an inability to tie together the loose ends at the end of their analysis. Lying is antithetical to everything medicine and nursing stand for.[108]

I asked Dr. Hébert to define an ethical emergency. He responded:

> An ethical emergency involves the potential loss of trust in the healthcare professionals and the healthcare institutions by the survivors. The longer the failure to explain and apologize continues, the greater the chasm between the survivors and the professionals. This situation pertains in all unexpected death scenarios whether or not the deaths were preventable.[109]

Dr. Hébert reviewed each of the three cases in our trilogy. He felt that each precipitated an ethical emergency.[110]

> Doctors often respond to bad outcomes in a cavalier way—"that death can occur". However, it is vitally important that the healthcare professionals appropriately handle the unexpected nature of outcomes like death. What is being done to understand these unexpected

106 Author interview with Dr. Philip C. Hébert on March 6, 2011.

107 Ibid.

108 Ibid.

109 Ibid.

110 Ibid.

outcomes? The more serious the outcome, the more seriously the healthcare institution should take the case. The family doesn't want to see the hospital proceeding as if it's "business as usual". Adopting the "these things happen" approach is not the way to respond. These are not pure accidents such as if someone gets hit by a meteorite. In the Shore case:

i. Lisa wasn't sick;
ii. They gave her morphine;
iii. This created a dangerous milieu;
iv. Lisa required professional monitoring;
v. Lisa didn't get professional monitoring;
vi. A medical emergency ensued;
vii. This medical emergency wasn't appropriately responded to;
viii. Lisa died;
ix. This created an ethical emergency.[111]

Dr. Hébert said that what must be done to be effective is to advise the family right away what is known and what is unknown. Ongoing communication with the family is critical, and that communication must be a dialogue which allows for questions. If answers are unavailable they should be sought and provided as they become available. Transparency is critical.[112]

Dr. Hébert explained that the Shore case got off track when the hospital personnel failed to meet with the Shores to tell them what was known in the immediate aftermath of Lisa's death. The "whole process got derailed". Where there was chaos, the hospital ought to have attempted to impose some order. It failed to do that.[113]

When I asked Dr. Hébert about the hospital's inability to locate the missing orders which Lisa's nurse printed up a few days after Lisa's death; the failure to segregate the Corometric monitor; the erasure of the tape; the "ghost heartbeats"; and the nurses signalling answers to the witness at coroner's court, Dr. Hébert called all of this:

> A litany of cover-up. It's egregiously unprofessional. It doesn't work. It is stupid. They wanted an outcome they couldn't manufacture. They couldn't do it because the coroner's jury had oversight over this series of events. It's a failure of the medical and healthcare systems when legal oversight must be brought into it. These are moral and medical emergencies and must be handled within the healthcare system. That's what professional training is all about. The real professional says "I'm responsible. I made a mistake. The buck stops with me." They say it regardless of any consequences, legal, moral or monetary. If a healthcare professional makes a mistake, he shouldn't compound it by lying about it.[114]

I asked Sharon Shore what kind of apology she wanted from HSC. I suspect that had I asked the Blake and Smith family members, their responses would have been almost identical. This is what Sharon Shore wrote on March 1, 2011, more than twelve years after Lisa's death:

111 Ibid.

112 Ibid.

113 Ibid.

114 Ibid.

My daughter is dead. I blame you—you, the two nurses who were supposed to be caring for her but instead left her to die and then tried to cover it up, and you, the hospital who helped them cover it up and who continues to protect and defend them to this day.

You, the two nurses, you never apologized at all, directly or indirectly. Even when you were found to have committed professional misconduct by the College of Nurses, you still did not express an iota of remorse. Why should you, when the hospital who employed you—and still employs you, as far as I know—has wrapped you in its protective cocoon and denied that you did anything wrong? I suppose I should give you a modicum of credit for being honest about your lack of remorse, considering that you lied about everything else.

You, the hospital, you knew what happened was not "system error"—a convenient little catchphrase used to excuse anything that takes place in a hospital setting no matter how egregious or criminal. You tried to say it was, and you still say it, but you couldn't fool the lay people who made up the coroner's jury, who found my daughter's death a homicide. The jury was not any smarter or less smart than you, only more honest.

I have been asked to write about the apology I would have liked to receive. That apology would have three things which yours did not: it would have been timely, it would have acknowledged that the two nurses had been grossly negligent, and the two nurses would have been fired and reported to the College of Nurses for professional misconduct.

No apology in the world could ever have assuaged my pain, but a genuine one from you would have allowed me to forgive. Instead, your apologies were nothing but hot air. Each one made me hate you a little more.

You, the hospital, employer of the nurses, you did apologize on several occasions. The first apology came at the end of the coroner's inquest, a year and a half after my daughter's death, by your chief of nursing. We had met several times before, and we both attended each day of the weeks-long inquest. How could you fail to realize that your nursing chief's rehearsed, emotionally flat apology proffered from the witness stand at the eleventh hour to the gathered media and hospital executives, would be seen as offensive and insincere? Your second apology, by your vice-president at the press conference following the inquest, was solely for the media's benefit since we weren't there to hear it. How was that sincere and meaningful? You put a bit more effort into your third apology, by having your president apologize to me privately. But did you really think that his words, coming as they did from this gold-jewellery laden man in his expensive suit, and without any more substance than the first two apologies, would mean anything more than those others

did? I said to your president that his apology was worthless unless he did something about the two nurses—fire them, I said—and he refused. You fired your chief of nursing instead, making her the scapegoat for your sins. Was that supposed to appease me?

Then there is the letter from the president that contained a promise that you broke soon after. Not only did you make empty apologies and refuse to take any real action, you outright lied to me—in writing. Is it really a surprise that I have nothing but contempt for you?

I accept that you didn't apologize to me in the days and even weeks following my daughter's death. You didn't know exactly what had happened, and the coroner's office was involved. But there was a point relatively soon after when you did know—and you knew beyond a reasonable doubt, as the lawyers say—that your nurses had been grossly negligent.

As a mother, I can say to you that this was the time to make the first apology—along with a commitment that when the dust settled, you would take appropriate action to deal with these nurses. As a lawyer, I understand the reasons that might have prevented you from saying anything that soon. But there was nothing to stop you from taking action behind the scenes. How much more believable an apology would have been when eventually tendered, if it was accompanied by hard evidence that the issues had already been appropriately dealt with.

Your apologies, without acknowledgment and ownership of wrongdoing, were glib and self-serving. I needed you to acknowledge that your nurses had been grossly negligent. I needed to hear you say that what happened—my daughter's death—should not have happened.

Part of an admission of wrongdoing is taking responsibility for it. You did not. Along with responsibility, there should be remorse, shame, guilt—emotion!—that this happened under your watch. There was none of that.

Most of all, I needed to see concrete action taken, proof that you would not—could not—employ nurses who did not follow hospital policies, procedures, or doctor's orders, and who lied to cover up their wrongdoings.

It is still not too late. I am here.[115]

Two risk managers at the University of Utah Health Sciences Center put it in more clinical language:

> Full disclosure after an adverse event is the best policy. Patients want to know what happened, why it happened, and that it will not happen again. Often, according to patient studies, this is the only reason they file a claim. If these concerns can be eased at the outset, it could save a lot of time, resources and psychological suffering for both patient and physician. Studies show that full disclosure does not lead to more litigation; in fact

115 E-mail from Sharon Shore to the author dated March 1, 2011.

it has decreased the number of claims filed and the average amount of settlement. Plaintiff's lawyers also seem to respect the policies, stating that they know better up front whether they have a legitimate claim.

The move toward full disclosure by healthcare institutions is only a recent trend, but it seems to be taking off. As more institutions establish full disclosure policies and more states enact legislation, which protect expressions of apology and sympathy accompanying those disclosures, the result can only lead to a positive impact on improving patient care, treatment, and the prevention of future errors.[116]

6. APOLOGY, MORALITY AND LAW

Adverse Event

An event which results in unintended harm to the patient, and is related to the care and/or services provided to the patient rather than to the patient's underlying medical condition.[117]

Disclosure

The process by which an adverse event is communicated to the patient by healthcare providers.[118]

For the purposes of this discussion, I am defining morality to be "conformity to the rules of virtuous or right conduct".[119]

It is imperative that statutory, regulatory and other administrative provisions be consulted to determine whether apology for the unexpected death of a child is supported, impeded or otherwise impacted by any of these provisions.

An appropriate departure point for this discussion is the Canadian Patient Safety Institute's *Canadian Disclosure Guidelines*, released in May, 2008.[120] As provided in the heading "The Patient's Perspective on Disclosing Adverse Events":

> We support the need that patients and families receive an apology for what has happened, and where it is applicable, that apologies are provided for adverse events that are known to have contributed to the harm of the patient. We know that these situations are very stressful for both the patient and family, and the healthcare providers involved. It is important that support is provided to all involved.[121]

The *Canadian Disclosure Guidelines* enunciate two stages of disclosure; the first stage is "the initial discussion with the patient that should occur as soon as reasonably possible after an event". The second stage "is called post-analysis disclosure". The first stage of disclosure should include:

116 Jenny L. Pelt and Lynda Faldmo, "Physician Error and Disclosure", (2008) 51 Clinical Obstetrics and Gynecology 700 at pp. 707-708.

117 Disclosure Working Group. Canadian Disclosure Guidelines. (Edmonton, Alberta: Canadian Patient Safety Institute; 2008) at Appendix C p. 30.

118 Ibid.

119 www.dictionary.reference.com/browser/morality.

120 Supra note 117.

121 Ibid at p. 3.

- An expression of regret for what happened.
- The avoidance of blame and speculation.
- The provision of emotional and practical support for the patient.[122]

The second stage may include an apology.

> It is at this stage that patients may learn of improvements made to prevent similar events, if such improvements are possible. In addition, a further expression of regret is important that may include an apology with acknowledgement of responsibility for what has happened as appropriate.[123]

The *Canadian Disclosure Guidelines* appropriately summarize the competing interests faced by a physician agonizing over whether to apologize.

> In principle, apology as part of disclosure of an adverse event (for example related to a system failure or provider performance) is consistent with patient-centered care, honesty and transparency, and intuitively is the right thing to do. In practice, apology as part of disclosure is complex because of the ambiguity of commonly used apology language. There is a belief that apology implies blame for providers, which is often inconsistent with a just patient safety culture. There is also a widely expressed concern that an apology could be taken as a confession or admission of legal responsibility, exposing healthcare providers, organizations and others (e.g., professional colleagues, defense organizations and liability insurers) to potentially unwarranted risk. While there is little evidence to date that Courts have taken apology in this way, if this perception persists it can discourage participation in and support for disclosure.[124]

Medical authors have substantiated the long-held view of medical negligence lawyers that until fairly recently:

> the traditional approach to disclosure of preventable adverse events in the health care setting has been "disclosure by necessity". When performed, disclosure has consisted of a dispassionate statement of fact rather than an apology, out of fear that an apology would create legal liability. Self-shame, self-blame, and concern over one's reputation have further deterred proactive disclosure of medical error (footnote omitted).[125]

The puzzling aspect of all of this is that it has taken so long for medical ethics to catch up to what most would view as societal ethics. As the medical, health and ethics experts point out, it wasn't until 2001 that a world class institution like HSC convened a multi-disciplinary "task force" to develop a hospital policy on disclosing preventable adverse events to patients at HSC. Insofar as apology is concerned:

> (parents) appreciate hearing the apology of the clinician and feeling the caretaker's pain, particularly where the adverse event has resulted in a fatality.

122 Ibid at p. 16.

123 Ibid.

124 Ibid at p. 23.

125 Anne Matlow et al, "Achieving Closure Through Disclosure: Experience in a Pediatric Institution", (2004) The Journal of Pediatrics 559.

> They want reassurance that their case is being investigated fully and that corrective actions will be implemented to prevent a reoccurrence of the event. Although disclosure has not eliminated litigation, it has reduced the degree of adversarial interaction between families and the health care team, and preserved the integrity of the therapeutic relationship. Finally, disclosure has served as the start of a healing process for the physician having been done within the context of a supportive framework that acknowledges human vulnerabilities. Our experience would urge other institutions to develop and promote a similar policy.[126]

What does the law in Ontario say about apology and what do organizations like The CMPA tell their members to do when an adverse event occurs?

The *Apology Act*,[127] which was enacted by the Ontario Government just under two years ago (on April 23, 2009), protects expressions of sympathy, contrition, commiseration **and admissions of fault or liability.** The Act defines apology as follows:

> 1. In this Act,
>
> "apology" means an expression of sympathy or regret, a statement that a person is sorry or any other words or actions indicating contrition or commiseration, whether or not the words or actions admit fault or liability or imply an admission of fault or liability in connection with the matter to which the words or actions relate.[128]

The zone of protection established by the Act therefore precludes the plaintiff in a medical negligence lawsuit from using the apology as an admission against the physician's interest, and therefore renders the fact of the apology and its contents inadmissible as evidence establishing physician liability (negligence) at trial.

> 2. (1) An apology made by or on behalf of a person in connection with any matter,
>
> (a) does not, in law, constitute an express or implied admission of fault or liability by the person in connection with that matter;[129]

It is noteworthy that the protection afforded to "words or actions which admit fault or liability" is much broader in Ontario's *Apology Act* than in most of the statutes enacted in jurisdictions in the United States. Runnels points out that thirty-five states had passed apology legislation as of 2009, but of these 35 states, only four states specifically protect full apologies (defined as an expression of sympathy plus an admission of fault).[130] The other 31 states protect only partial apologies (defined as an expression of sympathy without an admission of fault). If an admission of fault is included in the apology, then in 31 U.S. states, the "fault part" of the apology is admissible at trial in order to prove liability. In these 31 states, only the "sympathy part" of the apology is protected. Ebert's analysis of how state statutes promote "sympathetic" apologies but not "fault-admitting" apologies is similar to Runnels'.[131] As Jonathan Cohen put it:

126 Ibid at p. 560.

127 S.O. 2009, C.3.

128 Ibid S.1.

129 Ibid S.2.

130 Michael B. Runnels, "Apologies All Around: Advocating Federal Protection for the Full Apology in Civil Cases", (2009) 46 San Diego Law Review 137 at pp. 155 and 156.

131 Robin E. Ebert, "Attorneys, Tell Your Clients to Say They're Sorry: Apologies in the Health Care Industry", (2008) 5 Indiana Health Law Review 337 at p. 357.

> Under existing American law, (fault admitting) apologies are ordinarily admissible to prove liability.[132]

With this backdrop, what does The CMPA tell Ontario doctors?

In May, 2008 The CMPA revised two articles published a few years earlier. These were "Disclosing adverse events to patients: strengthening the doctor-patient relationship",[133] and "How to apologize when disclosing adverse events to patients".[134]

As The CMPA specifically references the CPSI definition of "adverse event" in the May 2008 revision of "Disclosing adverse events to patients" it seems likely that the timing of The CMPA revision was prompted by the release of the Canadian Disclosure Guidelines. I suggest that The CMPA correctly identifies that patients and their families:

> …may even be forgiving of preventable adverse events but are less inclined to be so if they perceive that the physician or hospital is evasive or dishonest. Patients appreciate physicians who have a caring attitude and who support them through an adverse event.[135]

The CMPA has re-iterated in May 2008 that it has:

> for many years encouraged member physicians to disclose to patients the occurrence and nature of adverse outcomes as soon as is reasonable to do so after their occurrence. This is an ethical, professional and legal obligation.[136]

Though this sounds like an excellent approach to adopt, the article no less than three times suggests to CMPA members that they seek telephone or other legal advice from The CMPA or its legal counsel prior to communicating with the patient.[137]

The CMPA quite properly states that "adverse clinical outcomes usually are not caused by negligence".[138] Why doctors are repeatedly encouraged to contact The CMPA or its lawyers and to "avoid attribution of fault, particularly concerning the care provided by others",[139] is surprising and indeed counter-intuitive in the age of apology legislation and in the spirit of "openness and transparency".[140]

In "How to apologize when disclosing adverse events to patients", The CMPA states:

> Physicians rushing to apologize however, may inappropriately shoulder blame…
>
> It is important to remember that it is difficult to withdraw an apology in which you accepted blame even if other factors are later found to have contributed to or to have caused the adverse event. An apology in circumstances in which you were not actually responsible may not only be inappropriate,

132 Jonathan R. Cohen, "Legislating Apology: The Pros and Cons", (2001-2002) 70 University of Cincinnati Law Review 819 at p. 824.

133 The Canadian Medical Protective Association, "Disclosing adverse events to patients: strengthening the doctor-patient relationship", An article for physicians by physicians, originally published March 2005/Revised May 2008.

134 The Canadian Medical Protective Association, "How to apologize when disclosing adverse events to patients", An article for physicians by physicians, originally published September 2006/Revised May 2008.

135 Supra note 133.

136 Ibid.

137 Ibid at pp. 1-2.

138 Ibid at p. 1.

139 Ibid at p. 2.

140 Supra note 117 at p. 3.

but may also prevent an investigation into all the factors leading to the adverse event, with a resulting loss of an opportunity to correct any systemic problems.[141]

The CMPA conclusion is as follows:

> Following an appropriate analysis, after all the facts and circumstances are known, and if the outcome is indisputably due to deficient care, the responsible health professional may apologize and acknowledge responsibility. The use of the word negligence or fault, or reference to failing to meet the standard of care, should be avoided. Such determinations are complex and should be left for the courts or other bodies to decide. While apologizing can have a beneficial psychological healing effect both for the patient and members of the health care team, forgiveness from the patient may not necessarily follow.[142]

The language of this passage is interesting. Without subjecting it to the parsing we lawyers apply to statutes and their interpretation, the qualifications to "may apologize" surely confound the sophisticated reader. "May" is permissive, not directory. "Indisputably" and "deficient" are far different than "likely" and "less than optimal". Surely in the Shore, Blake and Smith cases, enough was known immediately post-autopsy (and after a fairly perfunctory review of the hospital records and nurses' notes) to conclude that apology was mandatory in each case. Though the Shore and Blake deaths arose from adverse events and the Smith death did not, the grieving parents in all three cases wanted, needed and deserved an explanation and an apology which never came. They didn't get what they wanted and with apologies to the Rolling Stones, didn't get what they needed either.[143] It is submitted that it didn't require CPSI Disclosure Guidelines to prompt appropriate disclosure and apology. The Hippocratic Oath and doctors and ethicists like Marc Rothman, Philip Hébert and others ought to have been heeded long before the millennium.

What then is the status of medical and nursing apology in 2011? As a neutral, I have mediated a number of medical negligence cases. Before I was a mediator, I acted for plaintiffs in a number of medical negligence cases which proceeded to mediation. As lawyer and mediator, I have never seen a CMPA representative attend on a mediation, nor have I ever seen an allegedly negligent physician or nurse actually attend on a mediation. HIROC sends an insurance adjuster, not a defendant. The CMPA sends its lawyer only, not even a CMPA decision-maker. In my view, for these mediations to provide any possibility for human interaction (including contrition, regret, sorrow, apology or forgiveness) it is imperative that doctors and nurses actually attend mediation and personally apologize. At least in Ontario (and in all Canadian jurisdictions with Apology legislation[144]) the apology at mediation has double protection. The Apology legislation protects the apology and so does mediation privilege. Certainly mediation privilege alone would be sufficient to protect the in-mediation apology from use at trial. This would apply in all Canadian provinces and territories, even those where there is an absence of apology legislation. To dissuade doctors, nurses and other healthcare professionals from attending mediation

141 Supra note 134 at pp. 2-3.

142 Ibid.

143 See www.lyricsdomain.com/18/rolling_stones/you_cant_always_get_what_you_want.html.

144 In addition to Ontario, the Canadian jurisdictions which have apology legislation either in the form of stand-alone *Apology Acts* or by way of amendment to the various provincial *Evidence Acts* are Nova Scotia (*Apology Act*); Alberta (*Evidence Amendment Act*); British Columbia (*Apology Act*); Saskatchewan (*Evidence Amendment Act*); Manitoba (*Apology Act*) and Newfoundland and Labrador (*Apology Act*). At present, Quebec, Prince Edward Island and New Brunswick have no apology legislation. The Yukon Territory drafted but never enacted an *Apology Act*. The Northwest Territories has no such legislation, whereas Nunavut has enacted the *Legal Treatment of Apologies Act*, S. Nu. 2010 c. 12.

is, in my view, misguided and counter-productive; and it serves to further alienate them from their patients and from the families of their deceased patients. This approach flies in the face of a significant body of literature which concludes that attending mediation, participating, explaining and apologizing serves everyone's best interests including the interests of allegedly negligent healthcare providers.[145]

The power of an apology in environments other than medicine has been repeatedly documented and discussed. Michael Dasrath, an Indian American employee of J. P. Morgan and two other men of colour were thrown off a Continental Airlines airplane by the pilot on December 31, 2001. This happened because a white female passenger told the pilot that "the brown men are behaving suspiciously". Mr. Dasrath sued Continental Airlines in Federal Court, advancing a civil rights claim. All he really wanted was an apology; which Continental refused to give him. The irony is that Dasrath's wife worked for Continental; he was allowed on the next plane with no further screening; his luggage had remained on the first plane and he had repeatedly been searched and cleared to fly before getting on the first plane. Though the U.S. Federal Court lacks jurisdiction to order an apology, it is significant that Dasrath refused to settle without one. As he put it "I know for a fact it won't be sincere at this point. I just want them to acknowledge what they did was wrong. They may not believe it, but at least I could say I have it in writing that [they] admitted that what [they] did was wrong".[146]

This "on the record" acknowledgment of responsibility is important to each of the apology theorists (Tavuchis, Lazare, Kador, Goffman (Benoit) and Smith). As discussed above, victims require the wrongdoer to engage in self-castigation and shame (Tavuchis); acknowledge the offence and confirm that the grievance was a violation of the social or moral contract between the parties (Lazare); recognize the behaviour as a violation of the social norm (Kador); repudiate the behaviour and the self committing it (Goffman-Benoit), and corroborate factual blame and identify moral principles underlying each harm (Smith). All of these attributes of effective apology were absent from the Shore, Blake, Smith and Micalizzi cases.

145 See Donna L. Pavlick, "Apology and Mediation: The Horse and Carriage of the Twenty-First Century", (2002-2003) 18 Ohio State Journal of Dispute Resolution 829 at 858, where Professor Pavlick states that "Due to the binary nature of both apology and the mediation process, the use of apology in mediation seems to be a "natural fit".

See also Deborah L. Levi, "The Role of Apology in Mediation", (1997) 72 New York University Law Review 1165 at pp. 1206 and following in which Levi argues that "By finding a way to accommodate expressions of sincere regret, lawyers may increase party satisfaction without monetary loss". Levi does contend that "the defendant's lawyer or insurance adjuster does not bear the personal responsibility for wrongdoing, and thus her responsibility would not be poignant enough to move the injured party to forgiveness (see pp. 1207-1208). This supports my thesis that doctors, nurses and other healthcare providers must attend mediation if apology offered at mediation is to have any currency.

See also Professor Jonathan Cohen's article "Advising Clients to Apologize", (1998-1999) 72 Southern California Law Review 1009 at p. 1069 in which Cohen advocates incorporating apology into a lawyer's repertoire because apology makes clients better off and is often the key element to resolving a dispute. As set out in footnote 131, Robin Ebert is a proponent of apology and he argues at p. 361 that "If the communications come directly from the wrongdoer, the patient is more likely to feel that the wrongdoer acknowledges the error, prioritizes the importance of communicating with the patient and expresses sympathy for the patient.

See also Professor Jennifer Robbennolt's conclusion in "What We Know and Don't Know About The Role of Apologies in Resolving Heath Care Disputes", (2004-2005) 21 Georgia State University Law Review 1011 at p. 1027 in which she advocates the use of apologies to settle health care disputes and suggests that this "will likely yield benefits that will redound to health care providers and patients alike".

Max Bolstad in "Learning from Japan: The Case For Increased Use of Apology in Mediation", (2000) 48 Cleveland State Law Review 545 at p. 567 advocates physician apology to "provide patients with the restorative benefits sought by others through litigation".

Jesson and Knapp in "My Lawyer Told Me to Say I'm Sorry: Lawyers, Doctors and Medical Apologies", (2008-2009) 35 William Mitchell Law Review 1410 at p. 1425 describe how when the Veterans' Hospital in Lexington, Kentucky adopted an extreme honesty policy in 1987 (where there was fault, the hospital offered a personal apology and a fair financial settlement) the costs in claims paid out was reduced. This too augurs in favour of a personal apology at mediation by the doctors/nurses involved.

Professor Nowicki in "Apologies and Good Lawyering", www.ssrn.com/abstract=1430212 also believes in the "inherent moral and ordering value" of apology and she articulates the view that a personal apology may be valued "as much as or perhaps more than any potential monetary settlement". It seems likely that Professors Bibas and Bierschbach would also advocate direct apology in unexpected child-death cases as they advocate emotional healing and apology for victims in criminal cases which go to mediation. I suggest that the emotions which infuse a criminal case are similar to those which infuse a wrongful death claim. See Stephanos Bibas and Richard Bierschbach "Integrating Remorse and Apology into Criminal Procedure", (2004) 114 Yale Law Journal 85 at p. 138.

146 Brent T. White, "Say You're Sorry: Court-Ordered Apologies As A Civil Rights Remedy", (2005-2006) 91 Cornell Law Review 1261 at p. 1272.

The absence of an "on the record" acknowledgment of responsibility is well illustrated in the Shore case. When the wrongdoer goes on record and accepts responsibility with no qualifications or excuses, this restores the victim's self-respect and dignity, assures the victim the offense wasn't her fault, and empowers the victim (who is now raised to the moral high ground) to forgive the apologizer (who is now on the moral low ground). This symbolic transfer of humiliation and power between offender and victim generates healing as:

> By apologizing, offenders admit to being immoral, insensitive or mistaken. And as anyone who has ever offered a difficult apology can attest, such an admission of guilt can be humiliating. In addition, the offender, having originally abused his or her power in hurting the victim, is placed in the vulnerable position of giving the victim the power to absolve the wrongdoer or not to do so.[147]

The creation of a record is crucial as it precludes what to victims is galling and unacceptable; revision of history with the passage of time. The American Government has gone on record admitting that the failure to treat black syphilis victims (first with mercury and arsenic compounds and thereafter with penicillin) was wrong,[148] and that infecting Guatemalans with syphilis to test whether penicillin could treat the disease was also wrong,[149] and has apologized for both experiments. Prime Minister Mulroney apologized in 1988 for Canada's internment of Japanese Canadians during World War II.[150] So too a formal and full HSC apology to the Shores would have created a timely record, and obviated the following insulting (to the Shores) article in the Association of Operating Room Nurses Journal of August, 2002 pertaining to the late Dr. Jean Reeder, head of nursing at HSC at the time of Lisa Shore's death:

> In 1998, there was a medical error resulting in a child's death in the facility where Jean was employed. She told the nurses involved that she was concerned about how the incident and subsequent investigation were affecting them, but she also told them that it was her responsibility to assess their nursing practice and that they, together, had to do the right thing for the family. She lived by her belief that nurses are responsible and accountable as professionals for the nursing decisions they make and actions they take.
>
> This incident was not resolved fully at the time of Jean's death. Until she died, Jean continued to believe that the nurses involved did not inflict intentional harm on the patient. She said that systems issues contributed to the event, mistakes were made, and the family deserved better. Jean recognized the organizational, professional, and personal consequences of sentinel events and strove to help others learn from this particular event. She did not want anyone to make the same or a similar error. The death of this young child deeply affected Jean.

147 Ibid at pp. 1274-1275.

148 For a video of President William Clinton's May 16, 1997 apology see www.youtube.com/watch?v=l1A-YP24QwA. See www.cdc.gov/tuskegee/clintonp.htm for the text of President Clinton's apology. For a comprehensive treatment of this disgraceful Nazi-like medical experiment see James H. Jones. *Bad Blood: The Tuskegee Syphilis Experiment* (New York: The Free Press, 1993).

149 For a description of the October 1, 2010 apology delivered by U.S. Secretary of State Hillary Clinton and U. S. Health Secretary Kathleen Sebelius to Guatemala, see Olivia Ward, "U.S. Infected Guatemalans with syphilis: Top government officials make startling apology for experiments on 696 prisoners in 1940's", The Toronto Star, Saturday, October 2, 2010 at p. A19.

150 See Susan Alter, "Apologising for serious wrongdoing: Social, psychological and legal considerations", Final Report of the Law Commission of Canada (May, 1999) at pp. 5, 7, 15.

> Those who knew her best had a sense of how much this influenced Jean's life and her subsequent efforts related to patient safety (footnotes omitted).[151]

Had a responsibility-admitting apology (like the one which follows) been made, the Shores would never have had to confront objectionable revisionist history about the various roles health care providers played in Lisa's death and in the ensuing cover-up.

A seven year old being treated for leukemia died at B.C. Children's Hospital. The child was to have received four different chemotherapy drugs. One drug was to be injected into her blood and the other three into her spinal fluid. The drug Vincristine was the drug to go into the blood. It is highly neurotoxic and almost always lethal when injected into spinal fluid. In error, Vincristine was injected into the child's spinal fluid with a catastrophic result—death. Lynda Cranston, President of B.C. Children's Hospital stated:

> We commit to them and to British Columbians that we will do everything in our power to learn from this error so that such a tragedy never occurs again. We must do better and honour the memory of this little girl....There are no words that can adequately communicate our apologies or regret to this girl's family....There is nothing we can do to bring their child back to them and we are devastated by that knowledge....It is clear that in this case the policies and procedures were not sufficient.[152]

It is critical to note that in addition to what is set out in this quotation, Ms. Cranston acknowledged the medication error, asked the family to forgive the mistake, acknowledged the lethal nature of the drug going into the spinal fluid, advised that the treating physician was devastated and had given up clinical medicine for research and further advised that the treating doctor had apologized to the family and had reported himself to the B.C. College of Physicians. All of this was done within 3 days of the death, and while simultaneous coroner's and hospital investigations were ongoing. One might infer that all of this was attributable to the national publicity generated by the Shore Inquest; however, this child's death occurred on June 3, 1997, 16 months before Lisa Shore died.

7. CONCLUSION

I began this paper with a discussion of *Lex Talionis*. It is necessary to return to the *Lex Talionis* principle in order to have a contextual overview of apology in general and specifically of apology in the medical sphere.

The *Lex Talionis* "eye for an eye"[153] model is completely incompatible with "The Golden Rule" and indeed is a perversion or devaluation of "The Golden Rule". Our parents taught us as young children to "treat others as you want to be treated"[154] or to "treat others only as you consent to being treated in the same situation".[155] The Golden Rule

151 Suzanne C. Beyea et al, "Lessons about patient safety from Jean Reeder-Patient Safety First", (2002) Association of Operating Room Nurses (AORN) Journal available at www.findarticles.com/p/articles/mi_m0FSL/is_2_76/ai_90749865/?tag=content;col1.

152 Canadian Press, "Girl Dies After Drug Wrongly Injected", The Globe and Mail, Friday, June 6, 1997 at p. A8.

153 Supra note 24.

154 See "The Golden Rule" at www.jcu.edu/philosophy/gensler/goldrule.htm.

155 Ibid.

encourages the offender not to harm the victim in the first place—don't harm "the other" because you wouldn't want similar harm inflicted upon you. This is particularly the case in those highly emotional situations involving the unexpected deaths of children in healthcare facilities. As Dr. Kübler-Ross has remarked, there is often a cycling through the five stages of grief which means that the survivors don't enter or leave denial, anger, bargaining, depression and acceptance in a linear or an orderly fashion.[156] Who more than physicians ought to understand these psychiatric concepts; yet the inability of doctors to effectively and meaningfully apologize bespeaks a discomfort with the emotions that infuse "The Golden Rule".

It is arguable that the civil litigation process itself embraces a *Lex Talionis* approach; for to involve the arguably negligent healthcare provider in the litigation process—at least in common law jurisdictions—inflicts significant pain on the healthcare provider. This must bring some measure of satisfaction to the families of deceased children, at least in the short term, because the victims through the lawsuit process itself achieve a rough kind of justice: vengeance. The problem with all of this is that it fails to recognize the very toxic effects of litigation on all of the litigants. As Cohen and Vesper so accurately state:

> Neither the claimant nor the defendant can escape the emotional stress of litigation. Both expect to emerge victorious, yet neither party is aware of the psychological price of the process. Lengthy investigations, complex laws, unfamiliar language, and adversarial interchanges create anxiety and suspicion in clients. Singlely-focused attorneys, driven by competition and zeal, heighten client emotion and distress. Some individuals can tolerate the uncertainty of the legal process, while others find it overwhelming and maddening. For these individuals, litigation is a traumatic experience creating sleepless nights and agonizing days filled with obsessive thinking, panic attacks, and fear. Intrusive thoughts of the legal case can invade daily activities and disrupt evening dreams. It is as though time has stopped for everything else except the law suit (footnotes omitted).[157]

Thus, in bringing a lawsuit to discover what happened, the dead child's family unleashes a process with detrimental "side-effects" for plaintiffs and defendants alike.

Although it sounds simplistic and somewhat naive, what we were taught as children holds some hope for us—if we as adults can strip away the years of "socialization" and return to basic precepts. If the nurses in the Shore case or the doctors in the Blake, Smith and Micalizzi cases had listened to their mothers and not their lawyers, a lot of anguish and pain could have been obviated for the families and for the healthcare providers. An apology is a vehicle of reconciliation for apologizer and apologizee alike. Whatever it leads to must obviously be better than forensic stress disorder. As such, I submit that there is little detriment to an apology, particularly in Ontario and in the Canadian provinces and territories with *Apology Act* or *Evidence Act* protection for full apologies.

156 Supra notes 28, 30 and 36.

157 Larry J. Cohen and Joyce H. Vesper, "Forensic Stress Disorder", (2001) 25 Law and Psychology Review 1 at pp. 4—5.

It is important to consider the views of ethicists and legal scholars on both sides of the question of whether apology when insincere or cynical may, by reducing compensation to the victim (who gets some satisfaction and healing from a counterfeit apology) cheats the victim out of just compensation for the loss of his or her child. Taft calls this the "Commodification of Apology"[158] and he makes a fairly persuasive argument that by protecting apologies, we encourage fake or insincere apologies—which are done for purely tactical/monetary reasons.

> If the apology is made at the insistence of a mediator or encouraged by a lawyer as a strategic choice during a mediated proceeding, the moral process is potentially corrupted, the moral dialectic challenged. At the very least, it is proper to question the legitimacy of an apology in such a context. Such an apology occurs in an environment that values and encourages bargained-for exchange, and such an apology may be prompted more by a desire to expedite settlement than to respond to a call to repent. When the apology is shrouded with legal protection, when it cannot be considered an admission, when no legal consequence can attach to the party through the apology, apologetic discourse moves from potential to actual corruption. The moral process of apology in such a protected environment is now subverted (footnotes omitted).[159]

Taft argues that for an apology to be morally authentic, it must be made in a morally meaningful manner. Taft concludes:

> I close with the hope that I have convinced those who are engaged in mediation that apologetic discourse is an intensely moral discourse, yet subject to subversion when viewed as a commodity. I hope this Essay leads those who participate in the mediation process to consider carefully the purpose of apology. If it is not an authentic response by an offender to a call to repent, then those who participate in mediation ought not to subvert this moral ritual for strategic purposes. In those cases, all must be satisfied with resolution without reconciliation, and trust the offended party to find healing in another quarter.
>
> I have shown that the law can accommodate authentic apology, and that this performative act can in fact be fostered in the context of civil mediation. Authentic apologetic discourse occurs in an environment where the participants respect apologetic discourse as a moral activity and resist subverting the discourse for strategic and instrumental purposes. What this suggests is that there are spaces in law where apologetic discourse can lead to the kind of healing I originally envisioned for my clients. Yet these spaces must be understood as interstices within a system that focuses on rights and duties rather than on restorative acts. After all, the law is a "blunt instrument," a tool better suited for telling people what to do and how to behave than how to care for each other. For this reason, a litigant's

158 Lee Taft, "Apology Subverted: The Commodification of Apology", (2000) 109 Yale Law Journal 1135.

159 Ibid at p. 1156.

> quest for healing must often extend beyond the law into disciplines more practiced in healing hearts and souls (footnotes omitted).[160]

Professor Robbennolt, on the other hand, appears to argue in favour of protected apologies when she discusses the proposition that apologizees seem to value protected apologies as much as unprotected apologies. If this is so, she argues, then protecting full apologies (which express sympathy and admit responsibility) is the way to go. It must be emphasized that full apologies are protected by all Canadian provinces and territories which have enacted apology protection but as stated above, the full apology only has protection in a very limited number of American jurisdictions. As Robbennolt says:

> There is, then, at present, no evidence to suggest that protected apologies will be less effective or less valued by claimants than unprotected apologies. Accordingly, providing evidentiary protection for apologies may serve to encourage the offering of apologies, or at least to signal that apologies are a desired response to an injury-producing event, without diminishing the value and effectiveness of apologies so offered.
>
> To the extent that the goals of such provisions are to encourage apologies in order to facilitate settlement, however, the current statutes may be protecting the wrong apologetic expressions. The current and proposed statutes predominantly protect partial apologies and those portions of full apologies that constitute expressions of sympathy, not admissions of responsibility. The results presented here suggest that it is full, responsibility-accepting, apologies that have a positive impact on settlement decisionmaking, rather than the partial apologies that are typically protected by the statutes. Moreover, full apologies, because they are admissions, are more likely to raise defendants' concerns about adverse liability rulings and are more likely deterred by potential admissibility. At the same time, however, offering protection to full apologies may result in the exclusion of probative evidence and may limit a plaintiff's ability to bring a successful lawsuit.
>
> Accordingly, these data suggest that policy discussion ought to focus on the appropriateness of statutory protection for *full* apologies. Such policy discussion must consider the present findings regarding the beneficial effects of full apologies on settlement decisionmaking in light of other relevant considerations such as how best to encourage apologies, concerns about undue limits on the ability to bring lawsuits, the probative value of full apologies, and so on.[161]

Robbennolt is not nearly as concerned as Taft that plaintiffs may settle for less money because they are deceived by "insincere apologies".[162]

160 Ibid at p. 1160.

161 Jennifer K. Robbennolt, "Apologies and Legal Settlement: An Empirical Examination", (2003-2004) 102 Michigan Law Review 460 at pp. 504-505.

162 Ibid at p. 510.

Taft was sufficiently aggrieved by Robbennolt's apparent willingness to sacrifice morality on the altar of utility that he responded. As he put it:

> While I appreciate Professor Robbennolt's useful insights, I also have two sets of concerns about her suggestion that policy discussion focus on the appropriateness of statutory protection of the full apology. First and primarily, her empirical results—even if interpreted by policymakers as showing the efficacy of the protected full apology in promoting settlement—do not by themselves make an adequate case for legislation protecting apology. Rather, those who favor legislation protecting full apology must take into account the moral dimension of apology, and the implications of giving this moral dimension short shrift. As I explain, even a solid empirical case showing a high increase in settlement due to apology would not adequately address the moral harm of legislative protection for apology. More than utility is at stake when a legislature tailors a moral process to fit within a system that is primarily adversarial.
>
> ....
>
> My interest in responding to Professor Robbennolt is both theoretical and practical. I am a proponent of the full, unprotected apology. I believe that if we do not understand apology as part of a moral dialectic we risk subverting its moral dimension. Apology is integral to repentance, itself a complex process that when authentically performed can inspire forgiveness and reconciliation between a party injured and the one causing the injury. Repentance starts as feeling of remorse within the conscience of the party causing harm and is given voice in apology. This experience is, for some, a deeply religious process. Yet, for all, it should be an ethical and moral response to harm inflicted.

Legal scholars often give this moral dimension short shrift, especially when they evaluate apologies using a standard of legal efficacy. Yet, when utility becomes the primary standard for legislative initiatives, there is a cost to both individuals and society. This harm rises dramatically when one extracts components of moral processes and inserts them into utilitarian schemas (footnotes omitted).[163]

For our purposes it is important to keep in mind that an insincere apology or an apology that is perceived to be insincere will likely not work to effect any reconciliation but will serve to exacerbate an already bad situation. It is well beyond the scope of this paper to deal with the sociopathic or pathological apologizer who successfully fakes an apology to achieve a financially favourable result. It is my submission that it would be misguided to sacrifice genuine, albeit protected, apologies because there exists a possibility that counterfeit apologies may be misperceived by the apologizee as genuine. To do so would eliminate the majority of apologies which are genuine and which hold at least the potential to heal. Those who write about legal problem solving would in all likelihood argue that apology plays an important part in permitting negotiators to

163 Lee Taft, "Apology Within A Moral Dialectic: A Reply to Professor Robbennolt", (2005) 103 Michigan Law Review 1010 at pp. 1011 and 1014.

more effectively accomplish their goals "by focusing on the parties' actual objectives and creatively attempting to satisfy the needs of both parties, rather than by focusing exclusively on the assumed objectives of maximizing individual gain".[164]

Menkel-Meadow does not discuss apology in any detail in her article "When Winning Isn't Everything: The Lawyer As Problem Solver".[165] It is however clear that as a proponent of the view that lawyers should be problem-solvers, not modern day equivalents of mercenaries for hire, she believes:

> In the vastly changing multi-cultural and international context in which lawyers do their work, processes like negotiation, mediation, consensus building, and other forms of facilitated communication will be essential to bridge the language, cultural, and legal divides of the parties to any dispute or transaction. To negotiate or mediate is to use communication to achieve results for groups of people who cannot do it alone. Lawyers have an opportunity to serve as leaders of a hybridized "bridge" discipline, which can, on its good days, speak to different kinds of people. To the extent that traditional lawyers speak only the adversarial language of litigation and winning, they will be used narrowly for only one function, trial work, when that function is increasingly wasteful and inefficient, as well as emotionally draining, on most, if not all, of the players. Being a problem-solver has been, for me, far more creative, empowering, and exciting than the times I have spent using a stylized and specialized, but limited, vocabulary of thought and language in the courtroom. Even as tough a lawyer as the hero of A Civil Action, Jan Schlictman, now touts mediation to avoid "the total war of litigation". Bob Bennett, the President's lawyer in the Paula Jones case, said recently of the settlement, "sometimes you have to rise above principle". To the extent that processes like negotiation and mediation open up broader passages of communication and allow more creative forms of thought than the boilerplate of form contracts or the bargains extracted "in the shadow of the law", legal work, for both lawyer and clients, will be improved as more creative forms of problem solving are pursued (footnotes omitted).[166]

Although it hardly seems creative, the following vignette illustrates what seems to be the prevailing contemporary attitude amongst academics who write about medical apology. It is surprising that this approach does not seem to be the norm, nor is it encouraged by The CMPA and HIROC in Canada:

> The story of Linda Kenney and her routine ankle surgery is an example of the power of apology. During her surgery, Ms. Kenney's anesthesiologist, Frederick van Pelt "inadvertently injected a painkilling drug in the wrong place, causing [her] heart to stop."

164 Carrie Menkel-Meadow, "Aha? Is Creativity Possible in Legal Problem Solving and Teachable in Legal Education?", (2001) 6 Harvard Negotiation Law Review 97 at p. 98.

165 Carrie Menkel-Meadow, "When Winning Isn't Everything: The Lawyer As Problem Solver", (2000) 28 Hofstra Law Review 905.

166 Ibid at pp. 921-922.

To remedy the situation, doctors had to split open Ms. Kenney's ribcage, a surgery from which she ultimately recovered. The anger over the entire situation drove Ms. Kenney and her husband to seek legal representation. Dr. van Pelt, however, refused to follow his hospital's protocol following the accident and "wrote Ms. Kenney a personal letter saying he was 'deeply saddened' by her suffering." Ms. Kenney and her former doctor later met for coffee where he apologized for the incident. Through these interactions, Ms. Kenney realized that the doctor "was a real person" and she was impressed that "[h]e made an effort to seek [her] out and say he was sorry [she] suffered", "and she ultimately abandoned her plans to sue" (footnotes omitted).[167]

Lucian Leape M.D. advocates a prompt apology. As Leape says:

> Apologize at once. Compassion defuses anger and begins to restore trust. If investigation shows that the injury was caused by an error, then a "true" apology should be made. Two elements are essential: accepting responsibility and showing remorse. An apology also helps physicians deal with their feelings of shame and sets the stage for forgiveness by the patient.[168]

Leape's view is echoed by Hickson et al[169] who summarize their findings that patients sue because of poor physician communication with families and patients' perceptions that they have been misled:

> Others indicated that they filed when they finally realized their child would have no future (20%). For example, "The baby was a year old and we realized she was never going to be normal."
>
> The same percentage said they filed when they decided that the courtroom was the only forum in which they could find out what happened from the physicians who provided care. For example, "We couldn't understand, and no one would tell us what went wrong with her."
>
> ....
>
> Most respondents complained about at least one aspect of physician-family communication. Of all families interviewed, 32% believed that their physicians would not talk or answer questions, 13% that their physicians would not listen, 48% that their physicians had misled them, and 70% that no one involved in providing medical care during the perinatal period ever told them that their infants might have permanent medical problems or die.[170]

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167 Ashley Davenport, "Forgive and Forget: Recognition of Error and Use of Apology as Preemptive Steps to ADR or Litigation in Medical Malpractice Cases", (2006) 6 Pepperdine Dispute Resolution Law Journal 81 at pp. 101-102.

168 Lucian Leape M.D., "Disclose, Apologize, Explain", Newsweek, U.S. Edition, October 16, 2006 at p. 50.

169 Gerald Hickson et al, "Factors That Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries", (1992) 267 Journal of the American Medical Association 1359.

170 Ibid at p. 1361.

The authors go on to say:

> Our results also suggest that communication problems between physicians and their patients contribute to many decisions to file malpractice claims. Even when physicians provide technically adequate care, families expect answers to questions and want to feel as though they have been consulted concerning important medical decisions. If these expectations are not met, even patients who have not experienced adverse outcomes will become angry and express dissatisfaction with care.
>
> Our respondents identified two general types of communication problems. They believed that some physicians had misled them and that others simply would not listen or answer their questions. Some families who believe that they were misled may have come to that conclusion when what they remembered hearing about their children's prognoses differed from actual outcomes.
>
> The sources of such discrepancies may be many. Some families may well be correct when they complain that their providers did not tell them the full story. Few physicians are eager to share bad news. Physicians may feel that they are trying to preserve some hope for the family by withholding the full details of an infant's grim prognosis, while others may fear getting sued. The responses of families also contribute to misunderstandings about expected outcomes. They may not understand medical terminology or may fail to raise their most deep-seated concerns or seek clarification of points about which they are confused, either because they have been acculturated not to ask questions or because they are intimidated or made anxious by discussions with physicians. Other families may experience denial as a part of grieving; some who are given bad news later deny that they were ever given information. To point out these sources of misunderstanding is not to say that families somehow ought to "understand better." Rather, it is to suggest that physicians should be aware that some families have trouble understanding or remembering what they hear so that an attempt can be made to overcome these barriers to communication. It also suggests that physicians would be well advised to make contemporaneous records of what they tell families, especially with respect to children's long-term medical problems.
>
> Physicians' difficulties in sharing information and families' problems in hearing what has been said also may have contributed to the perception of some families that they could not find out what had happened. Several studies suggest that physicians and patients have differing ideas about the amount and type of information that can or should be transmitted. Parents' desire for information may go beyond specifics of diagnosis and treatment options. Many need information to help them cope and to deal with feelings of guilt and loss that may accompany a devastating pregnancy outcome.

Some families' requests for information are simply unmeetable. For example, physicians are frequently asked why a child has cerebral palsy, but in a majority of cases there are no clearly identifiable antecedents. Physicians struggle with what to do in the face of requests for unobtainable information. Those who tell parents that there are no clear answers may find that families are unhappy. Other physicians, perhaps less comfortable with uncertainty or parental dissatisfaction, may try to offer answers only to find that families are unhappy when things turn out differently than predicted. Not all misunderstandings, however, are the result of physicians' well-intentioned efforts to provide information in the face of uncertainty. Some physicians simply fail to appreciate the full extent of patients' informational needs. In other instances, including some cited by our respondents, physicians actively avoid families after bad outcomes, are not available, have brusque personalities, or, in fact, provide incorrect information.

Our study suggests that patients who sue physicians are not a homogeneous group in that they offer an array of reasons for claiming. The reasons offered for filing are, in turn, affected by families' views of their relationship with physicians. Frequently patients are disappointed or angered when they perceive problems in communication with their doctors. This is hardly surprising, but it makes clear that physicians still have much to learn about what their patients want to know and how to convey such information effectively.

In addition, institutions, boards, and societies charged with medical education must redouble their efforts to train physicians to be better communicators. Physicians need to understand that families need detailed information and often do not hear what is said. Providers may need to discuss the same issues with families several times. All students must be taught to be forthright, to answer families directly and to be honest, even when the message is unpleasant.

Our results, however, also suggest that not all interactions between physicians and families who file suit are characterized by a lack of candor. In particular, many families said they sued because doctors told them that their children had been injured by negligent care. While one might question whether telling parents about earlier inadequate care is an efficient way of policing the profession, one can argue this is information to which parents are entitled. A physician's real obligation is to ensure that his or her representations regarding earlier care are fair and appropriately informed (footnotes omitted).[171]

It is readily apparent that Hickson et al considered many of the issues discussed by Kübler-Ross in her writings on death and dying. They also scientifically studied what motivates patients to

171 Ibid at pp. 1362-1363.

transform into plaintiffs. The article is an important contribution to those of us who study apology as a prophylactic to litigation.

In his 2005 article "Apology and Medical Mistake: Opportunity or Foil?",[172] Taft discusses a physician-friend's dilemma. The friend made a mistake and wanted to apologize to the patient. The doctor's lawyer and his risk manager both advised him not to apologize. As Taft put it:

> I write to counter the kind of advice and systemic perceptions that lock a physician within this "intolerable dilemma." The purpose of this essay is to explore the healing possibilities of apology in the face of medical mistake. My thesis is that the authentic expression of remorse should be given voice, not only because morally and ethically it is the right thing to do, but also because it is potentially spiritually healing for both the patient and the physician. I will demonstrate that when cast into a legal arena, the authentic expression of remorse carries additional practical benefits that outweigh the real and presumed risks that lead lawyers, risk managers, and insurers to give advice like that provided to my friend. Hopefully, proof of the moral and practical dimensions of authentic apology will inspire physicians and others in the health care industry to think more critically in the face of advice that interrupts their moral inclinations and garner sufficient courage to "bring medical mistakes out of the closet (footnotes omitted)."[173]

The reason that Taft is against both partial apologies (which express sorrow without admitting responsibility) and statutorily protected full apologies is that:

> Apology is much more than a conveyor of information. It is the centerpiece in a moral dialectic between error and forgiveness. Its purpose is to give voice to repentance through the expression of sorrow and the admission of wrongdoing. These two elements are essential, so that the absence of either renders the apology incomplete and interrupts its moral dimension. In its authentic expression, apology is an invitation to the party harmed to extend forgiveness and, thus, provide the opportunity for reconciliation. Its ultimate end is healing for both the party who has inflicted harm as well as for the one who suffers. It is healing for the party who has erred because the one who risks apology demonstrates moral courage by speaking a truth that carries potentially grave consequences. Yet paradoxically, it is the taking of risk that also restores one's integrity with the party harmed, with one's self, and with the community. The receipt of apology sparks healing in the party harmed, not only because it restores moral balance by demonstrating the regard and care in which the party harmed is held by the party causing injury, but also because apology invites the party harmed to extend forgiveness, itself a courageous and moral act (footnotes omitted).[174]

172 (2005) 14 Annals of Health Law 55.

173 Ibid at p. 59.

174 Ibid at pp. 71-72.

The conclusion that Taft reaches is compelling and ought to be considered notwithstanding the presence of legislation protecting full apologies in most Canadian jurisdictions:

> The empathic disclosure that admits no wrongdoing is like a "botched apology". It informs, it expresses regret, but it does not heal. Ultimately, a disclosure without authentic apology lacks the central element required to restore moral balance. Without an admission of wrongdoing, it does not and should not, inspire forgiveness. It is the confession within authentic apology that invites healing and it is this healing that physicians who err seek.[175]

Though Professor Jonathan Cohen advocates "responsibility-taking", he does acknowledge that denying the offence may be economically sound. Notwithstanding this, Cohen argues for responsibility-taking and for paying damages. This approach is reminiscent of Taft's.

> Let me be clear that I am not asserting that in every case responsibility-taking will be economically beneficial to the injurer. In many cases, responsibility-taking may well be economically costly. Indeed, under our system of ordinary compensatory damages, economically speaking, denial may at times become a nearly "no-lose" gamble. Though deeply problematic morally, denial often makes economic sense. Regardless, I suggest that, in all but extremely unusual cases, denial is an act of moral regression, and hence poses significant spiritual and psychological risks to the injurer. In some cases, particularly when long-term effects are considered, it is likely to be economically costly as well (footnotes omitted).[176]

Like Taft, Professor Cohen concludes that "people commonly, but mistakenly, attempt to justify what should be (the normative) based upon what is (the positive). Even if denial after injury is the common response, it remains immoral".[177]

In an earlier article Cohen put it succinctly as follows:

> Next comes responsibility. By responsibility, I do not mean a broad set of moral duties. Rather, I mean a specific course of action, namely, an injurer actively taking responsibility after harming another. If the basic moral axiom is "[d]o not harm others," surely the first corollary to that axiom is to take responsibility if you do. Apologize for the harm and seek to make amends. Frequently this will include *offering* fair compensation. To see how far astray from this moral practice we are now, consider the contrast between how we teach children and how we teach adults to respond to harms they commit. If a child injures another, good parents will teach the child to take responsibility for her actions. If an adult injures another and goes to a lawyer, the usual focus is on precisely the reverse: denial. The goal is to avoid responsibility, or if that is not possible, minimize liability. This pattern is not only morally bizarre, but it is likely psychologically and spiritually harmful to the

175 Ibid at p. 73.

176 Jonathan R. Cohen, "The Immorality of Denial", (2004-2005) 79 Tulane Law Review 903 at p. 943.

177 Ibid at p. 947.

> injurer in the long run. Unlike the defense attorney, a minister or psychologist would typically urge an injurer to face the results of the injurious conduct and to take responsibility for it. Ultimately, we must change from being a society where denying the injuries we commit is the norm, to one where taking responsibility is the norm. Injurers need to learn to place morality above money. The moral lesson we teach children is also the one we should practice as adults.[178]

It is important to recognize that the doctor-patient relationship (and for that matter all relationships between healthcare workers and their patients) is probably the most fiduciary of all fiduciary relationships; for the doctor touches, explores and examines the patient, and then discusses the most intimate of bodily functions with him or her. In this context:

> ...apologies are vital to professional relationships because honesty is central to these fiduciary associations. Apologies can cement the relationship by emphasizing the victim's importance to the professional and the professional's loyalty to the victim. Professionals who do not apologize run the risk of alienating their clients and losing their trust.[179], [180]

Orenstein's feminist analysis yields insightful commentary. As she states:

> Disclosure alone is not enough to heal the breach caused by a medical error. Information alone, though useful, is more meaningful and more acceptable if offered in the context of remorse and regret. From a strictly physical vantage point, disclosure may remedy the potential harm and address classic legal concerns with autonomy. But a feminist approach to the relationship, recognizing that the harm done by a doctor's error affects a vital connection between doctor and patient, demands more. The patient needs to know that the doctor is sorry because that validates the relationship and the significance of the patient. Apologies, because they are personal and emotional, provide a remedy that traditional tort law simply cannot provide.

This concern to know the facts, receive an apology, and the assurance that the loved one mattered to the doctors and the medical establishment, is also accompanied by the desire to make sure such tragedies do not happen again. In the largest sense, the concern that the error not be repeated reflects an ethic of care for the entire community. The motive strikes me not so much as punitive regarding the doctors, but purposeful—stemming from a desire to make some sense out of tragic and unnecessary loss, and a hope that the lessons from a loved one's death will spare others. Obviously, if the doctors

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178 Jonathan R. Cohen, "Let's Put Ourselves Out of Business: On Respect, Responsibility and Dialogue in Dispute Resolution", (2003-2004) 108 Pennsylvania State Law Review 227 at pp. 229-230.

179 Aviva Orenstein, "Apology Excepted: Incorporating A Feminist Analysis Into Evidence Policy Where You Would Least Expect It", (1998-1999) 28 Southwestern University Law Review 221 at p. 256.

180 It is interesting to contemplate what might happen to a lawyer who advises a doctor to apologize—and after such an apology the doctor gets sued nonetheless. In such a case, might the doctor sue the lawyer for giving him bad advice—the advice to apologize? This very situation arose in Texas where a doctor apologized for mistakenly removing a patient's non-cancerous lung. See Linda Campbell, "Doctor Loses Suit Against Lawyers", Fort Worth Star-Telegraph, April 30, 1998 for a description of this fiasco.

> stonewall and pretend nothing untoward took place, the family is deprived of its need to make sense of the tragedy and express its grief through positive action (footnotes omitted).[181]

To return to the apparent disagreement between Robbennolt (who advocates protection for full apologies) and Taft and Cohen (who are skeptical about the moral integrity of protected apologies), I believe that apologizees are more than capable of evaluating the moral genuineness of apologies. As I have already stated, a bogus or counterfeit apology is dangerous for the apologizer as it incorporates the inherent risk of detection by the apologizee. The bogus apology therefore increases the harm to the victim, inflames the situation and inflates the financial compensation payable. It would be expected that for most, the risk of detection is therefore sufficient deterrence to preclude the apologizer from engaging in bogus apology in the first place. Consequently, I would leave it to apologizees to assess the sincerity of apologies and not worry too much about the possibility that the apology legislation we have enacted in Ontario will serve to neuter apology of its moral dimension:

> In fact, victims are often quite discriminating in their responses to apology. The nuances of apology matter a great deal to a judgment of the apology's sincerity. Victims scrutinize everything from context to word choice and order, timing, elaborateness, eye contact, breath, body posture, facial expressions, tone of voice, and pace of speech. In fact, where sincerity is important, written apologies alone are typically much less effective than face-to-face communication. Simple apologetic gestures may suffice for very slight harms, but a more complex apology is typically demanded for more severe harms. And partial apologies, or apologies that do not accept blame, can actually increase the victim's spiteful feelings (footnotes omitted).[182]

In a fascinating article entitled "Interest Based Mediation of Medical Malpractice Lawsuits: A Route to Improved Patient Safety?"[183] the authors discuss the results of a feasibility study called Mediating Suits Against Hospitals. The authors point out that in the thirty-one cases they mediated "Not a single physician attended a....mediation".[184] The authors had previously mediated cases where physicians had attended and found physician attendance very valuable:

> In two mediations of wrongful death claims for the demonstration project, the chief of medicine participated and with humanity, thoughtfulness, and empathy was able to describe to both surviving spouses changes in hospital procedures based on what had been learned from these cases. He addressed the lack of adequate communication between the physicians and the surviving spouses and steps that would be taken to prevent such lapses in the future.[185]

181 Supra note 179 at p. 268.

182 Erin Ann O'Hara, "Apology and Thick Trust: What Spouse Abusers and Negligent Doctors Might Have in Common", (2004) 79 Chicago-Kent Law Review 1055 at pp. 1067-1068.

183 (2010) 35 Journal of Health Politics, Policy and Law 797.

184 Ibid at p. 807.

185 Ibid at p. 801.

The authors support my contention that for mediations to be meaningful, the apologizer must attend and must show humanity and compassion. It is only with this human bonding that the mediation holds some prospect of improving what is clearly a disaster for all—the unexpected death of a child. The healthcare provider's participation in the mediation is critical. Without it, I submit that all the process can do is shuffle around money—an unfortunate and unnecessary limitation.

> Defense lawyers often explained their failure to bring physicians to the mediation by citing the physicians' work schedules or stating that they wanted to protect their clients from the discomfort of being subjected to a verbal attack from the plaintiff. They did not seem to consider the physicians' own emotional needs after a patient has been harmed by medical care and the possibility that participation might have been helpful to a physician coping with feelings of guilt or remorse. Perhaps, being familiar only with evaluative forms of mediation focused on money, defense counsel may have doubted that a physician's needs could be met in the mediation setting.
>
> Lawyers, hospital representatives, and insurers did not seem to understand many of the benefits of mediation. The nonparticipation of physicians limited the ability of participants to improve physician-patient communication or seek information to prevent recurrence of the adverse event or medical error. Benefits of mediation can be realized only when both the plaintiff and a health care provider familiar with events participate. When only the lawyers (or the lawyers and the plaintiff) attend the mediation, the primary focus is likely to be money. While there is value to finding a dollar amount that will settle a claim, this limited vision misses opportunities for patients, family members, and health care professionals to exchange information that may lead to improvements in how institutions communicate with patients or, in some instances, improvements in the way care is delivered. In addition, participation by physicians in the mediation creates the potential for repair of the relationship between the physician and the patient or family member. Given research findings of patient and family members' needs after a medical error, it is possible that plaintiffs would have been even more satisfied with the process had their physicians demonstrated respect and caring by attending the mediation, listening to their accounts of suffering, and answering their questions.[186]

The question then arises whether a delayed apology is a devalued apology. Since mediation often takes place four or even more than four years after the child's death, is it too late for the nurses and doctors to attend the mediation and apologize when they haven't heretofore apologized? As Sharon Shore has poignantly put it almost 13 years after Lisa's death "It is still not too late. I am here".[187]

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186 Ibid at page 817.

187 Supra note 115.

This issue of belated or delayed apology is a topic for discussion in and of itself and a complete treatment is well beyond the scope of this paper. Suffice it to say that the topic recurs—as recently as March 29, 2011.[188]

In one of the most moving and eloquent speeches I have ever seen or heard, President Clinton apologized to the victims of the Tuskegee Bad Blood experiment.[189], [190] The apology was delivered in person by the President to five survivors and to family members of those who had died. The apology was on May 16, 1997, some 25 years after the horrific experiment was terminated. President Clinton emotionally stated that the United States had "failed to live up to its ideals", "broke the trust with our people that is the very foundation of our democracy", must "make amends", must "repair our nation", must apologize for having "betrayed" its citizens, had "lied" to its citizens, had "trampled upon" their rights, did something "deeply, profoundly, morally wrong", and engaged in "an outrage to our commitment to integrity and equality for all our citizens". The President characterized the behaviour as "shameful" and he apologized for it and also for the belated apology ("I apologize and I am sorry that this apology has been so long in coming"). He apologized for the "clearly racist study", and talked about the many steps that would be taken by way of reparations. President Clinton's apology is a model of inclusion of all of the components that the apology theorists advocate must be present for an apology to be effective. One must contrast President Clinton's words and demeanour with the hollow and emotionless words of Dr. Jean Reeder as delivered at the Shore Coroner's Inquest.[191]

As I believe that apology in the context of medical error and adverse events falls within the more general topic of societal apology, I spent a morning with Dr. Izzeldin Abuelaish, a truly remarkable human being. On January 16, 2009, Dr. Abuelaish, a Palestinian obstetrician/gynecologist who was working in the public health field in Tel Aviv, Israel was home with his family in the Gaza Strip. Dr. Abuelaish was a beloved figure in Israel, well integrated into the Israeli medical establishment and into greater Israeli society. His patients were mostly Israelis. He spoke fluent Hebrew. He had scores of friends in the Israeli medical and general communities and in the Israeli media. On January 16, 2009, during an Israeli offensive in Gaza, the Israeli Defence Forces blew up Dr. Abuelaish's house, killing his three daughters and his niece. Dr. Abuelaish had lost his wife to leukemia on September 16, 2008. The shelling of his house and the devastation to his family occurred a mere four months later. On December 26, 2010, just within the two year Israeli limitation period, Dr. Abuelaish sued the Israeli Government for compensation and for an apology. In the two years after the deaths:

> Abuelaish has devoted much of his energy to lobbying Israeli authorities through

188 See Shawn Pogatchnik, "'It has been a long time coming': Britain apologizes for 1976 slaying of girl, 12, in IRA stronghold", The Toronto Star, Tuesday, March 29, 2011 at p. A13. In this article, Pogatchnik, an Associated Press writer describes the private meeting between Owen Paterson, Secretary for Northern Ireland and the late Majella O'Hare's family members in which the O'Hares were presented with an official apology letter signed by Defence Secretary Liam Fox. This "was only the second time that Britain has said it was sorry for a killing committed by its forces in Northern Ireland". Majella's father saw her shot in the back while she was walking to church to give her confession. The father died in 1992, long before the apology. The shooter was acquitted of manslaughter by Justice Maurice Gibson, a Belfast judge. The IRA later assassinated Judge Gibson. The case is a perfect example of why Israel should heed Dr. Abuelaish's call for an apology (Infra note 195). It is a case study of the escalating cycle of violence that Dr. Abuelaish is trying to avoid. As such, though the case is a sample of delayed apology, it also stands for the proposition that a prompt apology may avoid retribution and much anguish for all.

189 For the video of President Clinton's apology see www.youtube.com/watch?v=l1A-YP24QwA. Site last visited March 22, 2011.

190 For the text of President Clinton's apology see www.cdc.gov/tuskegee/clintonp.htm. Site last visited March 22, 2011.

191 Supra note 75 and the Appendix for the actual audio of Dr. Reeder's apology.

informal channels, in hopes of securing a full apology for the killings as well as monetary compensation to benefit his foundation. But the answer was no.

"Despite the severe outcome, from a legal standpoint our stance is that the operation during which Dr. Abuelaish's family members were hurt was an operation of war," the Israeli defense ministry's legal advisor Ahaz Ben-Ari, said recently, according to Israeli media reports. "Therefore the state of Israel does not carry the responsibility for the damage it caused."

It was this refusal that triggered Abuelaish's decision to proceed with a lawsuit, and legal papers were filed Sunday with the Jerusalem district court.[192]

As Dr. Marek Glezerman, Chairman of the Hospital for Women and Deputy Director, Rabin Medical Center in Israel says:

> What the Israeli authorities have come out with so far isn't sufficient. If a formal investigation comes to the conclusion that a huge mistake has been made, as it seems it has, the army should admit it in a straightforward and candid way—and apologize and take responsibility.[193]

Dr. Abuelaish spoke at a press conference held at the Israeli hospital where his daughter and his niece were being treated. As he described it, he felt re-victimized, as if his daughters had been killed all over again when an Israeli woman suggested to Dr. Abuelaish that the Israeli attack must have been precipitated by Dr. Abuelaish hiding weapons in his house, providing safe haven for Hamas or otherwise assisting Hamas. Indeed, one person watching the press conference suggested that Dr. Abuelaish's daughters and niece had been killed by a Hamas rocket and not by Israeli fire.[194]

All of this supports the literature which enunciates that when an apology is delivered, it prevents a distortion of events and self-attributes responsibility to the apologizer, while vindicating the apologizee of any moral responsibility for the event.

What then does Dr. Izzeldin Abuelaish think about apology in general and medical apology in particular?

> I want an apology because the current situation is a vicious circle. No-one is willing to move forward. If we want to move forward, and that's what I am determined to do, we have to change course. To change course is to go from a position where we defend ourselves and justify our actions and blame the other to a position of goodwill. We take responsibility and we are accountable as Palestinians and Israelis. This comes from speaking the truth. It helps all of us when we speak the truth and refrain from blame. Truth requires courage.

192 Oakland Ross, "Gaza doctor sues Israel over deaths: Toronto resident whose daughters were killed during military operation wants compensation", The Toronto Star, Tuesday, December 28, 2010 at p. A4.

193 Dr. Izzeldin Abuelaish. *I Shall Not Hate: A Gaza Doctor's Journey* (Toronto: Random House Canada, 2010) at p. xiii (from the Introduction by Dr. Marek Glezerman).

194 Ibid at p. 163.

To say “I made a mistake” is a value we must practice and we must teach it to our children so it can be practiced in future generations.

If we care about our children then we must teach them that not telling the truth is harmful to everyone.

The victim needs healing and needs to move forward. This cannot happen while the victim is plagued with nightmares, hate, revenge and self destruction. I am sure that the perpetrator when he hides or distorts the truth is also suffering. Is the perpetrator sleeping? Is the perpetrator living a normal life? The perpetrator who denies the truth suffers, just as the victim suffers.

When there is no apology, there is a corruption of societal values. We are all interdependent. The failure to tell the truth affects the moral fibre of all of us and affects the functionality of all of those in contact with the perpetrator and the victim.

> Reconciliation requires truth. Without truth then conflict will continue.[195]

I asked Dr. Abuelaish about the Janice Blake case and The Defibrillator Which Didn’t Defibrillate. Dr. Abuelaish responded by asking –

How can I help them heal? I have to keep in touch with them and determine how I can help them. My actions must confirm the words of apology. I have to visit them and call them on Janice’s birthdays. I have to try to connect with them. We as doctors must show humanity and behave in a humane way. We are healers. If we are healers and we don’t practice healing then what is the value in what we do? We heal others, but we need others to heal ourselves. To help the Blakes requires more than a one time meeting. The connection must be infused with meaning and action. I must feel it and translate it into action. When I do, the Blakes’ reaction will radiate back to me; for after all I, the physician must also recover from this tragedy.[196]

I asked Dr. Abuelaish whether there are certain enormous injustices, such as the deaths of his daughters, where apology cannot lead to forgiveness. Dr. Abuelaish described anger, anger over his daughters’ deaths as “an acute disease”.[197]

> Anger comes and goes but one cannot lose control and disconnect. One must direct anger into positive energy in an effort to correct the situation which gave rise to anger. One needs time to think. One has a choice to retaliate or to attempt to do something positive. If one exacts revenge then all are worse off. The

195 Author interview with Dr. Izzeldin Abuelaish on March 11, 2011.

196 Ibid.

197 Ibid.

> Koran says that if one endures patiently and forgives, God will reward you.[198]

I suggest that if Dr. Abuelaish is to be believed, then he should be considered for the Nobel Peace Prize. Just as one must assess the credibility of an apologizer when he or she delivers an apology, so one must assess Dr. Abuelaish's credibility. One can do this by reading his book and by talking to him. As a physician and healer he has much to offer in terms of his insights. As a victim of an unspeakable tragedy he knows what must infuse an apology in order for it to be genuine.

As Dr. Abuelaish has said:

> Anger and hate are self-inflicted. You drown in these emotions. They destroy your life and they impact on the lives of all those around you. You must forget the anger and forgive yourself for forgetting the anger. I don't want to be labelled a victim. By forgiving oneself one moves from victimhood to survival, to life.
>
> It is necessary that we encourage perpetrators to ask for forgiveness. The victims are waiting to forgive. The victim asks "why is he (the perpetrator) not coming?" The victim will gain strength from forgiveness. The perpetrator will be valued and highly respected by the apology. The cycle of apology and forgiveness spreads; it is contagious in a positive way; it impacts society.[199]

If this is so in the context of the horror inflicted on Dr. Abuelaish's family, we must mark his words when we study ways to deal with the iatrogenic deaths of children.

I have tried to highlight some of the major issues in order to improve the discourse of apology in the context of unexpected deaths of children in healthcare facilities. I have created the trilogy of tragedy for use as stand-alone modules in mediation courses, seminars and hopefully in ethics courses in medical schools, in order to advance the pedagogy of apology. As I said in the Introduction, my goal was to "add something valuable" to the discourse on apology. I sincerely hope that I have done so. The unexpected death of a child in a healthcare facility is a uniquely horrific event. As lawyers, mediators and doctors we must try to forge some interpersonal connections after these horribly agonizing events. To fail is to lose some of our humanity. To succeed permits us to go on—in the name of something better in the future.

The unexpected death of a child in a healthcare facility is a uniquely horrific event. As lawyers, mediators and doctors we must try to forge some interpersonal connections after these horribly agonizing events. To fail is to lose some of our humanity. To succeed permits us to go on—in the name of something better in the future.

~ G. K. Chesterton

198 Ibid.

199 Ibid.

Appendix

Audio recording of Dr. Jean Reeder's apology delivered at Coroner's Court on February 8, 2000 (see footnote 75 at p. 22).

Bibliography

1. ARTICLES

Allan, Alfred, "Apology in Civil Law: A Psycho-Legal Perspective", (2007) 14 Psychiatry, Psychology and Law 5.

Allan, Alfred, "Functional Apologies in Law", (2008) 15 Psychiatry, Psychology and Law 369.

Alter, Susan, "Apologising for Serious Wrongdoing: Social, Psychological and Legal Considerations", Final Report for the Law Commission of Canada, (May, 1999).

Baker, Stephen, Lauro, Christine and Sintim-Damoa, Akosua, "Malpractice Allegations and Apology Laws: Benefits and Risks for Radiologists", (2008) 5 Journal of the American College of Radiology 1186.

Barber, John, "Sick Kids' saga grows ever more disturbing", The Globe and Mail, Friday, February 25, 1990 at p. A16.

Barnett, Peter B., "Rapport and the Hospitalist", (2001) 111 The American Journal of Medicine 315.

Bartels, William K., "The Stormy Seas of Apologies: California Evidence Code Section 1160 Provides a Safe Harbor for Apologies Made After Accidents", (2001) 28 Western State University Law Review 141.

Belhorn, Scott R., "Settling Beyond the Shadow of the Law: How Mediation Can Make the Most of Social Norms", (2005) Ohio State Journal on Dispute Resolution 981.

Belkin, Lisa, "The Way We Live Now: Unforgivable", The New York Times Magazine, July 4, 2010.

Bell, Sigall K., Moorman, Donald W. and Delbanco, Tom, "Improving the Patient, Family and Clinician Experience After Harmful Events: The 'When Things Go Wrong' Curriculum", (2010) 85 Academic Medicine 1010.

Beyea, Suzanne C., Killen, Aileen R. and Berrandi, Jackie L., "Lessons About Patient Safety from Jean Reeder (Patient Safety First)", Association of Operating Room Nurses (AORN) Journal, (August, 2002).

Bibas, Stephanos and Bierschbach, Richard A., "Integrating Remorse and Apology into Criminal Procedure", (2004) 114 Yale Law Journal 85.

Bismark, Marie M., "The Power of Apology", (2009) 122 New Zealand Medical Journal 96.

Bolstad, Max, "Learning From Japan: The Case For Increased Use of Apology in Mediation", (2000) 48 Cleveland State Law Review 545.

Brandom, Barbara W., Callahan, Patrick and Micalizzi, Dale Ann, "What Happens When Things Go Wrong?", (2011) Pediatric Anesthesia 1.

Brazao, Dale, "Former Sex Slave Cries Out For Justice; Woman, 83 Speaks For Thousands Abused by Japanese Military in World War II", Toronto Star, Sunday, October 3, 2010 at p. A4.

Brown, Jennifer Gerarda, "The Role of Apology In Negotiation", (2004) 87 Marquette Law Review 665.

Canadian Patient Safety Institute, “Canadian Disclosure Guidelines”, Edmonton, Alberta, May, 2008.

Canadian Press, “Girl Dies After Drug Wrongly Injected”, The Globe and Mail, Friday, June 6, 1997 at p. A8.

Carr, Nancy, “Two nurses charged in death of girl at Sick Kids”, The National Post, Friday, October 26, 2001 at p. A10.

Chapman, Dick, “Apology at inquest”, The Toronto Sun, Wednesday, February 9, 2000 at p. 18.

Chapman, Dick, “Confusion delays inquest: Sick Kids cover-up: lawyer”, The Toronto Sun, Tuesday, November 8, 1999 at p. 23

Chapman, Dick, “Coroner fumes over ‘ambush’”, The Toronto Sun, Wednesday, November 10, 1999 at p. 10.

Chapman, Dick, “Inquest told of crucial tape”, The Toronto Sun, Tuesday, February 8, 2000 at p. 1.

Chapman, Dick, “MD’s orders ‘lost’: Lisa 10, not monitored hourly, inquest told”, The Toronto Sun, Tuesday, November 9, 1999 at p. 7.

Christie, Dugald E., “Gratuitous Apologies: A Discussion Paper On Apology Legislation”, (2007) 40 U.B.C. Law Review 761.

Christmas, Colleen and Ziegelstein, Roy C., “The Seventh Competency”, (2009) 21 Teaching and Learning in Medicine 159.

Clark, Cheryl, “The Ghost of Tuskegee”, The San Diego Union-Tribune, January 28, 1996 at p. D-14.

Clinton, Hillary Rodham and Obama, Barack, “Making Patient Safety the Centerpiece of Medical Liability Reform”, (2006) 354 The New England Journal of Medicine 2205.

Cohen, Jonathan, “Advising Clients to Apologize”, (1998-1999) 72 Southern California Law Review 1009.

Cohen, Jonathan R., “Apologizing for Errors: Ethical Corporate Conduct Can Also Be Good for Business”, (2000) 6 Dispute Resolution Magazine 16.

Cohen, Jonathan, “Legislating Apology: The Pros And Cons”, (2002) 70 University of Cincinnati Law Review 819.

Cohen, Jonathan R., “Let’s Put Ourselves Out of Business: On Respect, Responsibility, and Dialogue in Dispute Resolution”, (2003) 108 Pennsylvania State Law Review 227.

Cohen, Jonathan, “The Immorality of Denial”, (2004-2005) 79 Tulane Law Review 903.

Cohen, Larry J. and Vesper, Joyce H., “Forensic Stress Disorder”, (2001) 25 Law and Psychology Review 1.

Cohen, Mitchell L., “The Power of Apology: When a patient suffers from a medical mistake, two words can usher in healing”, www.aafp.org/fpm (Family Practice Management Web Site). Site last visited February 28, 2011.

Coyle, Jim, “At Sick Kids a day to be struggled through”, The Toronto Star, Saturday, February 26, 2000 at p. A6.

Cose, Ellis, “Forgive and Forget”, Newsweek, U.S. Edition, April 21, 1997 at page 45.

Daicoff, Susan, “Growing Pains: The Integration vs. Specialization Question For Therapeutic Jurisprudence And Other Comprehensive Law Approaches”, (2008) 30 Thomas Jefferson Law Review 551.

Davenport, Ashley A., “Forgive and Forget: Recognition of Error and Use of Apology as Preemptive Steps to ADR or Litigation in Medical Malpractice Cases”, (2006) 6 Pepperdine Dispute Resolution Law Journal 81.

De Cremer, David, Pillutla, Madan M. and Folmer, Chris Reinders, “How Important Is an Apology to You? Forecasting Errors in Evaluating the Value of Apologies”, (2011) 22 Psychology Science 45, also at www.pss.sagepub.com/content/22/1/45. Site last visited February 12, 2011.

Dresser, Rebecca, “The Limits of Apology Laws”, (2008) Hastings Center Report 6.

Dudzinski, Denise M., Hébert, Philip C., Foglia, Mary Beth and Gallagher, Thomas H., “The Disclosure Dilemma—Large-Scale Adverse Events”, (2010) 363 New England Journal of Medicine 978.

Ebert, Robin E., “Attorneys, Tell Your Clients to Say They’re Sorry: Apologies in the Health Care Industry”, (2008) 5 Indiana Health Law Review 337.

Editorial, “Hospital homicide”, The Toronto Sun, Saturday, February 26, 2000 at p. 14.

Editorial, “Lisa Shore didn’t have to die”, The Toronto Star, Friday, February 25, 1990 at p. A26.

Editorial, “Sick Kids mistreats grieving parents”, The Toronto Star, Friday, April 6, 2001 at p. A24.

Epstein, Joe, “Mediating Wrongful Death Cases”, www.mediate.com/pfriendly.cfm?id=2095. Site list visited February 24, 2011.

Foucar, Elliott and Wick, Mark R., “Tort Reform: The Pathologist’s Perspective”, (2007) 24 Seminars in Diagnostic Pathology 131.

Gallagher, Thomas H., Waterman, Amy D., Ebers, Alison G., Fraser, Victoria J. and Levinson, Wendy, “Patients and Physicians’ Attitudes Regarding the Disclosure of Medical Errors”, (2003) 289 Journal of The American Medical Association 1001.

Galton, Eric, “Mediation of Medical Negligence Claims”, (1999-2000) 28 Capital University Law Review 321.

Getz, Russell J., “Uniform Apology Act”, Uniform Law Conference of Canada, Civil Law Section, Charlottetown, Prince Edward Island, September 9-13, 2007.

Gillespie, Kerry, “Girl’s doctor says orders not followed”, The Toronto Star, Tuesday, November 9, 1999 at p. B1.

Gillespie, Kerry, “Status of cardiac monitor at question in girl’s death”, The Toronto Star, Saturday, November 13, 1999 at p. B4.

Golann, Dwight, “Is Legal Mediation a Process of Repair—or Separation? An Empirical Study, and Its Implications”, (2002) 7 Harvard Negotiation Law Review 301.

Gollom, Mark, “Coroner’s inquest rules girl, 10, a homicide victim: Lisa Shore died at Sick Kids”, The National Post, Friday, February 25, 2000 at p. A1.

Griffin, Kathleen, “Sick Kids death deemed homicide”, Markham Economist and Sun, Saturday, February 26, 2000 at p. 1.

Hébert, Philip C., “Disclosure of Adverse Events in Health Care”, (2010) Oral Health and Dental Practice at www.oralhealthjournal.com/issues/story.aspx?aid=1000384418&type=Print%20Ar.

Hickson, Gerald B., Clayton, Ellen Wright, Githens, Penny B. and Sloan, Frank A., “Factors That Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries”, (1992) 267

Journal of The American Medical Association 1359.

Ho, Tanya, “Girl’s death at hospital a homicide”, The Montreal Gazette, Friday, February 25, 2000 at p. A8.

Hyman, Chris Stern, Liebman, Carol B., Schechter, Clyde B. and Sage, William M., “Interest-Based Mediation of Medical Malpractice Lawsuits: A Route to Improved Patient Safety”, (2010) 35 Journal of Health Politics, Policy and Law 797.

Jenkins, Jonathan, “Surrender: 2 nurses turn themselves in on negligence rap”, The Toronto Sun, Friday, October 26, 2001 at p. 7.

Jenkins, Jonathan, “2 Nurses ‘shocked’ charges looming in death”, The Toronto Sun, Thursday, October 25, 2001 at p. 10.

Jesson, Lucinda E. and Knapp, Peter B., “My Lawyer Told Me to Say I’m Sorry: Lawyers, Doctors, and Medical Apologies”, (2008-2009) 35 William Mitchell Law Review 1410.

Josephs, Hilary K., “The Remedy of Apology in Comparative and International Law: Self-Healing and Reconciliation”, (2004) 18 Emory International Law Review 53.

Keeva, Steven, “Does Law Mean Never Having to Say You’re Sorry?”, (1999) 85 American Bar Association Journal 64.

Kellett, Ann J., “Healing Angry Wounds: The Roles of Apology and Mediation in Disputes Between Physicians and Patients”, (1987) Missouri Journal of Dispute Resolution 111.

Kleefeld, John C., “Thinking Like a Human: British Columbia’s Apology Act”, (2007) 40 U.B.C. Law Review 769.

Latif, Elizabeth, “Apologetic Justice: Evaluating Apologies Tailored Toward Legal Solutions”, (2001) 81 Boston University Law Review 289.

Lazare, Aaron, “Understanding Apology: Mechanisms For Repairing Relationships”, A Paper delivered by Dr. Lazare at The National Association of the College and University Attorneys Meeting, Washington, D.C., June 27-30, 2010.

Leape, Lucian, “Disclose, Apologize, Explain”, Newsweek, U.S. Edition, October 16, 2006 at page 50.

Lee, Ilhyung, “The Law and Culture of The Apology In Korean Dispute Settlement (with Japan and The United States in Mind)”, (2005) 27 Michigan Journal of International Law 1.

Levi, Deborah, “The Role of Apology in Mediation”, (1997) 72 New York University Law Review 1165.

Levine, Samuel J., “Teshuva: A Look At Repentance, Forgiveness and Atonement In Jewish Law And Philosophy And American Legal Thought”, (2000) 27 Fordham Law Journal 1677.

Levy, Harold, “Absence of Accountability; The Victims of Charles Smith May Wonder Why Prosecutors Worked So Hard to Hold Them Accountable But Continue to Leave Smith Untouched”, The Toronto Star, Thursday, February 10, 2011 at p. A19.

Levy, Harold, “Apology rejected”, The Toronto Star, Wednesday, February 9, 2000 at p. A1.

Levy, Harold, “Hospital contradicted at Inquest”, The Toronto Star, Friday, January 28, 2000 at p. B3.

Levy, Harold, “Juror supports probe”, The Toronto Star, Sunday, February 27, 2000 at p. A5.

Levy, Harold, “Nurse found doctor’s ‘missing orders’: made printout of hospital’s computer file, inquest told”, The Toronto Star, Monday, January 31, 2000 at p. B5.

Levy, Harold, "Records withheld inquest jury told: Sick Kids failed to disclose doctor's orders, coroner says", The Toronto Star, Thursday, January 20, 2000 at p. D3.

Levy, Harold, "Sick Kids cover-up charged: Inquest juror points finger at Toronto hospital", The Toronto Star, Friday, February 4, 2000 at p. A1.

Levy, Harold, "Nurse Back on Stand in Girl's Inquest: Sick Kids witness had not told jury of taped record", The Toronto Star, Tuesday, February 8, 2000 at p. B3.

Levy, Harold, "'Unusual' inquest a low point for Sick Kids: Hearing into death of Lisa Shore was tense, adversarial", The Toronto Star, Friday, February 25, 2000 at p. B1.

Levy, Harold, Gillespie, Kerry and Porter, Catherine, "Hospital nurses to face criminal charges", The Toronto Star, Thursday, October 25, 2001 at p. A1.

Levy, Harold, and Quinn, Jennifer, "Lisa's death called homicide: parents call for police investigation and public inquiry", The Toronto Star, Friday, February 25, 2000 at p. A1.

Loren, David J., Garbutt, Jane, Dunagan, W. Claiborne, Bommarito, Kerry M., Ebers, Alison, Levinson, Wendy, Waterman, Amy D., Fraser, Victoria, Summy, Elizabeth A. and Gallagher, Thomas H., "Risk Managers, Physicians, and Disclosure of Harmful Medical Errors", (2010) 36 The Joint Commission Journal on Quality and Patient Safety 101.

Loren, David J., Klein, Eileen J., Garbutt, Jane, Krauss, Melissa J., Fraser, Victoria, Dunagan, W. Claiborne, Brownstein, Dena R. and Gallagher, Thomas H., "Medical Error Disclosure Among Pediatricians: Choosing Carefully What We Might Say to Parents", (2008) 162 Archives of Pediatric Adolescent Medicine 922.

MacDonald, Noni, Attaran, Amir, Hébert, Paul C., Stanbrook, Matthew B., Sibbald, Barbara and Flegel, Ken, "Medical errors, apologies and apology laws", (2009) 180 Canadian Medical Association Journal 11.

Macleod, Leslie H., "A Time For Apologies: The Legal and Ethical Implications of Apologies in Civil Cases", Cornwall Public Inquiry, Phase 2 Research and Policy Paper; Final Paper April 12, 2008, www.attorneygeneral.jus.gov.on.ca/inquiries/cornwall/en/report/research_papers/Phase_2_RP/3_Macleod_Apologies.

Matlow, Anne, Stevens, Polly, Harrison, Christine and Laxer, Ronald, "Achieving Closure Through Disclosure: Experience In A Pediatric Institution", (2004) 144 The Journal of Pediatrics 559.

Matlow, A. G., Moody, L., Laxer, R., Stevens, P., Goia, C. and Friedman, J. N., "Disclosure of medical error to parents and paediatric patients: assessment of parents' attitudes and influencing factors", (2010) 95 Archives of Disease in Childhood 286.

Mazor, Kathleen M., Simon, Steven R., Yood, Robert A., Martinson, Brian C., Gunter, Margaret J., Reed, George W. and Gurwitz, Jerry H., "Health Plan Members' Views About Disclosure of Medical Errors", (2004) 140 Annals of Internal Medicine 409.

McCord, Ronald S., Floyd, Michael R., Lang, Forrest and Young, Victoria K., "Responding Effectively to Patient Anger Directed at the Physician", (2002) 34 Family Medicine 331.

McDonnell, William M. and Guenther, Elisabeth, "Narrative Review: Do State Laws Make It Easier to Say 'I'm Sorry'?", (2008) 149 Annals of Internal Medicine 811.

Menkel-Meadow, Carrie, "Aha? Is Creativity Possible in Legal Problem Solving and Teachable in Legal Education?", (2001) 6 Harvard Negotiation Law Review 97.

Menkel-Meadow, Carrie J., "When Winning Isn't Everything: The Lawyer as Problem Solver", (2000) 28 Hofstra Law Review 905.

Nowicki, Elizabeth A., "Apologies and Good Lawyering", www.ssrn.com/abstract=1430212. Site last visited February 24, 2011.

O'Connor, Elaine, Coates, Hilary M., Yardley, Iain E. and Wu, Albert W., "Disclosure of Patient Safety Incidents: A Comprehensive Review", (2010) 22 International Journal for Quality in Health Care 371.

O'Hara, Erin Ann, "Apology and Thick Trust: What Spouse Abusers and Negligent Doctors Might Have in Common", (2004) 79 Chicago-Kent Law Review 1055.

O'Hara, Erin Ann and Yarn, Douglas, "On Apology and Consilience", (2002) 77 Washington Law Review 1121.

Okimoto, Tyler G., Hedrick, Kyli and Wenzel, Michael, '"I Make No Apology": The Psychological Benefits of Refusing to Apologize', Paper delivered at the 23rd Annual Conference of the International Association of Conflict Management (IACM), Boston, Mass., ssrn.com/so13/papers.cfm?abstract_id=1612866. Site last visited February 12, 2011.

Orenstein, Aviva, "Apology Excepted: Incorporating a Feminist Analysis into Evidence Policy Where You Would Least Expect It", (1998-1999) 28 Southwestern University Law Review 221.

Pavlic, Donna L., "Apology and Mediation: The Horse and Carriage of the Twenty-First Century", (2002-2003) 18 Ohio State Journal of Dispute Resolution 829.

Pelt, Jenny L. and Faldmo, Lynda P., "Physician Error and Disclosure", (2008) 51 Clinical Obstetrics and Gynecology 700.

Penzell, Abigail, "Apology in the Context of Wrongful Conviction: Why The System Should Say It's Sorry", (2007) 9 Cardozo Journal of Conflict Resolution 145.

Pfrimmer, Dale M., "Nursing's Role in Disclosure and Apology", (2010) 41 The Journal of Continuing Education in Nursing 342.

Pogatchnik, Shawn, "'It has been a long time coming': Britain apologizes for 1976 slaying of girl, 12, in IRA stronghold", The Toronto Star, Tuesday, March 29, 2011 at p. A13.

Postema, Miles J., "Institutional Apologies: When, Why and How To Apologize To The Aggrieved, The Campus and The Public", A Paper delivered by Vice President and General Counsel of Ferris State University, Miles J. Postema at The National Association of College and University Attorneys Meeting, Washington, D.C., June 27-30, 2010.

Quinn, Jennifer, "Hospital 'failed' Lisa", The Toronto Star, Friday, February 25, 2000 at p. A1.

Rehm, Peter H. and Beatty, Denise R., "Legal Consequences of Apologizing", (1996) Journal of Dispute Resolution 115.

Robbennolt, Jennifer K., "Apologies and Legal Settlement: An Empirical Examination", (2003-2004) 102 Michigan Law Review 460.

Robbennolt, Jennifer K., "What We Know and Don't Know About The Role of Apologies in Resolving Health Care Disputes", (2005) 21 Georgia State University Law Review 1009.

Roberts, Richard G., "The Art of Apology: When and How To Seek Forgiveness", (2007) Family Practice Management 44.

Ross, Oakland, "Gaza Doctor Sues Israel Over Deaths; Toronto Resident Whose Daughters Were Killed During Military Offensive Wants Compensation", The Toronto Star, Tuesday, December 28, 2010 at p. A4.

Rothman, Marc D., "The Apology", (2007) 80 Yale Journal of Biology and Medicine 77.

Runnels, Michael B., "Apologies All Around: Advocating Federal Protection for the Full Apology in Civil Cases", (2009) 46 San Diego Law Review 137.

Sarick, Lila, "Timing of evidence at inquest criticized: some facts about girl's death at Sick Kids should have been revealed earlier, coroner says", The Globe and Mail, Friday, January 28, 2000 at p. A18.

Schafer, Roy, "Cordelia, Lear and Forgiveness", (2005) 53 Journal of The American Psychiatric Association 389.

Schneider, Andrea Kupfer, "The Intersection of Therapeutic Jurisprudence, Preventative Law, and Alternative Dispute Resolution", (1999) Psychology Public Policy and Law 1084.

Scott, Vivian, '"I'm Sorry You're Such a Crybaby" Isn't Really An Apology', www.mediate.com/articles/ScottV2.cfm. Site last visited February 12, 2011.

Shamah, Rabbi Moshe and Barry, Rabbi Ronald, "Parashat Mishpatim Part III On 'An Eye for an Eye'", www.judaicseminar.org/bible/mishpatim3.pdf, (2009) Sephardic Institute, Brooklyn, New York 1. Site last visited February 17, 2011.

Shuman, Daniel W., "The Psychology of Compensation in Tort Law", (1994-1995) 43 University of Kansas Law Review 39.

Smith, Graeme, "Two nurses face charges of criminal negligence: Death of girl the result of drug interaction that led to cardiac and respiratory arrest", The Globe and Mail, Thursday, October 25, 2001 at p. A21.

Southworth, Natalie, "Girl's death not due to monitor, lawyer says: Inquest told machine does not malfunction", The Globe and Mail, Saturday, November 13, 1999 at p. A12.

Southworth, Natalie, "Lawyer calls testimony 'outrageous': Inquest into girl's death erupts at suggestion alarm may have been faulty", The Globe and Mail, Wednesday, November 10, 1999 at p. A9.

Southworth, Natalie and Bourette, Susan, "Sick Kids death ruled a homicide", The Globe and Mail, Friday, February 25, 1990 at p. A1.

Staff, "A homicide at Sick Kids hospital", Macleans, March 6, 2000 at p. 19.

Staff, "Hospital Death 'Homicide'", The Toronto Sun, Friday, February 25, 2000 at p. 1.

Stephens, Mitchell A., "I'm Sorry: Exploring The Reasons Behind The Differing Roles of Apology in American and Japanese Civil Cases", (2008-2009) 14 Widener Law Review 185.

Taft, Lee, "Apology and Medical Mistake: Opportunity or Foil?", (2005) 14 Loyola University Chicago Institute for Health Law, Annals of Health Law 55.

Taft, Lee, "Apology Subverted: The Commodification of Apology", (2000) 109 Yale Law Journal 1135.

Taft, Lee, "Apology Within a Moral Dialectic: A Reply to Professor Robbennolt", (2005) 103 Michigan Law Review 1010.

Taft, Lee, "On Bended Knee (With Fingers Crossed)", (2005-2006) 55 DePaul Law Review 601.

Tanick, Marshall H. and Ayling, Teresa, "Alternative Dispute Resolution By Apology: Settlement By Saying 'I'm Sorry'", (1996) The Hennepin Lawyer, 22.

Taylor, David McD, Wolfe, Rory and Cameron, Peter A., "Complaints from emergency department patients largely result from treatment and communication problems", (2002) 14 Emergency Medicine 43.

The Canadian Medical Protective Association, "Disclosing adverse events to patients: strengthening the doctor-patient relationship", originally published March 2005/Revised May 2008.

The Canadian Medical Protective Association, "How to apologize when disclosing adverse events to patients", originally published September 2006/Revised May 2008.

Trafford, Abigail, "The Ghost of Tuskegee", The Washington Post, May 6, 1997 at p. A19.

Vanderlinde, Rick, "Hospital covering for nurses: mother", The Liberal, Thursday, November 18, 1999 at p. 1.

Van Rijn, Nicholas, "Homicide finding unusual in Ontario", The Toronto Star, Friday February 25, 2000 at p. A3.

Vincent, C.A. and Coulter, A., "Patient Safety: What About The Patient?", www.qualitysafety.bmj.com. Site last visited February 23, 2011.

Vines, Prue, "Apologising to Avoid Liability: Cynical Civility or Practical Morality?", (2005) 27 Sydney Law Review 483.

Vines, Prue, "Apologies and Civil Liability in the U.K.: A View from Elsewhere", (2008) 12 Edinburgh Law Review 200.

Vines, Prue, "The Power of Apology: Mercy, Forgiveness or Corrective Justice in the Civil Liability Arena?", (2007) 1 Public Space: The Journal of Law and Social Justice Article 5 p.1.

Wagatsuma, Hiroshi and Rosett, Arthur, "The Implications of Apology: Law and Culture in Japan and The United States", (1986) 20 Law and Society Review 461.

Waldman, Ellen A., "The Evaluative-Facilitative Debate in Mediation: Applying The Lens of Therapeutic Jurisprudence", (1998) 82 Marquette Law Review 155.

Ward, Olivia, "U.S. Infected Guatemalans With Syphilis; Top Government Officials Make Startling Apology For Experiments on 696 Prisoners in 1940's", The Toronto Star, Saturday, October 2, 2010 at p. A19.

Ward, Robert, "On Apology", (2006) 1 New England Roundtable Symposium Law Journal 166.

White, Brent T., "Saving Face: The Benefits of Not Saying I'm Sorry", (2009) 72 Law and Contemporary Problems 261.

White, Brent T., "Say You're Sorry: Court-Ordered Apologies As A Civil Rights Remedy", (2006) 91 Cornell Law Review 1261.

Wiesel, Elie, "Elie Wiesel's Nobel Lecture December 11, 1986", www.nobelprize.org/nobel_prizes/peace/laureates/1986. Site last visited February 12, 2011.

Wiesel, Elie, "Elie Wiesel's Acceptance Speech on the occasion of the award of the Nobel Peace Prize in Oslo, December 10, 1986", www.nobelprize.org/nobel_prizes/peace/laureates/1986. Site last visited February 12, 2011.

Woolverton, Frederick, "Lives: The Most-hated Son; One last attempt to connect with an estranged mother", The New York Times Magazine, November 14, 2010 at page 66.

Wu, Albert W. and Huang, I-Chan, Stokes, Samantha and Pronovost, Peter J., "Disclosing Medical Errors to Patients: It's Not

What You Say, It's What They Hear", (2009) Journal of General Internal Medicine 1012.

Yarn, Douglas H. and Jones, Gregory Todd, "A Biological Approach To Understanding Resistance To Apology, Forgiveness, and Reconciliation in Group Conflict", (2009) 72 Law and Contemporary Problems 63.

2. BOOKS

Abuelaish, Izzeldin. *I Shall Not Hate: A Gaza Doctor's Journey* (Toronto: Random House Canada, 2010).

Belkin, Lisa. *First Do No Harm* (New York: Ballantine Books, 1994).

Benoit, William L. *Accounts, Excuses and Apologies: A Theory of Image Restoration Strategies* (Albany: State University of New York Press, 1995).

Blanchard, Ken and McBride, Margaret. *The One Minute Apology* (New York: William Morrow, 2003).

Engel, Beverly. *The Power of Apology: Healing Steps to Transform Your Relationships* (New York: John Wiley and Sons, Inc., 2001).

Gawande, Atul. *Better: A Surgeon's Notes on Performance* (New York: Metropolitan Books, Henry Holt and Company, 2007).

Gawande, Atul. *Complications: A Surgeon's Notes on an Imperfect Science* (New York: Picador, A Metropolitan Book, Henry Holt and Company, 2002).

Groopman, Jerome. *How Doctors Think* (Boston. New York: A Mariner Book, Houghton Mifflin Company, 2008).

Groopman, Jerome. *The Anatomy of Hope: How People Prevail in the Face of Illness* (New York: Random House Trade Paperbacks, 2005).

Groopman, Jerome. *The Measure Of Our Days: New Beginnings at Life's End* (New York: Viking Penguin, 1997).

Hébert, Philip C. *Doing Right: A Practical Guide To Ethics For Medical Trainees And Physicians Second Edition* (Oxford: Oxford University Press, 2009).

Hilfiker, David. *Healing the Wounds: A Physician Looks at His Work* (Omaha, Nebraska: Creighton University Press, 1998).

Jones, James H. *Bad Blood: The Tuskegee Syphilis Experiment* (New York: The Free Press, 1993).

Kador, John. *Effective Apology: Mending Fences, Building Bridges, And Restoring Trust* (San Francisco: Berrett-Koehler Publishers Inc., 2009).

Kübler-Ross, Elisabeth. *On Death and Dying* (New York: First Scribner Paperback Edition, 2003).

Kübler-Ross, Elisabeth and Kessler, David. *Life Lessons* (New York: First Scribner Paperback Edition, 2003).

Kübler-Ross, Elisabeth and Kessler, David. *On Grief and Grieving* (New York: First Scribner Paperback Edition, 2007).

Lam, Vincent. *Bloodletting and Miraculous Cures* (Anchor Canada edition, 2006).

Lazare, Aaron. *On Apology* (Oxford: Oxford University Press, 2004).

Matlow, Anne and Laxer, Ronald M. *Pediatric Clinics of North America; Volume on Patient Safety* (Philadelphia, London, Toronto,

Montreal, Sydney, Tokyo: Saunders, An Imprint of Elsevier, Inc., December 2006, Volume 53, Number 6).

Sacks, Oliver. *Awakenings* (New York: Vintage Books, A Division of Random House, Inc., 1999).

Sacks, Oliver. *Migraine* (New York: Vintage Books, A Division of Random House, Inc., 1999).

Sacks, Oliver. *Musicophilia* (Toronto: Vintage Canada, 2008).

Sacks, Oliver. *The Mind's Eye* (New York. Toronto: Alfred A. Knopf, 2010).

Sacks, Oliver. *The Man Who Mistook His Wife for a Hat and Other Clinical Tales* (New York: A Touchstone Book published by Simon and Schuster, 1998).

Shore, Sharon. *No Moral Conscience: The Hospital For Sick Children and the Death of Lisa Shore* (Toronto, Canada: Self-published, 2005).

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

Sugimoto, Naomi. *Japanese Apology Across Disciplines* (New York: Nova Science Publishers, Inc., 2010).

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

Van Winkle, John R. *Mediation—A Path For the Lost Lawyer* (Chicago: Section of Dispute Resolution, ABA Senior Lawyers Division, 2001).

Verghese, Abraham. *Cutting For Stone* (Toronto: Vintage Canada, 2010).

Verghese, Abraham. *My Own Country* (New York: Vintage Books, A Division of Random House, Inc., 1995).

Verghese, Abraham. *The Tennis Partner* (New York. London. Toronto. Sydney. New Delhi. Auckland: Harper Perennial, 1998).

Wiesenthal, Simon. *The Sunflower: On The Possibilities and Limits of Forgiveness* (New York: Schocken Books, 1998).

3. CASE LAW

Desjardins v Van Buren Community Hospital, 969 F.2d 1280 (United States Court of Appeals, First Circuit).

Phinney v Vinson, 605 A. 2d 849 (Supreme Court of Vermont, 1992).

Senesac v Associates in Obstetrics and Gynecology and Gray, 449 A. 2d 900 (Supreme Court of Vermont, 1982).

4. INTERVIEWS

i) Author interview of Dr. Philip Hébert on March 6, 2011. Notes on file with the author.

ii) Author interview of Dr. Izzeldin Abuelaish on March 11, 2011. Notes on file with the author.

5. LEGISLATION

The Apology Act, S.O. 2009, C.3 (Ontario)

6. VIDEO

Video of President Clinton's apology to the victims of the Tuskegee Bad Blood Experiment delivered on May 16, 1997 at www.youtube.com/watch?v=l1A-YP24QwA. Site last visited March 22, 2011. Text of Clinton's apology at www.cdc.gov/tuskegee/clintonp.htm. Site last visited March 22, 2011.

About the Author

Frank Gomberg

BA (McGill), JD (Osgoode), LLM (Osgoode), of the Bar of Ontario

Frank Gomberg was called to the Ontario Bar in 1979 and for 20 years acted principally for plaintiffs in wrongful death and personal injury claims. He represented families at a number of landmark Coroners Inquests, including the inquests into the 1995 TTC subway crash and the 1998 in-hospital death of Lisa Shore.

Mr. Gomberg was designated a Specialist in Civil Litigation by the Law Society of Upper Canada in January 1990. He resigned as a specialist in 2005 given his evolving practice to full-time mediator. He now spends all of his professional time mediating civil cases pending in the Ontario Superior Court of Justice. He has mediated over 5,200 such claims since he began mediating in 1995.

Mr. Gomberg is a graduate of the Harvard Mediation Workshop (1995) and of the Advanced Mediation Workshop (1996). He believes in the transformative power of apology as an element in mediated settlements.

Mr. Gomberg has taught Trial Advocacy for the former Ontario Centre for Advocacy Training (OCAT), The Advocates' Society, to law students at Osgoode Hall Law School and at Osgoode's annual Intensive Trial Advocacy Workshop (ITAW). He has lectured and written extensively on personal injury, mediation, negotiation and related topics. He has chaired or co-chaired numerous Advocates' Society, Law Society and Ontario Trial Lawyers Association programs.

He has taught for the Toronto Police Service and has been on many panel discussions on damages; settlement of civil cases at mediation; ethical considerations at mediation; strategies for success at mediation and related topics.

Mr. Gomberg is an avid downhill skier. He lives in Toronto, though he is a Montrealer at heart.

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