How to do Responsibility: Apology and Medical Error
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In a kind of hoary misreplication of the cancer diagnosis in which a patient is told he has only a short time to live before cancer kills him, a young man at Kaiser Permanente in San Jose man was recently told he had only three days to live after hospital staff mistakenly administered cancer treatment into his epidural shunt in place of another drug. Accidents involving toxic chemotherapy drugs have happened before, in other places, such as the highly publicized lethal overdose given to a young journalist of the Boston Globe a few years ago.[1] Chemotherapy drugs have evolved from nitrogen mustard gas, originally used as a chemical weapon. They have been used since the early 1940s in hospitals, and one might wonder, given the combination of the relatively long history of use and its extreme toxicity, why such seemingly avoidable errors happen with frequency.

One could imagine that in many hospital settings, doctors will be rushed, nurses under-trained, and pharmacists sloppy. Indeed, mistakes in pharmaceutical delivery have been recorded for hundreds of years, and offer some of the earliest cases of the burgeoning area of law involving medical error in the nineteenth century. One might well ask why drugs aren't color-coded such that certain classes of drugs can go only into certain colors or designs of containers. One might wonder about designing epidural shunt systems that would differ from chemotherapy delivery ports, such that poison drugs only match one or other type of hook up, and thus a nurse would be unable to put the wrong genre of chemical into the wrong part of the body. One might consider this issue as an issue of design: of labeling, bottle shape, storage cupboard organization, as well as one of human error. Further, one can imagine this kind of systematic error—no one's fault and no one is noticing—all the way back into the delivery systems, drug manufacturing, and into basic research. How can we trust that the active ingredients are in the pills we take, or that the cell line with the right cancer is being used in the basic research?

Some reports estimate that well over 100,000 people a year die in the United States due to medical errors—and these account for only immediate deaths, not short and long term

disability or premature death due to error.[2] Indeed, there is no good way to collect this data, since it relies on self reporting of physicians and hospitals who may have an interest in under-reporting. However, given the low rates of litigation (only about 2% of injured patients ever attempt a lawsuit), state-by-state legislation limiting compensation to only $250,000 in California (not enough to cover the cost of launching a medmal trial), and the lack of other systems of accountability, very little incentive exists for medical systems to improve.[3] What, then, does responsibility in medical practice mean, and particularly in relation to the recent fashion of medical apology?

The case outlined above case presents a more egregious and obvious case than many: it's hard to justify or evade fault for the unexpected deaths of young people in a clear case of drug misadministration. The aspect I dwell on in this paper concerns the hospital's publicity statement that it took "full responsibility" for the incident.[4] The press releases did not discuss what responsibility might mean in this context, one imagines it might cover one or more of offering compensation to the victim's family, redesigning the drug delivery systems at all Kaiser hospitals, or punishing or firing the individuals involved in the killing. However, the incident raises a new aspect of an emergent public relations adoption of the term responsibility, one that is found in the increasing demand on doctors to offer apologies to patients. From a legal studies perspective, the medical apology offers one place to better understand what responsibility means in conditions of bureaucratic for-profit medicine and how it relies on contradictory modes of care and corporate relations that balance and rely on a logic of individuated notions of neoliberal responsibility, an intense desire for a human and personal interaction, and principles of cost spreading central in different ways to risk management and tort.

Insurance companies present the apology to doctors as a way of limiting medical malpractice claims. The doctor is perhaps being asked to present a human face to what might be considered a medical bureaucracy that controls how much time she will spend with a patients, which tests and treatments insurance companies will pay for, and how carefully and competently the delivery of those treatments will be done. One might suggest that the generally high compensation for physicians includes taking on this role of providing a human face to the system at the same time as negotiating conflicting patient and industry interests. Others might suggest that such apologies force physicians become fall-guys for the medical bureaucracy. Such role

slippages in the job description offer an opportunity to reflect on medical responsibility in light of the humanist aspects of apology and the material expense of medical error for patients, physicians, and bureaucracies.

A paradox lies at the core of current discussions about medical error in accounts of both apology and medical malpractice law that has to with the human imperfections of even the best and most motivated physicians. On the one hand, doctors indisputably make mistakes in diagnosis and procedure that could have been avoided. Quite simply, doctors can maim and kill people with the slightest slip-up, the tiniest moment of inattention. Doctors make mistakes: some much more than others, some with more and less grace, and some with more and less associated attention and care. It is also virtually impossible for a non-specialist to know or find out how good a physician is, since good manners do not mean good medicine, nor, necessarily, do loving patients make a competent physician. The data on physician skill and efficacy are not collected. On this side of the paradox lie claims that vary as widely as the observation that mistakes will inevitably made (to err is only human, after all) and the claim that apology is simply a conceptual and linguistic impossibility in power dynamic within which one person's oversight can kill another person. Still, on this side of the equation, claims that doctors should have no responsibility for intentional or unintentional mistakes and that the responsibility should lie solely with the system seem too indemnifying.

On the other hand, fault for error can often be distributed in many ways, as one sees with the Kaiser Permanente example. Does fault lie with the system designer who neglected to use a system of color coding, the nurse who didn't check the drug name, the technician who mis-filled the prescription, the person who mis-stocked the shelves? Was it the doctor whose handwriting was illegible, or the names of the drug codes that were too similar? Was it the insurance company that would pay for only a few minutes, rather than for the thirty minutes adequate attention would have taken? In this sense, claims to individual fault miss the structural nature of injury production.

The use of the medical apology exemplifies the contradiction at the heart of contemporary corporate medical provision, and one that is rarely fore grounded and examined in the context of differing notions and presumptions of responsibility. At the level of analysis one question becomes: on what basis, to whom or what, and with what goals, can wrongs be

assigned? What political models do such assignments rely on and presume? At the level of structural change: if no one is responsible for the moral – rather than the economic – wrongs, then how can improvement in what is clearly a broken system of healthcare delivery be fulfilled? Is responsibility merely a public relations moment, something that is realized through the speaking of it? The conditions of modern medical bureaucracy call for the development of new ideas and analyses of responsibility than those offered by either medical malpractice law (which has utterly failed in regulating the provision of medical care) or medical apology (which does not indicate any responsibility toward systematic improvements to reduce medical error).

I: TRACING FAULT

Even the best doctors carry malpractice insurance in order to protect them from personally having to pay the costs of rectifying errors made when by definition peoples' lives are at stake.[5] It also protects them from having to pay for defending themselves in court in the case of a frivolous or misguided claim. Study after study has shown that juries tend to be predisposed in favor of physician-defendants, but even the winner of the case will have significant costs if the case goes to trial largely because of the high charges levied by medical experts and the high hourly wages of defense lawyers hired by the insurance firms (plaintiffs' lawyers work on a contingency fee basis).[6] Ideally, medical malpractice insurance also protects a physician's patients, potentially allowing a way for medical errors to be paid for without bankrupting the physician. Medical malpractice insurance accounts for about 2% of healthcare costs and is folded into the costs of healthcare, and in this ideal world, these costs present merely as the cost of doing a dangerous business. Most business owners carry insurance in case their customers are injured. Bugaboo Sports, in Santa Cruz, for example, carries insurance for $1 million lest someone slip on the floor and break a leg, the same amount carried by most California primary care physicians. In this sense, the medical malpractice system offers an insurance system, albeit in expensive and wasteful terms.

These theoretical underpinnings of medical malpractice law recognize that some medical errors are inevitable, and that neither should physicians be held criminally responsible nor should patients go untreated or personally pay for physician mistakes. This theory suggests that mistakes might be kept to a minimum through careful medical practice and that the threat of

litigation would ensure deterrence and systematic changes where necessary. Insurance premiums would be priced a little above the costs of pay-outs and no one would make undue financial profit or find themselves overcome by greed.

However, medical malpractice law is more typically understood as a system of blame, and doctors tend to take claims personally. This point is absolutely critical in understanding the culture and politics of medical malpractice law and the confluence of what one might expect to be very different investments in patient health. Of the many places to turn to understand this personalization, I look here to Atul Gawande's comments in his universally acclaimed book, *Complications: A Surgeon's Notes on an Imperfect Science*, which reached a wide audience in the United States after having been serialized in the *New Yorker*. Among the first of a popular genre of books by physicians, Gawande writes a compelling account of his training to become a surgeon.

In some sense the book offers a revolutionary account of surgery. While various internal debates in the profession have drawn an audience outside itself, particularly where patients have come to request higher standards of evidence that surgical interventions are not overly aggressive (as in the women's health movement), by and large the professional debates have remained inside the field of practitioners. Surgery's particular mode of physical labor, requiring cutting into other humans, the enormous risks of such endeavors, as well as leaps of faith in its efficacy against the huge costs and side-effects of surgery, nearly seems to require the "great man" philosophy after which the profession has modeled itself.[7] Gawande manages both stylistically and through the details of his medical training, to both remain inside of the surgical profession, but also to comment on it as an interested and informed observer. In this sense, he occupies a space that is both insider and not quite insider as he narrates his coming-of-age story as a surgical resident.

To be sure, his narrative brings all the elements of a good adventure – life, death, blood, close calls, quick decisions, emergency, and attempts to save lives in a system that seems often to work against him. In one instance, Gawande recounts his inability to successfully give an emergency tracheotomy to a patient.[8] He readily admits his own shortcomings in the event: he does not call for help soon enough out of hubris, he doesn't have enough light or suction, he is so inexperienced that he makes a cut horizontally rather than vertically. The patient only survives

through a pure last minute stroke of luck when another physician inserts a pediatric breathing tube.

Who knows if Gawande would have written about this case had the patient died. But this example, coming early in the book, does critical work on several levels. First, it factually records a simply horrifying instance of an improperly trained doctor with the pressures of ego and insecurity, and insufficient back-up of either institutional or professional support involved in a procedure. Second, the reader understands this instance as commonplace event in hospitals, and Gawande spends a fair amount of ink convincing his readers that the training of surgeons requires such risk and cost to real flesh. Third, the incident provides an opportunity for Gawande to explain the procedure for the hospital's safety and disciplinary review of such events. And fourth, the story and others interpellates the reader into Gawande's account through some key literary strategies in which the power differentials between doctor and patient are disavowed. (In this instance, for example, he comments that once his patient is able to breathe, Gawande is as well, as if actual and metaphorical breathing were the same, or as if the breath holding of a stressed professional were equivalent to the fact that this patient was actually dying on the table). Through this inauspicious conversational tone, *Complications* offers a hard hitting political argument. The reader cannot *but* sympathize with this autobiographical narrative in which the honest surgeon as up-standing citizen does his heroic best in a system that could be better.

The discipline Gawande receives after this failed tracheotomy consisted of a reprimand by a senior colleague and what become important in the retelling is Gawande's feelings and the private interactions among surgeons. There was no informing (or even discussion of informing) the patient or the family of the long period of oxygen deprivation and extraneous cuts and stitches, no apology to the patient, no discussion of compensation, and no consideration of systematic changes that may have led to a different situation. In thinking through surgical discipline and responsibility Gawande does not discuss those things, but rather turns to a posture about medical malpractice law, writing that:

> There are all sorts of reasons that it would be wrong to take my licenses away or to take me to court. These reasons do not absolve me. Whatever the limits of the M&M [the

> meeting of physicians that reviews the errors of the week, including that one], its fierce *ethic of personal responsibility for errors is a formidable virtue*. No matter what measures are taken, doctors will sometimes falter, and it isn't reasonable to ask that we achieve perfection. What is reasonable is to ask that we never cease to aim for it.[9]

The reader learns little about what this "personal responsibility" actually means, though certainly in a sense it seems to be something that surgeons have to each other rather that to the patient, though the patient ostensibly benefits when the surgery goes well. Responsibility in this case did not mean disclosing the events to the patient, nor did it mean completing a structural analysis of the factors that led to what would have been a death or serious disability.

Gawande sidesteps the two most controversial questions raised by his book. First, what *should* happen to those patients who provide the meat on which surgeons may practice their highly remunerated craft? While readers may agree that practice on real patients is a necessary evil, they may want some recognition of the human costs of that practice. In discussing how people unwittingly donate their bodies to the cause of training surgeons, he readily admits that he would never allow a surgical student to work on him or his family. He thus raises a question he does not pursue, questions that raise but also exceed class and education differentials in the receipt of medical care.

In the world beyond the training of Atul Gawande, those least able to afford the extra financial costs, lobby their carriers for coverage for the extra health problems caused by surgeons-in-training, and bear the physical costs of ill-health are the ones who unknowingly donating their health to this cause. But if we as analysts want to put our sympathies with the patients who will bear the costs, it is worth remembering that once inside the medical system, no one is immune to the basic fact that bodies are simply work objects which sometimes must bear mistakes, errors, and sloppiness. Second, had the botched tracheotomy ended in a death, how would it have been explained? As an accident that was not preventable? As an acceptable outcome of an emergency situation? As a compensable medical error?

Physicians have been unable to "murder" patients in the normal course of medical treatment since the mid-nineteenth century, when the law determined that anyone who called himself a physician would be legally protected from criminal charges.[10] This led to the

subsequent development of more clear professional training and certificate programs and to the ongoing externalization of alternative and "quack" medicine. Since that time, patients have had a legal a right not to the best care, but simply to average care. As a jury in 1857 was charged, since every physician cannot by definition give superior care, to require such care would mean that many people would simply get no medical attention at all: "That the law did not require of the defendants eminent or extraordinary skill; that this kind of skill is possessed by few. An absolute necessity requires that the wants of a community must be supplied with the best medical knowledge its means and location will command. To require the highest degree of skill would deprive all places, except large cities, of medical men."[11] It was never clear in Gawande's tale whether the successful emergency tracheotomy would have equated average or exceptional medical care.

Contemporary Medmal plaintiffs still must prove that the care they received did not meet the professional "standard of care," for which they depended on other physician experts to testify. Only very occasionally will a court attempt to push the profession to adopt higher standards, as in one case in which a judge ruled that even if it were not the standard of care to count sponges after a surgery, it should have been. By and large then, physicians are the gatekeepers to the standards of their profession.

How, then, do nodes of responsibility (in terms of how deaths are attributed to certain kinds of behaviors or intent) determine how deaths are categorized? A murder is different from an error, different again from an accident. Gawande's text provides an important clue to how deaths are scripted as acceptable or not. Gawande presents ideas about what a patient – or rather a population of patients – can reasonably expect, except that what he leads us to expect in the best case scenarios, is that these decisions are made behind the closed doors of the surgical M&M meetings. Surgeons will make mistakes, and in his view, when they do, they should not be taken to court.

Medical malpractice law operates on a parallel but opposite basis. The legal theory supposes that since statistically, some people will suffer inevitable mistakes, the costs of the mistakes should be spread across the population, such that each person pays a little bit for the inevitable mistake that one person will suffer. Medical malpractice law offers a means of distribution such that the cost of the error does not fall to just one person. In this view, it is

indeed precisely when a doctor injures a patient that the court should be called on to insure that amends are made.

In this sense, Gawande confuses several critically important issues. First, he mistakes the individual surgeon who has to learn and who will make mistakes throughout his career for someone who should be responsible only to the profession (and not to the patient) for those mistakes. He overrides the enormous costs of those mistakes, acknowledging them only through his own efforts to try to avoid them. He further confuses the compensatory function of law for a moral system of blame. While he admits to feeling shame (feelings in a man are good, though who knows how such sentimentality would have gone over had the author been one of the 3% of surgeons who are women?), he completely ignores the questions of patient knowledge of error, whether patients being practiced on should pay reduced rates for care, how systematic analysis of error might lead to corrections in healthcare delivery, such as lack of light, jammed suction equipment, or, as in another case he mentions, lack of resources for quick research into which emergency medical procedure might yield the best results and what backup plans would be appropriate. Aiming for perfection is certainly an admirable goal, but ultimately, in Gawande's book, perfection remains a noble individuated fantasy.

The medical system has notoriously little oversight. One physician reported to me that she has tremendous resistance from physicians in her clinic in trying to set up a system for analyzing medical error at her clinic. Dr. Yvez (name changed for privacy) attempts to employ "root-cause analysis"; in any given situation she asks the doctors at her clinic which parts of the error were preventable, potentially preventable, or not preventable?[12]

In her view, medical errors are often built into the system. For example, the two vastly different drugs, magnesium sulphate and morphine sulphate have the same prescription short hand. Or often very different drugs are stored in similar packaging and placed near each other in storage areas. The way that American health insurance works also means that patients change doctors often, making it virtually impossible to build relationships between physicians and patients or even to maintain complete patient records. Physicians, then, may not have the history and relationship necessary (an understanding of how an individual might present symptoms, a desire to spend some extra time with a patient when necessary, or a sense of the patient's personal and work life) to make good diagnoses. The National Academy concluded that the high

number of deaths due to medical error is simply the "price we pay for not having organized systems of care with clear lines of accountability."[13]

The potential success of the root cause method of understanding medical error was demonstrated in the 1970s, when the death rates of patients undergoing anesthesia in the United States was 1/10,000.[14] Simple mistakes were leading to the deaths of 3500 Americans a year, even with a doctor dedicated solely to administering the drug and watching the patient during surgery. In the early 1978, the engineer Jeff Cooper published a paper documenting his study on anesthesia, "Preventable Mishaps: A Study of Human Factors." He reported that:

> Most of the preventable incidents involved human error (82 per cent), with breathing circuit disconnections, inadvertent changes in gas flow, and drug-syringe errors being frequent problems. . . . [E]quipment design was indictable in many categories of human error, as were inadequate experience and insufficient familiarity with equipment or with the specific surgical procedure. Other factors frequently associated with incidents were inadequate communication among personnel, haste or lack of precaution, and distraction.[15]

The paper was notable in the sense that it was written from the perspective of an engineer, and took system design into account. While widely discussed in the late 1970s, there was no move to change the systems and the statistics became a stand-in for one of the acceptable risks of surgery. Oxygen monitors, for example, had been available for years but no one used them. The machines were not standardized so that on some one turned the knob to the left for more oxygen, and others had to be turned to the right. Shortly afterwards, ABC's 20/20 showcased the issue, illustrating the thousands of people permanently disabled from anesthesia. Finally, Ellison Pierce, president of the Society of Anesthesiologists, mobilized the society to focus on the problem after a friend's daughter died during a routine procedure.

Science and Technology Studies (STS) has developed some ideas of how responsibility can be shifted between objects and actors in technical systems. Peter Galison, in tracing accident reconstruction in airline accident investigation, writes that "there is an instability between accounts terminating in *persons* and those ending with *things* … *it is* always possible to

trade a human action for a technological one: failure to notice can be swapped against a system of failure to make noticeable."[16] Where blame rests -- with the person or the thing -- is an intensely political question. It becomes more complicated when the thing being blamed is a service, and one given not in the context of a contract where a patient has fully informed consent, but in the context of a tort, in which a patient has a right not to be injured. How might we think further through these notions of individual responsibility, bureaucratic systems, and patient injury? The medical apology provides one venue for such analysis.

II. Apology

Nearly everyone agrees that the medical malpractice system rarely works in its stated goals, either to fairly compensate those injured or to encourage systematic changes in healthcare provision to reduce injury rates. One recent approach adopted by insurance companies to reduce the incidence of medical malpractice litigation trains physicians to apologize immediately after a medical error. These apologies generally take the form of a carefully worded statement that takes "responsibility" for an incident and an offer of a small settlement. While leaving open the precise meaning of responsibility, this approach to medical error is based on studies demonstrating that the attitude of physicians matters a great deal in injured peoples' decisions to initiate litigation. Many times patients want an acknowledgement of the harm done and an apology rather than an actual monetary award, and the law does not allow for apology.

Despite the legal theory of tort that sees the laws role as something of a cost-spreading mechanism, the determination of the injured status requires the physician and patient to take an oppositional stance, one in which each side argues their case as strongly as possible in an effort to "win." Thus, parties that were initially assumed to have worked together for the higher goal of patient health, such as doctors and patients, take a stance that may be highly uncomfortable for both. In this legal positioning, the patient rarely gets and apology and the doctor rarely gets to acknowledge an error.

Commentators on the right and the left have welcomed apology as a means of healing and avoiding these oppositional and expensive compensatory regimes. However, these commentators have missed the critical and high stakes, and thus diminished the role of the apology in constituting new models of medical responsibility. On the one hand, the apology

offers a sort of human touch and patients who welcome the apology might well find that the system is at its most "human" precisely when it is attempting to limit its liability. On the other hand, apology implies a level of responsibility that may not exist, or implies that some action might be taken when it will not. And so it remains utterly unclear what the apology has to do with responsibility, and at the social level, it remains unclear what, precisely, medical responsibility entails.[17]

Tort, rather than contract law officially guides the terms of responsibility that inhere in medical practice are those of (this came about in the mid-nineteenth century). Tort and contract offer differing notions of chance and of the agency of the parties. Thus, the legal relationship between patient and doctor is not one of mutual agreement about the possible costs and benefits to a treatment, but rather one in which the patient has a right not to be injured and a right to sue if the care received does not reach standards set by the profession. The apology seems to be at odds with the legal framing of the relationship.

The apology offers a highly formalized mode of speech intended to promote social healing. Lucian Leape, a main advocate of the medical apology in the United States, writes that an apology serves six functions for the person to whom an apology is directed. The apology heals, he says, by a) restoring dignity and self respect to the injured party, where a lack of apology intensifies the humiliation of injury; b) providing assurance of shared values and reaffirming the injurer's commitment to the rules and values of the relationship; c) assuring the patient that he is not at fault; d) assuring the patient that he is now safe, that steps are being taken to ensure no further injury; e) showing that the doctor is also suffering, thereby leveling the playing field; and f) demonstrating an understanding of the impact of the injury.[18]

Leape's explication holds several assumptions about the doctor-patient relationship that are not drawn out. For example, he seems to assume that suffering levels the power differentiation between doctor and patient or that modes of suffering are in some way equal. Nevertheless, Leape proffers that a true apology can have an exonerating quality, theoretically similar to the effect of money in a legal damage award, through which everyone can feel heard and attended to. In this sense, as the philosopher of language J. L. Austin writes, apology is a performative act in which the verbal act of apologizing brings a new relationship into being.[19] Often in reporting on the apology, patient narratives are held up in support of its value: one

patient, who settled with the hospital after he received an apology for a sponge left inside his body cavity, "They honored me as a human being."[20]

Though the theory behind tort law differs from that of the apology, both doctor and patient can also feel that the costs of the mistake have been made up by a compensatory award negotiated through litigation. In this sense, by negotiating an apology, the insurance companies merely attempt to make the apology happen sooner, in a slightly different form, and in a less expensive way. An apology that enables an early settlement saves money for both plaintiff and defendant at a time when a potential plaintiff may be more inclined to settle for less. Citing reasons that vary from the healing effects of apology to the costs of litigation, many states have encouraged this mode of conflict resolution by disallowing apologies to be used as evidence of wrong-doing in courts, thus protecting doctors and hospitals from having "admitted" to any wrongdoing.[21] In that sense, the honoring of the human is a temporary initiative.

The kinds of errors that occur vary vastly in scope, seriousness, likelihood of being detected by patients or colleagues, and regulation. Certain injuries must be reported to regulatory boards and investigated, such as removing the wrong limb. These cannot be "apologized" for.[22] But for the vast majority of injuries, which have no regulatory infrastructures, insurance companies have significantly reduced their costs by using apologies. Such apologies typically claim responsibility in a vague way (rather than offering specific directives for how will change practices or procedures), and are used as an alternative method of negotiating settlements for injuries that a hospital's public relations might describe as "unanticipated medical outcomes," or "possible risks of the procedure."[23]

Citing multiple sources, Liz Kowalczyk wrote in 2005 that:

> Colorado's largest malpractice insurer, COPIC, has enrolled 1,800 physicians in a disclosure program under which they immediately express remorse to patients when medical care goes wrong and describe in detail what happened. . . . Since 2000, COPIC has reimbursed more than 400 patients an average $5,300 each for bad medical outcomes, or a total of about $2 million. . . . malpractice claims against these 1,800 doctors have dropped 50 percent since 2000, while the cost of settling these doctors' claims has fallen 23 percent. The University of Michigan Health System has cut claims

in half and reduced settlements to $1.25 million from $3 million a year since developing a disclosure policy in 2002."[24]

A complicated politics of medical malpractice law and insurance policies discussing the decisions and variability of medmal defense strategy beyond the scope of this essay, but worth noting since these insurance strategies make it nearly impossible to interpret the numbers cited by Kowalczyk. But my goal is not to enter the fracas about whether and why medical insurance rates are skyrocketing, or how the apology saves and costs money. Rather, I am interested in the politics of adding this particular mode of human interaction in explicating errors and compensating injuries.

One of the factors that makes *Complications* such a compelling read is the way that Gawande negotiates what he understands to be a central mystery of medical practice: the fact that a doctor simply will not perform perfectly every time. Statistically, a doctor will make mistakes every so often while performing relatively simple procedures. As he repeats often in the book: a doctor may strive for perfection, but she will never reach it. Thus, since error is inevitable, he struggles with how fault should be understood.

The medical apology adds another level of complexity to this question, for the question of compensation and structural change in health care delivery rests on the attribution of responsibility. In the case of medical error, the rescripting of injury is particularly interesting since the profession already requires a fine balance between the skills of each individual physician and her ability to rely on and work within circumscribed medical protocols (an oncologist would be remiss not to recommend chemotherapy in many instances, even though its actual efficacy for several cancers remains controversial) as well as bringing her unique judgment and expertise. Even the highest ranked physician in an operating theater will be dependent on the infrastructure of services and materials available. Thus Gawande analytically and ethically struggles with his apotheosis of the individual surgeon and how to understand him in relationship both to the social organization of the hospital and the social aggregate of patients.

To be sure, Gawande gives examples of the ways in which these statistics can be altered. He writes of a hernia hospital in Toronto that perfected the surgery and delivery and brought error rate to close to zero, with the implication that rates of all kinds of surgeries could be

brought to zero with attention to questions of structural design and technique. Elsewhere he has written about hospitals' refusal to adopt simple measures such as standardized hand washing and draping procedures that have been shown to diminish infection rates to practically zero. Nevertheless, in *Complications*, statistics perform something of a mystic discourse which grounds his assertion that surgeons will never reach perfection.

Constructing this language of chance requires a rendering of medical errors as detached from any particular actors or systems. Rendered at the level of the aggregate, a language of chance absorbs the particular circumstances of a wrong cut or a lost sponge, and then these incidents are ritualized into the language of accident. Any injury may be at once predictable at the level of the aggregate, and explicable through certain sets of particularized instances. This critical slippage stands in for a sort of humanist bind for Gawande: we want to do right, but we can't. Since we can't, we are doing our best and so should not be sued. The bind is one of action and being acted upon, the doctor is both the person in charge, and yet still only human in situations that do not "cover" for that humanity through the careful design of technologies and systems.

Only through the concept of the population can an injury be understood as accidental—on the individual level there is always a reason for it. A driver who runs over a pedestrian is nearly never criminally charged, since the structure of automobiles and intersections seems nearly to require the predictable 6000 annual pedestrian deaths. As I have argued elsewhere, changes to automobile design, changes to modes of responsibility, or changes to intersection politics could reduce these rates at the structural level. In lieu of those social changes, pedestrian fatalities remain predicable. We don't know who it will be, it will be someone and each time we walk outside we imply our consent that it may happen to us.[25]

Medical apology cannot be understood outside of the broader attack that insurance companies have led encouraging tort reform. The insurance industry lobbied extensively to cap damage awards on Medmal claims, leaving many people unable to retain a lawyer for their injuries. In California the maximum award for any medically induced injury is $250,000. Insurance companies have launched a media blitz ridiculing "frivolous claims," and set up in-house legal departments enabling them to battle claims and settle only on the court-room steps, thus purposely driving up costs and scaring contingency fee plaintiffs lawyers from taking cases.

As one plaintiffs' lawyer claimed, a "doctor's apology [will] get the case settled for a lower amount of money, but if there is no immediate settlement, they will aggressively defend their cases."[26]

In these circumstances, what is the potential for the kind of "real" apology described by Leape? Lee Taft, an apology theorist, writes that, "The remorse and regret conveyed by the words 'I'm sorry'" imply a willingness to change, a promise of forbearance, and an implicit agreement to accept all the consequences, *social, legal, and otherwise*, that flow from having committed the wrongful act [italics mine]."[27] The medical apology seems to be a linguistic and logical impossibility. Medical apologies are carefully scripted. One article reports that doctors are told: "'Don't say 'I'm sorry I cut the wrong blood vessel,' say, 'I'm sorry you had bleeding.'"[28] According to apology theorists, this set of phrases cannot be considered an apology. First, it does not acknowledge the reason for the bleeding. Second, it completely elides the question of responsibility that an apology by definition must address. As I mentioned above, the doctor/patient relationship is one guided by the law of tort. Yet the apology explicitly offers an attempt to avoid the tort system.

In a debate framed around a moot surgery in which an error leads to the patient's death, one commentary enlisted two doctors to argue the cases for and against medical apology. The case against it is particularly illuminating. Keith Naunheim MD argues that when a patient is killed during a procedure, the dead patient will not gain anything from the reasons for apology (enlisted by Leape, above). Further, Naunheim dismisses the benefits of compensation: "Thus, the only 'patient benefit' or goal that might be fulfilled is the potential for 'fair' compensation via litigation. Somehow the words 'fair' and 'litigation' just don't seem to belong in the same sentence in the 21st century medico-legal world."[29] While it is true that Naunheim too easily dismissed medical malpractice law, that is not what I want to dwell on here. What seems like a glib dismissal of the value of apology and an attempt to wriggle out of responsibility actually holds the kernel of an idea worth spelling out further, for Naunheim essentially argues that you can't apologize if you are in no position to.

In this case, Naunheim explains, the doctor is in no position to apologize for three reasons. First, the patient is dead, and so cannot play the critical performative role of receiving the apology. Second, medicine is a group project and so the head surgeon simply cannot be

responsible for everything that happens (and so why should he have to apologize?). Third, surgeons will make mistakes, as a basic fact of medicine. In other words, the goals of insurance and tort law aside, a surgeon's words can never meet the linguistic and ethical requirements of apology.

The critical point that Naunheim makes, unintentionally I think, since he does not discuss apology theory and dismisses law out of hand, is that an apology requires a prior relationship between two people, one that simply does not exist in the relationship between doctor and patient (even when the patient is still alive). Without that relationship, a non-sensical apology cannot be harnessed to do the work described by Leape, Taft, or Austin.

In claiming that apologies are non-sensical in the case of surgery because doctors will make mistakes, Naunheim reiterates Gawande's quandary. How do we think about well-intentioned physicians making mistakes: what does responsibility mean, how should it manifest in the statistically necessary mistake? In claiming that physicians should not be blamed for these statistical errors – and critically, should not be sued – the doctors mistake the legal compensation for a moral system of blame, as I mentioned above rather than simply as a cost spreading mechanism similar to any insurance scheme. But the quandary can be taken a step further in thinking about the apology.

This confusion between personal blame and paying the costs of and error can only happen because, as we see with Naunheim, the nature of the relationship between doctor and patient is so easily mischaracterized. A logical sleight of hand between the ethical and legal frameworks of the nature of the doctor-patient relationships plays out such that responsibility, chance, and compensation muddle among each other. In fact, the legal relationship, established in medical malpractice law, is very clear.

This mistaking of the relationship between doctor and patient matters here because the argument is so easily replayed by tort reformers and insurance companies to cut back on the compensation gained by injured patients – it makes sense, because we want to sympathize with the doctor and we don't want them to be blamed. We also live in a culture that privileges wellness and that hides sickness away – and so it is hard to fully grasp how powerless sick people are. But the costs of error don't disappear, they just become easier to hide because patients have to absorb them.

Recall that legally, a tort relationship is one in which the patient has a right to a certain standard of care – it isn't very high, it's just an average standard of care. The patient has the right to a surgery in which mistakes are not made. When mistakes are made, as they inevitably will be – the patient has a right to compensation. Torts provide a cost-sharing mechanism whereby everyone pays into a pot that pays out to the one or two people who suffer statistical errors. In that sense, tort offers a deeply biopolitical version of the distribution of accidents that takes into account the industrialization and inevitability of accident and injury distribution. Tort law allows both the threads – statistical probability over the population *and* the right of each individual patient not to be injured.

This relationship differs from the sort of contractual relationship that Gawande and Naunheim wrongly imply as guiding the doctor-patient relationship. While the chance of an error may have been accepted by a patient in an informed consent document, the relationship is still guided legally under tort, rather than contract law. No matter how predictable the mistake, no matter how careful the surgeon, the patient has a right to compensation by law. The attempt to circumvent the law as the driver of the apology nullifies it by definition. Naunheim's dismissal of law leads him to misunderstand his own legal obligations here, not of apology but of responsibility. According to him, each surgeon performs under a sort of professional contract to the best of his ability. If you are the patient on whom a mistake is made, that sucks for you, but that possibility lay in the initial in the contract. Naunheim is simply wrong there, no matter how difficult it may be, in the real world, for the plaintiff to defend that right.

Thinking that an apology can be inserted into the tort relationship is like putting icing on a rubber tire and trying to eat it for dessert. It mistakes the relationship and tries to make it into something else. According to Taft, an apology implies a willingness to accept consequences, including those in law. However, the purpose of the medical apology is precisely to *interrupt* the distribution of legal consequences.

Thus the apology, while posing as a humanist interchange of sentiment, produces a version of responsibility and professionalism based in a highly individuated subjectivity. The value of the "human" gesture of the apology lies in its use as a technique of neoliberal free-market governmentality. The apology builds on an older model of responsibility, one that is a verbal expression of regret and an acceptance of fault. In this case, the insurers—the very

bureaucracy that asks the doctor to defend his actions in a Medmal case (rather than accepting the insurance function of Medmal)—requires the doctor to play out the apology as a means of indemnity of legal responsibility.

In this sense, the very context of responsibility shifts in relation to a preservation of the profitability of medicine and the maintenance of the bureaucratic status quo of insurance driven medical care. The physician is caught in a set of contradictory loyalties between the health of the patient and the need to protect herself in a system that may not be in her personal or professional interest to criticize or change. The medical apology, then, keeps the doctor-patient relationship on a personal level, which has two effects. On the one hand, this move makes it easier to misunderstand the medical malpractice claim as a personal attack rather than as an insurance system to cover injured patients. On the other hand, it does add a human exchange into a system that can be extraordinarily dehumanizing precisely at the moment that people feel the most vulnerable. An apology in that context can be incredibly disarming. The new version of apology, as something of a public relations move, both monopolizes the notion of responsibility while also giving it away, either by not fully valuing the personal costs to those who suffer from errors, or by explaining them away in terms of population and the inevitability of error. Either way, no more knowledge about how and why errors occur is gained, and thus no pressure leads to structural and design understandings of medical error.

J. L. Austin claimed that apologies, as perlocutionary acts, are never false. They either create effects or they do not. In the case of the medical apology, the effects extend beyond the actual apology, creating potentially large- scale political effects that ironically may undercut patients' rights by sentimentalizing the doctor-patient relationship in a way that neglects to understand the institutional framing of medical practice. Both doctors and patients have an investment in believing in this relationship, and it provides a handy way for lucrative systems that frame this relationship (insurance, hospitals) to keep it personal even in a situation of vastly unequal power dynamics.

The rights and role of the medicalized body offers a morass of conflicting ethical, economic, and educational/expertise frameworks that constitute the doctor-patient relationship. After all, if a dead person cannot "receive" an apology, can a sick person? Can a very sick person in a coma? Can a person at the other side of the operating table under anesthetic? If the

apology cannot work in the way that Austin and Leape outline; that is, it cannot have effects in the relationship in which it is given, then how can responsibility be understood in these situations where peoples' lives, bodies, and consciousness is literally at stake? The patient brings money into the system, and a lot of it: what rights should this market relation carry? The patient also carries her body – as a work object, a practice object, and a site in need of particular kinds of care – into a system with many conflicting goals. These issues are nearly universally ignored in discussions about medical apology.

From the perspective of critical anthropology, apology serves a unique humanitarian role, and a human gesture that may at times be authentic (as an expression of the physician's trauma) and at others rhetorical (such as when the doctor pats the patient on the shoulder, or calls her "dear.") But if the term "responsibility" is to carry meaning as the backbone of apology, surely the acknowledgement that an action caused an injury lies at the core of figuring out ways for the responsible party to make amends. In the real-life context of insurance and medical provision in the United States, the apology cannot be extricated from its value as a technique of neoliberal free-market governmentality, where "I'm sorry I cut the wrong vein" becomes, indeed, must become, "I'm sorry you are bleeding."

But the *form* of the medical apology (divorced from its content) as an expression of moral sentiment can be read precisely as a technique of governmentality as Foucault outlined it: as a confession of fault and regret pressed into the service of an administration of life that outside of law. In this case of medical apology, medicine (with its highly paid experts and its delivery of high tech procedures within low tech/high error systems) presents the perfect refractive lens through which to understand how the apology has been harnessed by corporate public relations. The nearly nostalgic version of human interaction embedded in contemporary apologies, one that cites and emulates concern without actually expressing fault or responsibility, tend not, except in the most obvious cases, to acknowledge the cause of physical wounding; in other words, the tend to elide the definitional requirement of an apology.

Here, the confession of moral fault and regret produces indemnifying or exculpatory effect in the wider domains of law, such that paradoxically, the rhetorical admission of moral and personal responsibility becomes a mode of absolving oneself of legal responsibility. The absolving effect of these apologies, then, are precisely the opposite of the social function of

apology as described by Taft and other apology theorists, for whom the law provides the moral and necessary backing of the apology.

The universal embrace of Gawande's narrative, with its complete deletion of the patients' concerns about and entitlement to his physical body, echoes how deeply Americans have bought this version of medical practice and medical apology, a version that – together with the steady erosion of medical malpractice law – leaves them (us) with virtually no rights or means of recovery as receivers of the medical procedures that so misleadingly, innocently, and routinely present as health care.

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[1] Julie Sevrens Lyons, "Medical mistake may have killed man," Mercury News (San Jose, CA, November 2, 2005).

[2] And there are, of course, many dimensions to medical error –consider, for example, the fact that the American insurance system means that people will have to change doctors fairly regularly, making it impossible to build the kind of relationship (and personal connection) necessary for high quality care.

[3] TA Brennan, LL Leape, LM Laird, et al. "Incidence of adverse events and negligence in hospitalized patients: results of the Harvard Medical Practice Study I." New England Journal of Medicine 324 (1991):370–7 finds that fewer than 2% of patients receiving substandard care actually sue. Finding medical experts can be difficult, given the professional networks in medicine.

[4] "Kaiser Hospital Is Cited After 2nd Death From Double Dose," November 10, 2005 in print edition B-4.

[5] Medical malpractice law developed in the United States as the way in which people who were injured through medical error would be able to both recover a part of the damages they suffered as a result of that injury, and as a way to try to hold doctors accountable for their mistakes. In general, someone is entitled to a damage award if their physician's conduct falls below the standards of reasonable care. The profession generally determines what those standards will be, and in bringing a suit a plaintiff needs to find medical experts willing to testify that one of their colleagues gave substandard care. This can be difficult, for as Jerome Groopman has recently laid out in *How Doctor's Think*, the process of diagnosis varies vastly and in many, many cases, there simply is no "standard of care." (Jerome Groopman, *How Doctors Think* (Boston and New York: Houghton Mifflin Company, 2007.) In any case, as Tom Baker reports in the *Medical Malpractice Myth* (Chicago: University of Chicago Press: 2005), patients have virtually no access to information on their treatments, what errors may have been made, and the standards of

care in similar situations – occasionally this leads a patient to make a medmal claim just to have access to the records and procedures. Any case will be stacked against the patient. The doctor writes and has access to the medical records and all of the expertise and social networks of the field, while the patient will have only his or her body as a relatively intangible form of evidence. One study, for example, found that only 30% of surgeons would be willing to testify against another surgeon who had removed the wrong kidney Marc Franklin and Robert Rabin, *Tort Law and Alternatives: Cases and Materials*. (7th Ed. West Publishing Company, 2001), 116. Occasionally a judge will intervene in this internally judged standard. One judge determined that although it was not standard practice to count the number of clamps after a surgery (and one had been left in the body of the patient), it "requires no expertise to count," even if it is not the usual practice At best, then, at its most just, medical malpractice litigation offers a highly time consuming, expensive, and labor intensive fault-based insurance system.

[6] Between 1986 and 1994, the plaintiff win rate in med mal is about 33%, compared to plaintiff win rates of about 50% in other categories of cases. Gary T. Schwartz, "Symposium: Medical Malpractice, Tort, Contract, and Managed Care," 1998 University of Illinois Law Review 885-907. p. 893. Furthermore, since insurance attorneys are paid by the hour while plaintiffs attorneys are only paid out of winnings or settlement, insurance only very rarely settles before they hit the steps to the courthouse.

[7] While the old adage "do no harm" does a great deal of rhetorical work, in fact a great deal of harm has resulted from medical intervention. Estimates of the number of hospital patient that suffers negligent treatment resulting in death an disability range from 1 to 4%, and fewer than 30% of errors are disclosed. (Weiler, Hiat, Newhouse et al, *A Measure of Malpractice*, Harvard University Press 1993.) Considering as well the more institutionalized injuries of aggressive treatments such as surgeries or chemotherapy, the history of medicine provides also a history of the contested line between how trade-offs between the injuries of disease and the risk of injuries from treatment are rendered logical and acceptable. Some of these contestations that exist within the medical field have been made explicit. Cancer surgery provides a particularly gruesome example of extreme surgeries as the standard practice through the twentieth surgery, with virtually no proof of efficacy. For example, historians have analyzed the history of the Halsted radical mastectomy, which for decades removed muscles, bones, and lymph nodes, while other medical trade-offs – such as the use of chemotherapy for solid tumors – remain embedded within institutional practices. See, for example, James Olson, *Bathsheba's Breast: Women, Cancer, and History*, John Hopkins University Press, 2002. Although the history of breast cancer surgery throughout the twentieth century is one of the better documented in secondary literature, surgery for other cancers was equally as aggressive, operating (as it were) under the theory that all areas to which cancer may have spread should be removed. It is now understood that cancer metastasizes to distant organs. The rise of the randomized control trial, comparing survival rates of patients receiving lesser surgeries in the 1970s led to a reduction in the removal of organs and other body parts, but the use of these trials was exceedingly controversial. See S. Lochlann Jain, "The Mortality Effect," *Public Culture*, Winter 2010 (forthcoming).

[8] See for example Sherwin B. Nuland, "Whoops! *The New York Review of Books,* Volume 49, Number 12 · July 18, 2002. Nuland celebrates this refreshing new voice of the surgeon willing to admit to having made mistakes, but

collaborates in the erasure of the patient and the question of responsibility in inevitable mistakes. It is enough, for Nuland, that the mistakes are acknowledged – albeit not to the patients.

[9] Atul Gawande, *Complications* (New York: Picador, 2003) p. 77 (italics mine). Here is Gawande again: "There is… a central truth in medicine … all doctors make terrible mistakes." Gawande, *Complications* 55.

[10] The section on the "Liability of Physicians and Surgeons," reads: "When they put out a sign, it is to be presumed they consider themselves competent to prescribe, and perform operations; and the community, believing such to be the fact, feels a degree of security, in cases of emergency. But if they cal upon them, and physicians and surgeons refuse to act, or they act unskillfully, the party employing them has a right to demand damages at a tribunal of justice." JVC Smith, ed. *The Boston Medical and Surgical Journal*, Vol XLV III (Boston: David Clapp, 1853), 506.

[11] Walter Channing MD, "A Medico-Legal Treatise on Malpractice and Medical Evidence - Review," The Boston Medical and Surgical Journal LXII (12), Thursday April 19 (1860), 304.

[12] Four interviews with author, February-July, 2005.

[13] National Academy of Health Report, *To Err is Human: Building a Safer Health System*, (2000), pp. 1 and 3. On the ways in which physicians manage error internally, see Charles L. Bosk, *Forgive and Remember: Managing Medical Failure* (Chicago: Chicago University Press, 1979). His illuminative study highlights the fact that, "However lamentable the fact, the patient is an exogenous variable falling outside of the system of control." Bosk, *Forgive*, 25.

[14] One author reports the difference as, from 1:1000 in 1960 to 1 in 240,000 in 2002. R. Voelker, "Anesthesia-related risks have plummeted," Journal of the American Medical Association 273 (1995), 445-6.

[15] JB Cooper, RS Newbower, CD Long, B McPeek, "Preventable anesthesia mishaps: a study of human factors," Anesthesiology. 49(6) (1978), 399-406.

[16] S. Lochlann Jain, *Injury* (Princeton: Princeton University Press), 9. In furthering Galison's analysis, I argue there that at a certain point the persons and things are in fact mutually constitutive – and thus, in showing how the legal framework that attempts to set them apart and set out blame and responsibility can only miss read how commodities and technologies circulate through the culture, I ultimately disagree with Galison's nevertheless incredibly useful point.

[17] A recent World Health Organization ranked American mortality 36th in the world, despite being the most expensive system in the world. "Using five performance indicators to measure health systems in 191 member states, [the WHO study] finds that France provides the best overall health care followed among major countries by Italy, Spain, Oman, Austria and Japan.… The U.S. health system spends a higher portion of its gross domestic product than any other country but ranks 37 out of 191 countries according to its performance, the report finds." The reasons for the US's low performance can only partially be attributed to the large number of citizens who are un- and under-insured. http://www.who.int/whr/2000/media_centre/press_release/en/index.html accessed October 20, 2008.

[18] Lucian Leape, "Understanding the Power of Apology: How Saying 'I'm Sorry' Helps Heal Patients and Caregivers," *Focus on Patient Safety: A Newsletter from the Patient Safety Foundation*. 8(4) 2005. See also

Lazare, A. *On Apology* OUP 2005; Aaron Lazare MD, "Apology in Medical Practice: An Emerging Clinical Skill," Journal of the American Medical Association, Sept 20, 2006 296(11), 1401-1403; Thomas Gallagher Md et al, "Disclosing Harmful Medical Errors to Patients," New England Journal Medicine 356;26 (June 28, 2007) 2713-2717; Nicholas Tuvachis, *Mea Culpa: A Sociology of Apology and Reconciliation*, Stanford University Press, 1991.

[19] Janna Thompson, "The Apology Paradox". *The Philosophical Quarterly*, 50 (201) (2000), 470 – 475; Deborah Cameron, *Working With Spoken Discourse* (London: SAGE Publications, 2001); Lee Taft, "Apology Subverted: The Commodification of Apology," *The Yale Law Journal*, 109 (5) (2000), 1135-1160.

[20] Rachel Zimmerman, "Medical Contrition: Doctor's New Tool to Fight Lawsuits" The Wall Street Journal May 18, 2004, A1.

[21] The safe haven for apologizers was introduced by a Massachusetts legislator whose daughter killed by a driver when cycling, driver never apologized. Safe harbor statute provides: "Statements, writings or benevolent gestures expressing sympathy or a general sense of benevolence relating to the pain, suffering or death of a person involved in an accident and made to such a person or to the family of such a person shall be inadmissible as evidence of an admission of liability in a civil action." [Mass. Gen. Laws Ann. ch 233, ss 23D (West Supp. 1998). Cited in Taft, ibid, p. 1151. One critical aspect of this legislation is that it differentiates an accident from sequence of events, separating the emotions one might (should) have from being in an agentive position in an event where someone is hurt, as opposed to any legal responsibility for having caused this sequence of events

[22] Liz Kowalczyk, "Hospitals Study When to Apologize to Patients," Boston Globe, July 24, 2005.

[23] Reni Gertner "The Art of Apologizing takes hold in the Legal World," St Louis Daily Record, Dec 22, 2005. (FN: is there such a thing as a *possible* risk?).

[24] Liz Kowalczyk, "Hospitals Study When to Apologize to Patients," Boston Globe, July 24, 2005. These numbers pose complicated issues beyond the scope of this paper. Many of these complications have do with the politics of medmal and the enormous amounts of money involved in a private healthcare system. Because of the cost for insurance companies of litigating these claims (defense lawyers are paid by the hour and may charge $300 – $500/hour), many insurance companies have set up their own in-house legal departments. This has also enabled them to take more cases all the way to court rather than settling, thus forcing, with the caps on damages, a situation in it is simply not tenable to bring many legitimate claims to court (for example if someone cannot claim a huge loss of income settlement).

[25] In my essay "Dangerous Instrumentality (Bystander as Subject," *Cultural Anthropology*, February 2004, I examined how the introduction of the automobile shifted how urban dwellers were understood in relation to cars – as owners, drivers, mothers, and so on. I argued these posititionings were integrally tied up with the distribution of car-based injuries.

[26] Kevin Sack, "Doctor's Say I'm Sorry Before See You in Court," *New York Times* May 18, 2008.

[27] Taft, 1140.

[28] Rachel Zimmerman, "Medical Contrition: Doctor's New Tool to Fight Lawsuits" The Wall Street Journal May 18, 2004, A1.

[29] p 404. Constantine Mavroudis MD, Constantine D Mavroudis, Keith Naunheim MD, Robert Sade MD, "Should Surgical Errors Always be Disclosed to the Patient?" Annals of Thoracic Surgery 2005; 80:399-408.