A Cycle of Redemption in a Medical Error Disclosure and Apology Program

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Abstract

Physicians accept that they have an ethical responsibility to disclose and apologize for medical errors; however, when physicians make a medical error, they are often not given the opportunity to disclose and apologize for the mistake. In this article, I explore how one hospital negotiated the aftermath of medical mistakes through a disclosure and apology program. Specifically, I used Burke's cycle of redemption to position the hospital's disclosure and apology program as a redemption process and explore how the hospital physicians and administrators worked through the experiences of disclosing and apologizing for medical errors.

Keywords

communication; disclosure; emotions / emotion work; safety, patient

Medical mistakes are part of medical practice (Leape, 1994; Paget, 2004). Each year in the United States, approximately 15 million patients fall victim to a medical mistake and approximately 100,000 patients die as a result (Healy, 2008). Medical errors are the eighth leading cause of death in the United States, more than motor vehicle accidents, breast cancer, and AIDS (Cruez, 2008). There is debate among members of the medical community about how to handle the disclosure of medical errors and what actions providers and hospitals should take in response to medical errors (Dauer, 2003; Furrow, 2003; Lamb, 2004). The traditional approach to medical mistakes, the "gold standard," provides anonymity, nondiscoverability of victims' identities, and immunity from legal action (Andrus et al., 2003). Although the medical community generally accepts that disclosure is an ethical responsibility, a tension still exists between whether medical practitioners should be held legally responsible for the mistake or if, by admitting guilt, they should be absolved of that responsibility (Bernstein & Brown, 2004).

Since the release of the Institute of Medicine's report on medical mistakes (Kohn, Corrigen, & Donaldson, 1999), health care reform advocates, hospital administrators, and health care providers have struggled to develop and implement a new approach to medical errors and patient safety. Two of the more popular approaches include the passage of state health care benevolence laws, which dictate the types of emotions and language practitioners can use when discussing medical errors with patients (Carmack, 2010b), and the increased use of morbidity and mortality conferences, at which practitioners talk about negative outcome cases (Gawande, 2002). Neither of these approaches encourages open and honest communication between patients and providers, which is recommended by The Joint Commission on Accreditation of Healthcare Organizations (2005).

Disclosure and apology programs are one answer to the Institute of Medicine's (Kohn et al., 1999) and The Joint Commission on Accreditation of Healthcare Organization's (2005) calls for reduction in medical errors. These programs challenge the traditional approach to medical errors, where hospital administrators and providers ask patients for forgiveness without disclosing or apologizing for errors (Berlinger & Wu, 2005). These organizations challenge providers and administrators to craft an approach that allows them to disclose, apologize, and ask forgiveness for medical errors (Prtilo, 2005). Disclosure and apology programs create a space for practitioners to openly talk with patients and families about bad outcomes and begin the healing process (Carmack, 2010a).

Over the past two decades, communication and applied health scholars have slowly begun to explore the communicative nature of medical mistakes. Researchers have focused on how physicians construct and enact responses to errors (Mizrahi, 1984), how they disclose medical mistakes (Allman, 1998; Carmack, 2010b; Hannawa, 2009; Petronio, 2006), how physicians negotiate the aftermath

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of adverse events (Carmack, 2010a; Noland & Carl, 2006), and how practitioners are socialized to communicate errors (Noland & Rickles, 2009). Researchers have yet to explore the ways organizational programs, such as disclosure and apology programs, influence practitioners' experiences by formally disclosing medical errors. Moreover, scholars have yet to specifically examine the apology act associated with medical errors.

In this article, I explore how physicians at one hospital, referred to by the pseudonym MidSouth Health, negotiated the aftermath of medical errors through a disclosure and apology program. Specifically, I argue that MidSouth Health's disclosure and apology program was a redemptive process that involved physicians and hospital administrators working together to disclose and apologize for medical errors. I begin with a discussion of the importance of apology in health care contexts and move into how a cycle of redemption can be used in communicating about medical errors. I then explore how the disclosure and apology program was an example of a cycle of redemption of medical errors. Finally, I discuss the implications of this program on how health and communication scholars and practitioners think about apology and medical errors.

Exploring Apology in Health Care Contexts

Western societies place great value on the expression of an apology as a way of addressing wrongdoing and showing remorse (British Columbia Ministry of Attorney General, 2006). Apologies serve as a therapeutic means through which wronged parties make sense of the incident (Cohen, 2002; Shuman, 2000). Individuals also use apology as a vehicle for mending relational breakdowns (Sparkman, 2005). Communication scholars have explored issues of apology in multiple contexts, including sports (Kruse, 1981), political and religious scandals (Armstrong, Hallmark, & Williamson, 2005; Harter, Stephens, & Japp, 2000; Kramer & Olson, 2002; Simons, 2000), and organizational blunders (Benoit & Brinson, 1994; Hobbs, 1995; Ice, 1991). Apology researchers traditionally highlight two elements that complicate the apology act: the type of wrongdoing and how the accused responds. Regardless of the type of apologetic strategy used, apologies typically contain denial, deflection, or justification of actions to restore damaged character (Koesten & Rowland, 2004).

When individuals' reputation or character is damaged, it becomes difficult for them to engage in societal relationships (Gold, 1978). In response, apologists are "motivated to deny, to mitigate, or to purify" their tarnished image (Ryan, 1982, p. 257). Individuals must emphasize their moral character to counter attacks on their character. Specifically, they must express genuine remorse to bolster their moral responsibility to the community and the profession they represent (Simons, 2000). If individuals do not express some kind of remorse for making others question their character, then the apology will not be deemed successful. Individuals might seek absolution (acquittal of the act), vindication (preserving reputation while recognizing humanity), explanation (understanding motives), and justification of action (Hobbs, 1995; Ware & Linkugel, 1973).

Although individuals deliver the apology, the apology might be for organizational wrongdoing. Individuals apologizing for organizational wrongdoing often have the goal of showing that the organization is caring and decent (Rowland & Jerome, 2004). Organization leaders who want to maintain the appearance of adherence to key social values must "demonstrate concern for the victim(s), bolster individual or organizational values, make it clear that no harm was intended, and/or actively take steps to prevent the harmful action from occurring again" (Rowland & Jerome, p. 198). Requiring disclosure and apology of medical errors might be viewed as a response to the medical-mistake crisis. Organization administrators might be able to demonstrate to the general public that the organization and its providers are dedicated to patient care. Involving hospital administrators in the disclosure and apology process transforms medical errors from an individual misdeed to an organizational failure (Hearit, 1995).

The use of organizational apologies as a way to focus on a social crisis or problem is important, especially in the context of health care. Individuals delivering the organizational apology might redirect focus not on the actual apology but on the underlying social, political, or economic reasons for the error and apology (Hearit, 1995; Yamazaki, 2004). An organizational apology offered by administrators asks providers and patients to make sense of mistake experiences (Gallagher & Levinson, 2005; Gallagher, Waterman, Ebers, Fraser, & Levinson, 2003) and forces providers and hospital administrators to reflect on mistakes in the larger practice of medicine.

Theorizing About a Cycle of Medical-Error Redemption

MidSouth Health providers, like any individuals working in an organization, were prone to making mistakes. Burke (1954) argued that when individuals in an organization reject or fail to comply with the rules and norms of an institution, they must make amends for the discretion. This is known as the cycle of redemption. This cycle is predicated on "two great moments": "original sin" and "redemption" (Burke, 1954, p. 283). In explaining his concept, Burke drew on the Christian belief that God created a perfect world in which humans lived in harmony

together. The first humans violated this perfection when they did something they were not supposed to do (eat forbidden fruit) and tried to cover up the action. Sin included the action and the cover-up. Burke's concept of original sin was focused on the feelings of guilt and shame that result from disrupting perfection and trying to hide it from others.

Emotions such as guilt and shame are required for individuals to be redeemed. Individuals experience guilt when they believe they have injured, hurt, or failed to help someone (Andersen & Guerrero, 1998). Conversely, shame focuses on others' perceptions of individuals who have erred. Shame is unequivocally tied to embarrassment because attention is focused on sinful individuals (Andersen & Guerrero) and is the product of being exposed. Shame and guilt work together to magnify mistakes, forcing individuals to recognize and correct their wrongdoing. If individuals do not feel guilt or shame, then they believe they have not engaged in wrongdoing.

Individuals enter the purification stage of the cycle to rid themselves of guilt. Purification comes in two forms: mortification and victimage. In mortification, guilty individuals offer some kind of personal sacrifice (Samra, 1998). Individuals symbolically offer something to society to restore balance, usually in the form of publicly acknowledging mistakes. Victimage is a strategic act in which individuals transfer guilt by blaming another for the mistake, identifying a scapegoat or villain. An important element of the purification process is selecting a purification act that is equal to the wrongdoing (Samra). In mortification, the self-sacrifice must be equal to the sinful act. In victimage, the victim or scapegoat must be an appropriate actor on whom to place the blame.

Redemption, the last part of the cycle, is achieved when individuals' purification acts are recognized and accepted by others. Burke (1970) identified several options for redemption, ranging from rewards to punishment. For organization members dealing with redemption, the most appropriate option is counter order, when redemption is achieved through transcendence of sin by demystifying the wrongdoing and the organization. During transcendence through counter order, individuals are able to see the inner workings of an organization to understand why the mistake occurred (Burke, 1970); this removes the mystery of how the organization operates.

Medicine's "original sin" is the medical mistake. Medical mistakes run counter to the medical belief that the practice of medicine is the practice of perfection (Paget, 2004). In the traditional medical system, although mistakes are a common part of medicine, providers are prohibited from completing the redemption cycle. Mistakes occur, but purification and redemption do not. Redemption for medical mistakes is an extremely complicated process, especially because providers might continue to treat patients after the mistake. This redemptive experience is additionally problematized when programs and policies are created to direct providers' communication about medical mistakes. The use of organizational policy to help providers work through the redemption process led me to ask the following overarching research question: How does the MidSouth Health disclosure and apology program help physicians and administrators make sense of communicating about medical errors?

Research Practices

The findings presented in this article are from a larger study about physician sense making about medical errors and patient safety policies. Meaning making and sense making from an interpretive standpoint are collaborative endeavors, which allow researchers to meaningfully explore how social action and meaning are socially constructed (Lindlof & Taylor, 2002). I sought to capture MidSouth Health physicians' and administrators' experiences with medical errors and the impact a hospital policy had on these experiences. I began data collection once I received ethics approval from my university and MidSouth Health.

The Setting and the Program

MidSouth Health was a fully accredited, tertiary care, government-run medical center located in a mid-sized Midwestern city in the United States. MidSouth Health contained two major departments: the medical department and the administrative department. The medical department provided primary acute medical, neurological, surgical, and psychiatric inpatient services, as well as outpatient care. The administrative departments were comprised primarily of the chief of staff's office, billing, medical records, patient advocacy, and the in-house legal department. The administrative departments, especially the chief of staff's office and the legal department, played an integral role in negotiating the aftermath of medical mistakes by administrating the disclosure and apology program.

The disclosure and apology program was created in the late 1980s after a series of high-profile medical malpractice cases. The program cocreators felt these malpractice cases were the result of not talking openly with patients and patients' families about the errors. They wanted to create a program in which the hospital staff could be honest and open with patients and families. The disclosure and apology program involved several components. First, when a potential mistake was identified, physicians performed a clinical disclosure, an informal process whereby factual information was shared with

patients and families. Physicians explained what had happened but did not acknowledge fault in the potential mistake. The potential mistake case was passed on to the clearinghouse, which used medical and legal standards to determine if a mistake had occurred. If the clearinghouse determined that a mistake had not occurred, the chief of staff performed a closure, informing patients and families of the decision. If a mistake had occurred, the chief of staff performed an institutional disclosure, offering explanation, an apology, and compensation.

Data Collection

I conducted 34 interviews with MidSouth Health physicians ($n = 30$) and hospital administrators ($n = 4$). Of the 30 physicians interviewed, 14 were residents (physicians practicing medicine between 1 and 5 years) and 16 were attendings (physicians practicing medicine for more than 5 years). Seven attendings were also chiefs of medical departments. A majority of physicians were men ($n = 28$, 93%). Physicians identified working in a variety of medical specialties, including general surgery ($n = 6$), ophthalmology ($n = 4$), urology ($n = 4$), internal medicine ($n = 3$), anesthesiology ($n = 3$), ambulatory care ($n = 3$), optometry ($n = 2$), obstetrics ($n = 1$), cardiology ($n = 1$), vascular surgery ($n = 1$), pulmonary ($n = 1$), and infectious disease ($n = 1$). All of the physicians had been involved in a medical error and participated in the disclosure and apology process. I also interviewed the chief of staff and the three program cocreators: the head of legal services and in-house counsel, a physician, and the hospital's quality improvement officer.

Interviews ranged in duration from 45 to 120 minutes with physicians and 75 to 120 minutes with administrative staff. I used a semistructured interview protocol to allow participants to talk about their individual experiences and insights, recognizing that an interview is a coconstructed event (Heyl, 2001). The interview protocol focused on questions about medical-mistake experiences, disclosing and apologizing for medical mistakes, and the MidSouth Health disclosure and apology program. All of the interviews, with participants' signed consent, were audio recorded on a digital voice recorder. Transcription of interviews resulted in 330 pages of physician interview text and 51 pages of administration interview text, resulting in a total of 381 pages of single-spaced typed interview text.

Data Analysis

I engaged in a constant comparative method of analysis (Glaser & Strauss, 1967). A constant comparative method, as a type of grounded theory, requires researchers to "take control of their data collection and analysis, and in turn these methods give researchers more analytic control over their material" (Charmaz, 2002, p. 676). I began making notes of patterns while I conducted interviews and continued to highlight connections through the transcription process. After reading all of the transcripts and documents and gaining a holistic sense of the discourses, actual analysis of the data began.

The process began with data reduction and interpretation. I transcribed all interviews and read over the data to be fully immersed in the data. I manually coded the data from the transcripts and documents. I then identified recurring patterns of behavior and meaning in the data and used quotations from interviews and documents to illustrate these patterns. During the integration process, I was struck by how the ways physicians and administrators talked about the disclosure experience were similar to a cycle of redemption. My decision to use Burke's (1954) cycle of redemption emerged during the data analysis process as a particularly appropriate framework for this article.

I engaged in member reflection and debriefings to maintain credibility and rigor (Tracy, 2010). I shared initial analyses with an organizational informant (not interviewed for this article) involved with patient safety at the hospital who had participated in the disclosure program. Feedback was used to refine themes and analysis. I also engaged in debriefing sessions with a senior health communication scholar, who provided feedback on ideas and analysis for this article.

Disclosure and Apology Program as a Cycle of Redemption

MidSouth Health physicians worked through a redemption cycle when they participated in the disclosure and apology program after a medical error. The physicians reported experiencing guilt, shame, mortification, and victimage as they made sense of medical mistakes, disclosure, and apology. They experienced guilt and shame through the fears associated with failure and their unknown future. Through the disclosure and apology program, physicians engaged in mortification by disclosing and apologizing to patients and families. The physicians also performed victimage by re-envisioning themselves as second victims in medical-mistake experiences. Finally, the program's closures and disclosures served as spaces for counter order.

Failure and Fear as Guilt and Shame

After the medical "sin" of a mistake, physicians often experienced guilt and shame (Gawande, 2002). Guilt occurred because physicians inflicted unjust injury on a patient or because a patient died. Physicians experienced

shame as a result of the mistake being reported and exposed to patients and other physicians. For the physicians, guilt and shame resulted from failing their patients and in the fear of their unknown futures because of the mistake.

MidSouth Health physicians spoke in detail about how medical mistakes inherently represented a failure to patients and to the medical profession. For them, the practice of medicine was the practice of helping people. A mistake meant that the physician failed to help the patient, as explained by an obstetrics/gynecology attending:

> You just feel sorry. You can feel the emotion and the pain that the patient has. And most health care deliverers are pretty empathic people; otherwise, I don't think they would go into health care. . . . The other thing is, if it's a medical error, then you feel guilt. And you feel that you failed the patient in some way.

"Feeling sorry" highlights a key element of the cause of physicians' guilt: empathy. Although physicians are encouraged to emotionally detach to practice medicine (Halpern, 2001), empathy is still expected from physicians. This empathic connection to patients means that physicians place blame on the self. Failing the patient also means failing the self.

MidSouth Health physicians also saw the failure as a test of ego. Failure as a test of ego called physicians' competence into question. Admitting that they could make mistakes might break down physicians' confidence in their ability to practice medicine. The physicians conceded that admitting to mistakes challenged physician ego. If the physician is the "captain of the ship," as an internal medicine resident stated, ultimately, the physician is the one who must take responsibility for the mistake.

One element of MidSouth Health's mission statement was that patients should not leave the hospital in worse condition than when they entered. The pressure associated with that amount of responsibility might force physicians to shift the blame to another party. Another internal medicine resident discussed the defensive, ego-saving tactic that came with responsibility for errors:

> I think it is a real human tendency to look for blame in others. As I said, it's the nurse's fault, we don't have the right equipment, it was the patient's fault, they are too sick, it's their fault, how dare they die on me, or how dare they get this complication.

This resident's comment highlights how easy it was to identify a scapegoat in medical-mistakes experiences. By suggesting that another party was responsible for the mistake, the physician attempted to remove feelings of guilt and the shame that came with making mistakes. It was easier to put the blame elsewhere than to admit that the mistake might be of one's own making.

Finally, shame was experienced through physicians' fear of the unknown. A general surgery resident highlighted the questions that might race through a physician's mind as he or she attempted to negotiate guilt and shame:

> It was a sense of fear. What are people going to think about me? My peers; am I going to be embarrassed among my peers? Fear of failure in that my referring doctors are going to lose confidence in me. . . . I think fear of failure and embarrassment are much more stronger emotions than fear of lawsuit. And I think it is for most physicians.

For the physicians, there was a fear of not knowing the consequences for mistakes, be it judgment by their peers, a negative evaluation in their records, or disciplinary or legal action. An infectious disease resident questioned, "Why would you tell someone if you didn't know what was going to happen to you?" The guilt and shame physicians felt might never truly end, regardless of whether they had the opportunity to apologize and ask for redemption.

The Second Victim as Purification

In traditional medical-mistake narratives, the physician and hospital are often cast as villains and the patient as the victim (Carmack, 2010a). Often, the emotions physicians experience are internalized and silenced (Wu, 2000). The disclosure and apology program, in its re-envisioning of medical-mistake experiences, recast MidSouth Health physicians as second victims (Wu). The re-envisioning of physicians as second victims was a victimage act. Rather than strategically placing the blame on another individual, MidSouth Health physicians placed the blame on themselves, meaning there was no villain on whom to place blame for the mistake. Instead, there were only multiple victims in the tragedy.

One of the key components of victimage is that the newly identified victim must be an appropriate actor on which to place the blame. MidSouth physicians, like many other physicians, felt the guilt of failing their patients. As the individuals responsible for the medical errors, they were appropriate actors on which to place the blame. A cardiothoracic surgery attending explained how he placed the blame for an error on himself:

> You feel internally very bad about yourself. You look into yourself: "What could have I done differently? This person died on my watch." You feel really bad about it, you beat yourself a lot. Everybody does this. And people stuff it. Physicians especially, stuff it.

This act of internalization means that physicians were not taking the opportunity to work through the emotions of mistakes, further victimizing themselves by pressing their feelings.

Moreover, the cardiothoracic surgeon's reflection shines a light on the difficulties associated with making sense of medical mistakes. Physicians must deal with the knowledge that they have injured or killed a patient, and the recourse they seek is often to internalize the emotions. This internalization can be difficult at times, and physicians might not be able to detach the emotions experienced at work from the rest of their life. A urology attending reflected on how this tension influenced the way he emotionally made sense of mistakes:

> Of course you feel bad. I mean, you feel terrible because we all do. We aren't perfect, but we all expect perfection in ourselves. This is not a profession that accepts mediocrity. It just doesn't. I live by that standard and try to practice by that standard, but it's hard.

The urology attending's comment is interesting because it harkens back to the overarching tension in medicine of trying to be perfect and infallible. His comment also emphasizes that the drive for perfection is a requirement for physicians to practice medicine.

Many of the physicians talked about the need to detach and separate to make sense of mistakes. An infectious disease resident put this concisely when she said, "Well, you deal with it and move on." Moving on can be difficult because, although physicians might detach themselves from the experience, another patient or error might trigger emotional feelings; the physician still has other patients to treat. For MidSouth Health physicians, detaching from the experience served as an attempt to move past being a victim. If physicians did not think about the failure or work through the emotions, then they were no longer the victim of the experience.

Although a physician might make a mistake, he or she still has to see patients and care for others, potentially including the patient who was the victim of the mistake. It is this detachment for the patients' sakes that victimizes the physician (Halpern, 2001). Many of the MidSouth Health physicians used the excuse of detached concern to justify internalizing their feelings. By placing the patient's needs and care first, physicians were further victimized. The creators of the disclosure and apology program, although placing the patient first, were still concerned about the impact of medical errors on physicians and used the program to help physicians communicate their feelings of guilt.

Disclosure and Apology as Redemption

For many physicians, the redemption cycle abruptly ends before it can be completed because physicians are not encouraged or legally allowed to disclose and apologize for medical mistakes (Carmack, 2010b). Physicians at MidSouth Health were offered the opportunity to complete the redemption cycle. Redemption occurred in two ways. First, redemption and purification were achieved by physicians because they had the chance to talk to patients and families during clinical disclosures. Second, the hospital administrators had the opportunity to complete the redemption cycle by disclosing and apologizing for mistakes. MidSouth Health physicians did not actually have to apologize for mistakes; instead, the chief of staff did the apologizing.

The disclosure of mistakes is the mortification act. Disclosing mistakes to patients and families means physicians acknowledge that a mistake was made. Acceptance of the disclosure is essential to achieve forgiveness, and patients' perceptions of the process are used to judge success. An optometry resident reflected on the importance of obtaining patient forgiveness:

> I think probably in the beginning, I dreaded it. But now that's, I've been doing this a little longer, I try to keep things very professional instead of extremely personal. And I have found that when you work with patients and you are very honest and direct with them, and you really give them the sense that you have nothing to hide, they're actually very forgiving.

Many of the MidSouth Health physicians commented on how patients were extremely forgiving and understanding of mistakes when MidSouth Health disclosed and apologized.

Not only is redemption tied to forgiveness, but overall acceptance of making mistakes is tied to this forgiveness. An ophthalmology resident talked about how difficult it could be to accept a mistake when patients responded negatively to disclosure:

> Sometimes the patient's response to what you say helps or hurts, because if the patient really understands what you are saying and they give you this sense of forgiveness, then they understand and they forgive you. That makes you feel like, you know, it makes you accept it a little bit easier than if they get bitter and angry at you. You are already angry at yourself. . . . I will say this, if a patient is understanding and gives you that, it makes it a lot easier to accept and move on.

The resident emphasized the patient's response to his disclosure. The patient's response to a disclosure is just as important as the disclosure in the purification act.

Another important element of the mortification act is that the act must also be equal to the sinful act. In medicine, breaking the silence and talking about the mistake is discursively equal to the mistake. MidSouth Health physicians were able to seek redemption through disclosure of mistakes because disclosing mistakes offered physicians

the opportunity to demystify the sin. As discussed earlier, an important part of redemption is the counter order, or transcendence, of hierarchy. The entire purpose of disclosing mistakes is that physicians want patients and families to know what happened. By disclosing to patients and families, administrators demystify the mistake experience. Patients and families find out what happened during the procedure, when and how the mistake occurred, and have the chance to ask questions about the mistake. This helps to demystify not only the mistake but also medicine, because physicians have to explain medical terms and procedures so that patients and families understand.

The redemption cycle ended with partial mortification for the physicians interviewed because, although they were able to participate in the disclosure and explanation of the mistake, the apology and any compensation offer came from administration. Redemption of the mistake continued through the organizational mortification and counter order process of the closure or institutional disclosure. Closures and institutional disclosures were meant to foster warm emotions and forgiveness for all parties involved. The chief of staff said, "You know, one thing—and this may sound kind of funny—to me, these are very positive experiences. The prominent emotion that I feel is positive. We are helping somebody and we are doing the right thing." Regardless of whether patients and families participated in a closure or disclosure, some kind of support was always offered, either in the form of monetary support (for those in disclosures) or in the form of other medical assistance.

These meetings also served as a space to communicate the emotions associated with the mistake. Physicians, patients, families, and administrators might experience a wide range of feelings, including anger, contrition, guilt, and forgiveness. One of the program cocreators explained how closures and disclosures could be a positive emotional experience:

> So, you know, it has a lot of emotions. It is almost like a happy ending. We all cry. Can't tell you how many cases I've sat in and cried in when we have a disclosure. Even in closure. Because you do feel, you feel so sad for people who have a loss. It's nice to have some kind of closure for the mistake.

Closures and disclosures were redemptive because they provided a kind of ending to the medical mistake event, although the impact of the mistake might reverberate in physicians' and patients' lives long after the meeting had ended.

Closures and disclosures were also redemptive because, like the disclosure physicians delivered after a potential mistake, they broke down the mysterious ways the hospital handled medical mistakes. The chief of staff explained that during closures and disclosures, providers and administrators focused on what happened in the procedure that caused the mistake or complication. Once patients and families realized that the hospital was not out to hide or cover up the events, patients and families became more open about the process. The MidSouth Health program emphasized the mortification element of the closure and disclosure process by openly explaining the process and answering patients' and families' questions about the mistake or complication.

Patients and families did not always see the closure or disclosure as an act of redemption. Another program cocreator, in her recounting of a medical mistake case, remembered how one patient's family was not convinced that an error had not occurred:

> I think the son was feeling guilty. He became [slams hand on desk] belligerent and threatening and got in my face. I had doctors who had come down to spend their time going for hours through the records with the attorney and this family, explaining what happened. And explaining it. And to have this guy just continually, "You lie!" You know, and just, it was just horrible for all of us.

It was a "moral heartache," as she called it, that drove physicians and hospital administration to attempt redemption.

Although MidSouth Health physicians did not have the opportunity to participate in the final redemptive act of the apology, the physicians did participate in counter order by disclosing the mistake to patients and families. Simply completing the elements of the program, however, did not mean that the redemption cycle was completed. Patients and families might choose to reject the apology and offer of compensation. Disclosing and offering an apology did not automatically mean the physician or hospital was granted absolution.

Discussion

MidSouth Health physicians had the opportunity to work through the "sin" of medical mistakes, attempt redemption, and demystify medical-mistake events through the hospital's disclosure and apology program. The physicians experienced guilt and shame through a fear of unknown retribution and the feeling of failing patients. These physicians had an opportunity to move past these feelings through the disclosure of and apology for medical errors. Allman (1998) found that physicians might disclose mistakes to other physicians, but do not often get the chance to talk to patients and families about the mistake. The MidSouth Health program created a space for physicians to be re-envisioned as "second" victims, removing the label of villain. Finally, physicians had the opportunity to seek redemption by disclosing and explaining how errors occurred. Hospital administrators

completed the final task of redemption, offering an apology and compensation to patients and families.

The two components of the program, disclosure and apology, represented different elements of the cycle of redemption process. Disclosure was an example of counter order; physicians were able to explain what happened and demystify the event. The apology part of the program was a chance for administrators to enact mortification. For physicians, the mortification process was prevented because the apology for a medical error was co-opted by the administrators. When the chief of staff delivered the apology, the apology became an apology-by-proxy (Harter et al., 2000). This was done to highlight the social problem of medical mistakes and place blame on the hospital. This also meant that the physicians who made the mistake were not asking for redemption; the program served more as a way for the hospital to achieve organizational redemption. Redemption could not be truly achieved for physicians because they did not get a chance to complete the redemption cycle.

This co-opting of the apology act raises several issues. Can such a program be effective when physicians are not able to complete the redemption process? From the physicians' perspective, participating in the program was overwhelming positive, even if they did not actually deliver the apology. All of the physicians interviewed had participated in the program at least once, with cases ranging from a medication error (which was immediately corrected) to a misdiagnosis that resulted in the death of a patient. All of the physicians felt the program was a good program that allowed them to talk through the error and their emotions. From an organizational perspective, the program was effective. Since its inception, the hospital had seen a decrease in lawsuits, settlement costs, and defense costs; in fact, over the span of 13 years, only three cases went to trial.

The issue of effectiveness is tied more directly to the cycle of redemption. According to Burke (1954), individuals must go through the entire redemption process to reach forgiveness. By this definition, the program would not be effective because physicians did not deliver the final act of redemption; however, this article complicates our understanding of this theory in several ways. First, Burke (1954) assumed in his theory that redemption is being sought by an individual. One of the key elements of the MidSouth Health program was that the hospital reframed the medical error as an organizational error, not an individual one. Second, by stepping in and taking over the redemption process at the apology, the administration potentially sanitized the experience for physicians, saving them from the messiest and most difficult part of the discursive process. Although it might be possible to argue that physicians were able to complete the process without completing one part, removing the last redemptive act makes it almost impossible for this to happen.

Additionally, the redemption process is a continuous one because individuals are constantly sinning and seeking forgiveness (Burke, 1970). Most communication research on apology treats the sin, redemption, and apology as a single discrete act. Individuals make a mistake once, atone for that error, and promise that the mistake will not or should not happen again. What happens when mistakes are a part of that everyday organizational life? Medical mistakes are a continuous part of medicine (Paget, 2004), making the redemption process neverending. MidSouth Health physicians did learn from a medical error, but learning did not mean that the mistake would never happen again. This program highlights the need for communication and health scholars to study apology as a continuous process, especially when individuals are in professions in which mistakes will continue to occur. As disclosure and apology programs become more popular, an opportunity emerges to explore what happens when mistake and apology are common organizational practice.

Limitations and Future Directions

There are several limitations to this study. First, although I interviewed physicians, administrators, and the program cocreators, I was limited in the type of physicians I interviewed. I attempted to have equal representation from all different departments at MidSouth Health; however, the vast majority of physicians who agreed to be interviewed were surgeons. There are two reasons for this. First, my main informant was the former head scrub nurse. She helped recruit participants and primarily contacted surgeons. Second, although I extended the invitation to all physicians, some groups, such as emergency room doctors, did not wish to participate.

Additionally, the only type of provider I interviewed was physicians; I did not interview other practitioners who might have been involved in the program, including nurses, physician's assistants, or pharmacists. The experiences of these groups with the program might have been different from the physicians I interviewed, and future studies should explore their experiences with the program. Finally, there was a clear gender imbalance among the physicians. Only two women chose to be interviewed, although any physician who had participated in the program could have been interviewed. Gender, medical errors, and apology in health contexts have not been explored, but it is possible that women might approach the disclosure and apology policy differently or make sense of mistake experiences in different ways. More research is needed to explore the role of gender in medical errors, disclosure, and apology.

Patient experiences were also not included in this study. MidSouth Health was extremely protective of their patients, and providing me information about patients who had been involved in cases of medical mistakes was

not feasible. Exploring patients' views regarding medical mistakes and the ideas behind disclosure and apology is an important element of the complex medical-mistake experience. Future research should focus on patients' understanding of medical mistakes, disclosure, apology, and the MidSouth Health program.

Finally, there is need for a critical analysis of this program. This was an interpretive case study that leaves many critical questions unanswered. Future research should explore issues of authority, control, patient empowerment, and patient–provider relationships. Additionally, future research could problematize the impact of disclosure and apology programs on larger medical narratives of care and on well-established traditional hospital approaches of "deny and defend."

When physicians make medical mistakes, they strive for forgiveness from patients and patients' families. MidSouth Health's disclosure and apology program provided physicians and administrators the opportunity to work through the redemption cycle, expressing emotions that are often hidden away. The program raised interesting questions about the role of redemption in the practice of medicine. Ultimately, such a program reminds scholars and practitioners that medicine is filled with uncertainty, emotions, and absolution for all involved.

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