

Countering the Culture of Silence: Promoting Medical Apology as a Route to an Ethic of Care

by

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Bachelor of Arts, University of the Fraser Valley, 2017

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Supervisory Committee

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Abstract

This thesis investigates the impact of apology hesitation on medical relationships after an error occurs. Literature suggests that medical personnel are reluctant to apologize because an apology suggests legal liability, violates the drive to provide perfect care that is expected of medical personnel and reinforced during medical education, and violates the certainty over bodies and maladies expected of medical personnel. I suggest that a culture of silence, a pattern of conduct embedded in medical culture, encourages apprehensiveness towards apology and responsibility in the face of error. Despite the fear of litigation, ‘Apology Act’ legislation shields apologizers from having their apology used against them in court, and literature suggests that apologizing following an error benefits doctors by restoring conscience and confidence, assists in the healing of patients and families and restores trust in their relationship with their health care provider, and refines the practice of medicine by addressing how the error occurred.

I present two arguments in this thesis. First, I argue that a culture of silence has serious negative impacts on medical relationships and the safe provision of medical care as a whole by obstructing responsibility, apology, and preventing the discussion and correction of conduct that led to the error. Medical personnel who refuse to apologize, or provide an apology that is conditional, instrumental or otherwise of poor-quality leaves their relationship with patients and families in jeopardy. Further, by not apologizing, medical personnel obstruct their own ethical and moral development and obscure the origin and conditions surrounding the error, potentially jeopardizing the safety of future patients.

Second, I argue that the medical culture of silence should be replaced by a culture that embraces apology. Doing so would permit medical culture to draw from care ethics, the principles of which are appropriate to responding to, maintaining, and repairing relationships that have experienced damage. The emphasis that care ethics places on maintaining and repairing relationships is especially coherent with apologies that seek to morally engage with the victim, promise non-repetition, and establish a proper record of events. Further, care ethics offers normative recommendations for conduct to respond to and repair relationships, provides inroads to refining notions of human security and safety, and is particularly attuned to interrogating dynamics of power within relationships, dynamics that can limit the potential for and impact of apology.

This thesis offers the Tainted Blood Scandal of the 1980s and 90s as a case study. The provision of contaminated blood and blood product resulted in thousands of Canadians becoming infected with Human Immunodeficiency Virus and Hepatitis C. Through this case, I show that the actions of public health officials, the Red Cross, and healthcare providers reflected a culture of silence that sought to avoid and dispute attributions of responsibility by victims, blood activists, and the public. This is the culture that this thesis in its advocacy of apology seeks to challenge.

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I also wish to acknowledge the superlative support and guidance offered by my supervisor, Dr. Matt James, and by my friend and mentor, Dr. Fiona MacDonald, who continually inspires me to think about care and caring in every circumstance.

Finally, to my cohort. Love is not a big enough word.

Dedication

This thesis is dedicated to Melody, Darren, Emily, and Nolan Wilford, as well as my close friends. On your support I relied, through your care I sustained.

Introduction: Error and Silence in Medicine

This study aims to make sense of and address some implications of the impact of the apology-reluctant conduct of physicians and healthcare providers on medical care in Canada. Mistakes are an inevitable occurrence throughout life, and contemporary medical practices are no exception. Medical errors are impactful in several ways. First, given the physical, psychological, and emotional emphases of medical care work, medical errors have especially detrimental effects on the bodies and minds of patients. Second, the impacts of errors reach beyond the immediate site of the body of the patient. Medical errors also negatively influence confidence: when a mistake is made, the confidence and consciences of healthcare providers suffer, making further healthcare delivery difficult. As well, when errors are made public, a gap in confidence in healthcare provision is created, occasionally prompting political or legal action, such as a policy review, inquest, or a lawsuit to address the error and the conditions of its origin. Finally, upon disclosure or discovery of the error, the relationship between healthcare provider, physician, and patient is put under immense strain: what was formerly a relationship premised on the need and provision of care may become a frayed relationship involving distrust, offense, and harm. As the stakes of medical errors are high, the methods and actions taken to address them are similarly crucial. How parties address medical error will influence the avenues available for amends, the future status of the relationship, and the development of safe health care practices. One avenue of redress available to healthcare professionals to address harms resulting from error is to apologize.

However, healthcare providers (hereafter HCPs) and physicians are often hesitant to disclose details of an error and apologize.¹ Medical personnel are hesitant to apologize despite the nearly Canada-wide² implementation of ‘Apology Act’ legislation. These legislative acts

indemnify the apologizer from having their apology used as evidence against them to determine liability in court and are intended to shield and promote the use of apology following an error or offense. ‘Apology Act’ legislation was first introduced in British Columbia in 2006,³ with other provinces adopting the legislation using B.C.’s framework soon afterwards.⁴

Further, apology hesitance exists despite literature that suggests that apologizing for errors benefits medical relationships and medical practice. Healthcare providers and physicians who have experience with medical error indicate that the freedom to apologize would assist in easing their conscience after an error,⁵ and literature regarding patients and families indicates that receiving an apology would assist in their convalescence.⁶ There is literature that suggests that an apology would contribute to healing the damaged relationship between healthcare provider and patient,⁷ as well as evidence that suggests that the moral and ethical development of healthcare professionals is contingent on being able to provide apologies in conscience post-error.⁸ Finally, there is literature that suggests that a medical culture that supports open and fearless discussion of medical errors would improve the provision of medical care extensively⁹ by immediately addressing errors, examining what caused them, and taking steps to prevent them from harming future patients.

I term the prevailing apprehensiveness towards apologizing on the part of medical personnel a ‘culture of silence.’ I define this culture as not just reflecting a reluctance to apologize, but as the embedded patterns of conduct in medical culture that impart and reinforce the apprehensiveness towards apologizing for errors. These actions and inactions take the form of not apologizing for errors, apologizing for errors in conditional manners or in ways that obscure responsibility or suggest that responsibility is not properly attributable to actors, and

dismissing the appropriateness of apology to patients and families based on privileged medical knowledge, positions of power, or medical advocacy.

The two questions this thesis grapples with are what impacts the culture of silence has on medical relationships, and what culture should replace the culture of silence. I make two arguments to address these questions. My first argument is that a culture of silence has serious negative impacts on medical relationships by preventing medical institutions, authorities, and individuals from grappling with and discussing questions of responsibility and apology, leaving medical relationships impacted by error in a state of disrepair, and creating the potential that future caring relationships are put at risk for the same error. In my second argument, I argue that the culture of silence should be replaced by a medical culture that promotes apology, empathic engagement with patients and families, and responsibility, in order to allow medical institutions, authorities, and individuals to embrace an ethic of care, the principles of which are appropriate for responding to, maintaining, and repairing relationships. To make these arguments, this thesis relies on two key foundations of thought. The first foundation of thought is an understanding of apology, which is introduced through a broad discussion of its sociological and philosophical aspects. Apology as a key foundation of thought is necessary to engage with medical apology on a deeper level of inquiry. The second key foundation is an ethic of care, which is introduced through a discussion of its principles.

The reluctance towards apology and consequential culture of silence after a medical error are well-documented and complex. Vivienne Nathanson argues that a fear of litigation plays a significant role in inhibiting the provision of apology:

Many doctors are concerned about admitting their mistakes, or even admitting where there has been a problem for the patient to which no fault could attach...but underneath there is a

reluctance to be honest about mistakes, a fear that the UK could follow the USA down the road to ever increasing litigation about medical mistakes.¹⁰

Nathanson's observation predates the advent of 'Apology Act' legislation in Canada, as well as comparable legislation in the U.K. and most U.S. states,¹¹ making it reasonable to believe that apologizing after an error was previously more legally precarious. In a Canadian context, contemporary research indicates that there has not been change in the attitudes of physicians and HCPs towards apology in a post-Apology Act world.¹²

With the indemnification offered by 'Apology Act' legislation in mind, there is a question of why physicians and medical personnel are still reluctant to apologize. This question is subsidiary to the central arguments, and I do not intend for this discussion to offer a causal analysis of why the culture of silence persists but to instead outline some crucial aspects of the culture of silence that I suggest are obstacles to apology and the entrance of an ethic of care in medical practice. To address the question of persistence, it should be noted that apology and litigation are not mutually exclusive: a patient can request and receive an apology from doctors, HCPs, hospitals, and medical authorities, and still pursue litigation. As well, feelings of fear, shame, and guilt at having made an error do not have to correspond with reality to be convincing or persuasive, and thus influence conduct. While investigating medical reticence, Truog et al. find that medical training, idealized medical roles, and societal expectations of these roles all influence the reluctance to acknowledge errors:

Various reasons have been posited for the wall of silence. One explanation is that key characteristics of the medical culture contribute to a reluctance to disclose information about adverse events. One of these characteristics has been described as a preoccupation with perfection, which contributes to the belief that clinicians who have been properly trained and act in good faith do not make mistakes. The view of the physician as infallible is comforting to a vulnerable patient and also to the physician, who must live up to his or her role as healer. It also reinforces and justifies a physician's position of authority and aura of certainty...physicians are not prepared to deal with their mistakes; they hide them

from themselves, their patients, and their colleagues. When they do acknowledge a personal failing, they suffer strong feelings of guilt, remorse, and inadequacy.¹³

Four key observations can be drawn from Truog et al.'s investigation. First, their investigation shows that a fear of litigation is not the sole contributor to apology reluctance. Second, is that from Truog et al.'s investigation, the work that silence does can be characterized in two ways: silence protects against the fears of physicians being exposed as imperfect, and silence preserves the expectations of physicians and patients. Third, Truog et al.'s investigation shows that silence reflects the concentration of power in physicians within medical relationships; silence preserves the 'physician's role of authority and aura of certainty,' revealing a paternal association between power and care in the relationship between doctor and patient.

Finally, I suggest that Truog et al.'s investigation gestures towards a deeper sense of ethical obligation in physicians that arises from societal expectations. I argue that the silence of physicians illustrates an ethic of care that is distorted to adhere to expectation and a sense of obligation rather than the reality of the relationship at hand. This distortion arises due to the physicians' care for the patients' perceived expectations of perfection, regardless of whether these expectations are valid, healthy, or even true, imparts an obligatory urgency to meet and preserve them. The distorted ethic of care arising from a perfectionist sense of obligation presents itself in a duty-based manner; caring as a duty is distinct from caring about relationships as far as they impart responsibility towards others, a distinction that Tronto highlights.¹⁴ This distorted, duty-based ethic of care is focused on the expectation of perfection and leaves little room for admissions of errors and apology, and little room for the practice of a responsibility-based ethic of care. Together, these observations show that a fear of litigation is not the only thing preventing apology, and that there are deeper reasons for apology reluctance that are embedded in the relationships and patterns of behaviour between physicians and patients. It is

these patterns of behaviour that a culture that promotes apology must confront in order to draw from an ethic of care.

Emotional distance between patients and physicians is another aspect of the physician-patient relationship that can inhibit apology. In typical practice, physicians are confronted with a difficult cleavage between remaining professionally competent and emotionally distant from the patient, but also emotionally present and caring to themselves and their patient at the same time.

What can result is what Groopman refers to as a 'paradox' in medical caring:

Consider what happens in the ER when we try to save the life of a person smashed by a car or burned in a fire. If a doctor thought too much about the person before him, he couldn't insert his gloved hands into a hemorrhaging abdomen or maneuver a breathing tube past charred flesh...we have to detach ourselves from anguish that could impede our work. But to become immune to feeling, as Peabody indicated, is to diminish the full role of the physician as a healer and relegate him to a single dimension of his job, that of a tactician. If we feel our emotions deeply, we risk recoiling or breaking down. If we erase our emotions, however, we fail to care *for* the patient. We face a paradox: feeling prevents us from being blind to our patient's soul, but risks blinding us to what is wrong with him.¹⁵

This paradox manifests in silence when a physician is confronted with professional and emotional difficulty in delivering unwelcome news to a patient.¹⁶ Groopman's observation shows that empathic engagement with patients is challenged by the emotionally-taxing work of providing medical care. I suggest that this observation provides a glimpse into the deeper complexity of apology reluctance, because empathically and emotionally engaging with patients after an error occurs would be challenging if empathy and emotions are already precariously located in the provision of medical care.¹⁷ Echoing Truog et al., this paradox further establishes the paternal power relation between doctor and patient, in that, the physician can decide what news is appropriate to deliver to the patient. However, this paradox also shows that associated with the power to care for patients is a unique anguish when medical care is emotionally and professionally taxing. Noting this association helps to humanize the challenges of medical

relationships and suggests to us that the power of silence leveraged by doctors following an error is not coming from a place of animosity towards patients.

Qualitative studies also reveal deeper reasons for apology reluctance. A 2003 study by Gallagher et al.¹⁸ investigated differences in attitude and agreement between physicians and patients on medical error, apology, and disclosure. Gallagher et al. concluded that reluctance is the preeminent attitude of physicians towards disclosure and apology. This finding echoes Nathanson's argument regarding litigation. However, recalling Truog et al., Gallagher et al. also show that the issue of reluctance is more complex than a fear of litigation alone can explain. The findings of Gallagher et al. show that disclosure of errors is treated with a general sense of suspicion on the part of the physician, and that the possibility of disclosure is limited by different notions of what an error is and what should be disclosed between the physician and the patient. Gallagher et al.'s findings indicate that physicians wish to speak 'objectively' to errors and tend to rely on a narrow definition of error. This narrow definition describes error as an event that departs from a standard of care and must cause non-trivial harm that the patient can be expected to understand to qualify for disclosure. This definition contrasts with the broader definition of error that patients tend towards, which includes nonpreventable outcomes and *any* harm-causing effect, no matter how trivial.¹⁹ Also preventing disclosure is a belief that the patient might not understand what has happened in an instance of error. This belief reflects a paternalistic lack of confidence in the patient to take part in their own care. Altogether, the paternal and aspirational drive to be a perfect physician first brought up by Truog et al. is mirrored in Gallagher et al.'s qualitative study and reveals that the conduct of physicians regarding errors is not solely influenced by a fear of litigation but calls upon a deeply ingrained aspiration for perfection.

Finally, fears of reprimand by peers or superiors,²⁰ fears of the error having a corrosive effect on the relationship between patient and physician,²¹ and fear, shame, and guilt at having harmed rather than helped patients²² are well documented responses to error in the literature. The inhibiting impact of these feelings on apology are similarly noted; fears of litigation or other legal consequences stemming from apologizing are prevalent,²³ but are also associated with fears of a loss of professional status and respect.²⁴ A lack of confidence in the capacity of patients to understand the error also inhibits the willingness of physicians and healthcare providers to apologize.²⁵

In addressing the question of why apology hesitance persists despite ‘Apology Act’ legislation and the benefits of apology, the literature suggests that a complex set of social and professional circumstances precludes the possibility of disclosure and apology for medical errors and it is these circumstances that a medical culture that replaces the culture of silence will have to confront. Important to note is that the observations of Nathanson, Truog et al., and Gallagher et al. are limited to *physicians* and patients as opposed to healthcare providers more generally. An analysis of how disclosure, apology, and care intersect with patients, families, physicians, and other healthcare providers requires a more in-depth focus, and is explored more in chapter two.

The thesis is grounded in one case study: the provision of contaminated blood and blood product to patients in Canada in the 1980s, commonly referred to as the ‘Tainted Blood Tragedy’ or ‘Tainted Blood Scandal.’ The compounding errors of the improper screening of blood and blood-product, an initial neglect and dispute by officials of any emerging problem, myopic donor-recipient tracing, and a general slow response by authorities resulted in tens of thousands of patients becoming infected with Hepatitis C virus, and several thousand becoming infected

with Human Immunodeficiency Virus (HIV). These infections led to a multitude of harms, including intergenerational infection and death. The failures of public health officials, the Red Cross, and healthcare authorities to meaningfully address the concerns of victims left many patients and families feeling abandoned by their healthcare providers, their physicians, and their health authorities. Compensation in the form of financial reparations was offered to victims, based on a schema informed by the severity of infection and filial impact, though many affected felt that it was not enough.

I have selected the scandal as an appropriate case study on medical error and apology for three reasons. First, accounts of the scandal from the Krever Inquiry and Andre Picard's 1995 text *The Gift of Death* suggest that responsibility is attributable to public health officials, the Red Cross, and HCPs. However, the accounts of Picard and the Krever Inquiry show that the Red Cross, HCPs, and public health officials disputed, dismissed, and evaded responsibility for their roles in the scandal, indicating that these actors were embedded in a culture of silence. The initial reluctance towards apologizing and the precariousness with which silence on the issue was broached diminished trust in authorities to address the provision of contaminated blood. Patients and families were left in a communicative vacuum that contributed to a sense of abandonment by health authorities.²⁶ Second, the apologies eventually provided were not well-received by patients and families, particularly because the apologies failed to properly address the magnitude of the harms in a timely manner²⁷ and were seen as insincere.²⁸

Lastly, an argument put forward by Gilles Paquet and Dr. Roger Perrault (a physician and an authority in the Red Cross who was involved with and cleared of any wrongdoing²⁹ for his role in the Tragedy) shows that assigning responsibility for the scandal is complex. As Paquet and Perrault argue, the scandal is a possible example of a 'tragedy orphaned of personal

responsibility³⁰ due to the interconnected array of actors and institutions and the general complexity involved. Paquet and Perrault make a complex argument against the public attributions of responsibility for the scandal, which I consider in the third chapter. In brief, while Paquet and Perrault's argument against public attributions of responsibility is initially persuasive, I argue that their argument is hindered by suspect logic, and I argue that their arguments against public attributions of responsibility reflect not a healthy reconsideration of the circumstances of the scandal, but an effort to dispute, dismiss, and evade responsibility.

The first chapter will unfold in two sections. The first section establishes the first of two foundations on which this study relies. The first of these foundations is an understanding of the nature and impact of apology. The second foundation is an ethic of care. The normative principles and relational ontology of care ethics offer appropriate methods to address damages to medical relationships after an error has occurred. As I argue however, to draw from the benefits of an ethic of care, the medical culture of silence ought to be replaced by one that is more open to discussing the contexts of error, including responsibility, and apologizing for them. The second chapter provides three subsidiary arguments that show the importance of medical apology and show that the culture of silence has negative impacts on medical relationships and on the ability of medical institutions to engage with apology. In brief, these arguments establish that medical apologies are political, but are distinct from conventional political apologies, the moral and ethical role of apologies in medicine as a benefit to medical personnel, and the role of apology in preventing the reoccurrence of errors for future patients. The concluding chapter investigates the case of the Tainted Blood Scandal as an example of the larger pattern of medical behaviour in a culture of silence that is apprehensive towards apology. Throughout this study, I

use the phrase 'medical personnel' to refer to both physicians and healthcare providers where it is appropriate.

Chapter 1: Key Pillars of Thought and Arguments for an Apology-Favourable Culture

In this chapter, I introduce two key pillars of thought on which the rest of the study will rely. The first pillar is a discussion of apology, which I introduce through a broad discussion of its philosophical and sociological aspects. The second pillar is the ethic of care, which I introduce through a discussion of its principles. The purpose of this chapter is twofold. First, this chapter aims to outline how the sociological and philosophical aspects of apology relate to and are implicated in interpersonal medical relationships, medical authorities, and medical institutions. Second, this chapter aims to establish that the medical culture of silence should be replaced by a medical culture that embraces apology in order to draw from an ethic of care. This chapter is split into two sections. The first section has two subsections. The first subsection provides a working definition of apology and introduces some foundational discussion on apology. The second subsection focuses on the frailties, tensions, politics, and social impacts and implications of apology. The second section also has two subsections. The first subsection outlines the principles of an ethic of care, including some challenges that an ethic of care might face within medical culture. The second subsection provides four subordinate arguments in support of my argument that a medical culture of silence should be replaced by one that embraces apology in order to draw from an ethic of care.

1.1.1: What is an Apology?

The definition of apology on which this study relies is as follows: an apology is an expression of regret and acknowledged responsibility by an offender or offenders to an offended party or parties for an identified harm or harms done that the offended party experienced, that includes a promise to alter harm-causing behaviour for the future. I draw this definition from Smith's elements for a categorical apology. Smith's formulation for a categorical apology is complex and

involves eleven distinct elements, which I expand on in the endnotes of this chapter.³¹ My definition does not touch on every aspect of Smith's categorical apology, as the categorical apology represents an ideal apology and not a realistic one. I have drawn from the elements of the categorical apology based on what I suggest are the most pressing and common elements of apology, those being acknowledging responsibility, promising non-repetition, identifying harms, and expressing regret.

My understanding of apology for this study comes from the literature explaining the social meaning and significance of apology. In particular, I rely on philosopher Nick Smith's 2008 text *I Was Wrong*, and sociologist Nicholas Tavuchis' 1991 text *Mea Culpa*. This study draws its understanding of apology from these texts. These reflections on apology are relevant to medical relationships and medical errors because they grant insight into the politics of the apology process itself. Apology processes are themselves complex, connecting multiple actors, groups, and instances of an error together across time. The politics of the apology process is similarly complex in detail. The politics of the apology process is ingrained in the diverse ways harms, errors, and offenses are acknowledged or dismissed, recorded, and responded to, meaning that the social-interactive elements in the apology process (speaking, hearing, being heard) and reparative actions serve to establish the impact an error has had on the actors, and what will be done to address it. It is the politics of the apology process that connects responsibility and victimhood to relevant actors and establishes the meanings and impacts of error or cleaves responsibility from actors and fragments the meaning of errors and harms. In medical settings, the relevant actors following an instance of error are doctors, nurses, healthcare personnel, health care institutions and authorities, patients, and families. What a medical error can be is not

conclusive, and the possibilities of what an error can be are wide in scope,³² further complicating the politics of medical apology, and furthering the need for a background of apology.

Tavuchis' 1991 book *Mea Culpa* occupies a unique space in apology literature, being one of the first major texts to approach apology in an academic light. Tavuchis adopts an exploratory role in the text and begins by establishing what apologies cannot accomplish. Tavuchis begins by arguing that apologies cannot undo what harm or offense has been done but observes that apologies are used in such a way that suggests that undoing is ostensibly what they do.³³ Smith, in his 2008 text *I Was Wrong*, echoes this paradoxical tension, showing that in the etymology of the word apology "pulls in two different directions,"³⁴ in the sense that apology suggests defenselessness and functions as a defense simultaneously. How apologies accomplish such a paradoxical feat is found in the nuances of how they are performed and interpreted. To this, apologies have an influence on the offender that Tavuchis argues "recalls and is re-called to that which binds,"³⁵ meaning that apologies offer a method of making sense of offences, what is being offended, and who the offender and offended parties are.

The social terrain an apology must navigate is dyadic,³⁶ and as a result, has an inherently relational character.³⁷ In addition to the relational character of apologies, Tavuchis argues that apologies have an 'affective core',³⁸ and it is from this core that the act of apologizing itself becomes the critical action³⁹ in performing an apology. This affective core is key to the intelligibility of apology in terms of instances of medical error, especially in terms of the roles that shame, anger, and sorrow and their expressions take on as central and dynamic components to apology.⁴⁰ For example, the 2011 book *Talking with Patients and Families about Medical Error* begins with the imprint of affective abandonment from the point of view of a patient and his family following a compounding series of medical errors that ultimately ended in the death of

the patient. In an interview before his death from error, the patient recounts that “In terms of compassion or understanding another person’s sensitivity, he [the surgeon] did not make any effort to do that with me. You have no idea how far a ‘sorry’ will go.”⁴¹ Following his death, the patient’s wife and son each related their feelings that the hospital had abandoned them by refusing to acknowledge that harmful, imperfect care had been provided, and by refusing to apologize and engage with them on a vulnerable, human level.⁴² These brief examples show that when the desired and expected outcome of safe medical care is violated, the dependent relationship between healthcare provider and patient is strained, giving rise to a multitude of negative emotions. Further, the call for apology from the patient and the patient’s family shows the care and dependency properly inherent in medical relationships and shows the potential for apology to address, engage with, and contribute to repairing the damaged relationship.

1.1.2: Frailties, Difficulties, and General Struggles with Apology

Tavuchis and Smith each identify distinct struggles, fragilities, and difficulties of navigating apologies. These difficulties are reflected in instances of medical apologies. Tavuchis establishes apology as a discursive action,⁴³ although notes that its discursive aspect is fragile in terms of reciprocity.⁴⁴ Applied to medical culture, I argue that this discursive fragility means that though an apology can be provided, there is no guarantee that patients and families will forgive or engage equally with care providers. Smith picks up on Tavuchis’ dyadic apology,⁴⁵ and contends that apology is fraught with numerous difficulties beyond an individual dyadic instance – when multiple actors or groups of actors are involved, the complexity of providing an apology increases. Specifically, Smith finds that in terms of group or collective apologies, problems of establishing consensus,⁴⁶ as well as establishing who out of a group is responsible for harms,⁴⁷ may compromise the efficacy and integrity of the apology. I suggest that in medical culture, this

compromise might arise from hospitals, health authorities, and healthcare providers who broaden the language of apologetic discourse (through the use of ‘we’ statements for example). Smith notes that while broadening the language used can be useful in properly including relevant actors, the apology will lose precision.⁴⁸ Further, collective apologies are vulnerable to numerous other difficulties, such as a struggle to determine causation,⁴⁹ coordinating or comprehending group expressions of emotion,⁵⁰ and corroborating factual records,⁵¹ each of which threatens the integrity of the apology.

Smith concludes his text with several thoughts on collective apologies. The first is that for actors to make sense of an apology, personal responsibility must be realized.⁵² The realization of personal responsibility following medical error encounters immediate difficulty given the established hesitance to accept responsibility. The second observation points out a danger in collective apologies through what Smith terms ‘institutional doublespeak’. In this doublespeak, as Smith contends, we are quick to accept individual accolades, but are willing to ‘lengthen the causal chain indefinitely when an error occurs’.⁵³ Smith further unpacks his observation on the danger of institutional doublespeak by arguing that offenders can offer collective apologies rather than individual apologies, weakening the integrity and efficacy of the apology.⁵⁴ When a causal chain is lengthened, assigning responsibility for an offence becomes difficult, as responsibility can be shifted further and further along a causal chain. Institutional doublespeak and the extending of causal chains calls upon power and privilege to shift responsibility, spread it among many actors, or otherwise obscure who or what is responsible for an offence, meaning that the more power that is concentrated in an actor or organization, the more that responsibility can be shifted. A causal chain in medical circumstances may be complex and hard to follow, making attributions of responsibility and apology difficult.

The difficulties of collective apologies are especially relevant to health care practices due to the institutional nature of health care provision. Collective apologies, especially ones that engage in institutional doublespeak and causal chain extension, offer a way for healthcare providers to obfuscate responsibility and causation for errors by diffusing responsibility among health care systems or institutions,⁵⁵ or patients themselves,⁵⁶ leaving, as Smith would say, “important gaps in the historical record.”⁵⁷ Beyond historical gaps, establishing personal responsibility and collectively establishing whether or not an apology should be provided may result in no apology being provided at all or may inhibit an apology that engages with victims.

The final thought that Smith discusses comes from philosopher Richard Joyce, who opines that apologies and reconciliation are only called for “when someone cares.”⁵⁸ Care and caring emphasize a deep sense of connection between actors through relationships. I argue that care and caring resonate with a concept that Smith refers to as ‘standing.’⁵⁹ Through this concept, the analytical resonance that care and caring have with apologies is enriched because investigating the standing of actors calls for an investigation of the contextual position of actors in relation to other parties and the offense. In the concept of standing, an apology that is delegated or made from a position that is abstract from the offense and the offended suffers in quality due to a sense that the apology is insincere or is coming from an inappropriate actor. With regards to care and caring, a medical apology provided without proper standing may indicate that the truly responsible actors do not care about the harm and may be protected by an institutional extension of the causal chain. Further, an apology that is provided without standing may suffer political consequences: if there is a difference in the balance of power between offender and offended (an asymmetric distribution of power is a feature of medical relationships), I argue that an apology that is offered without standing reflects a leveraging of

power dynamics within the relationship and may indicate that one party has declared control over the apology process and over the circumstances of the harm.

In terms of care and caring, I suggest that standing connects the apologizer to the offense in relation to the offense and the offended. Apologizing from a position of proper standing enriches the relational connection between the offender and offended and makes apologies more meaningful for the recipient of the apology. Likewise, apologizing without standing de-emphasizes the connection between offender and offended, and risks harming the impact of the apology. Standing can clarify the connection of the care of actors about the offense to the offense, but also acts as a check to the power of care, ensuring that simply caring about an offense is not enough to assert that one occupies a position appropriate to provide an apology. In this way, a discussion of standing during apology formulation is key to enriching both a discussion of responsibility and a discussion of the distribution of power within the relationship, which overall elevates the importance of the relationship between the offender and offended.

Tavuchis concludes his text by describing its contents as prolegomena, suggesting that a robust discussion of apology is incomplete.⁶⁰ His concluding suggestion takes into account the monumental and familiar complexity of human interaction and prompts us to strive to ‘reknow’⁶¹ the social terrain apologies navigate, and the variegated manners in which they do so, before our apologetic behaviour can be meaningfully altered. I interpret Tavuchis’ concluding remarks as recommendations that offer a valuable bridge into examining what doctors know about their patients and their own relationships, how they know it, and what possibilities for improvement are offered by reknowing. The thrust of this recommendation prompts a look into the history and contemporary expression of the epistemology, phenomenology, and pedagogy of medicine as they inform the contemporary culture of silence and reluctance towards responsibility and

apology. The concept of ‘reknowing’ as it is key to Tavuchis’ apology discourse, is not an alien one to the practice of medicine. Reknowing, as far it suggests social and political circumstances that must be continually re-interpreted, is similar in theme to some historical medical ethics which still carry relevance today at the conclusion of medical education. A section of the Oath of Maimonides (attributed to the 12th century physician, perhaps anachronistically)⁶² displays a medical ethic that positively values the possibility of learning through the troubled relationship between medical practice and medical certainty. The relevant section of the Oath is presented below:

May I never see in the patient anything but a fellow creature in pain. Grant me the strength, time and opportunity always to correct what I have acquired, always to extend its domain; for knowledge is immense and the spirit of man can extend indefinitely to enrich itself daily with new requirements. Today he can discover his errors of yesterday and tomorrow he can obtain a new light on what he thinks himself sure of today.⁶³

The Oath of Maimonides promotes an empathic understanding of patients and unifies the physician and the patient under the ‘spirit of man,’ and exposes both to the capacity to err. Tavuchis’ ‘reknowing’ and the Oath’s testament to the enriching possibility of learning from errors are connected through a common theme of acknowledging and valuing the learning potential arising from uncertainty, the possibility to improve behaviour for the future based on revisiting past events and experiences. This thesis picks up on the note on which Tavuchis’ text concludes, and it is in part an exploration of what must be reknown to better understand how errors damage medical relationships, and how apologies help repair them. Through examining various aspects of apology as far as apologies impact medical relationships, the takeaway is that the tragic beauty of an apology is such that the connective, caring, reparative, learning, and healing potential is afforded to us only after a harm has occurred.

1.2.1: *The Ethics of Care: Principles and Challenges*

The second key concept utilized by this study is the ethics of care. The purpose of this section is twofold: first, I aim to show that care ethics is an appropriate ethic for responding to and maintaining medical relationships after an error occurs. Second, I aim to show that a medical culture that values apology is a culture that can promote and draw from the benefits that an ethic of care offers. This section will unfold in two subsections. In the first, I describe care ethics and its principles. In the second subsection, I provide four arguments that support my claim that a medical culture that favours apology should replace the culture of silence in order to draw from the benefits an ethic of care offers medical relationships.

Described by Gilligan in her pivotal 1982 text *In a Different Voice* the central principles of care ethics are the ability to recognize multiple intersecting contexts throughout life,⁶⁴ acknowledging responsibility as being central to care,⁶⁵ and recognizing dependence as an evolving, binding factor through which power ebbs and flows in human relationships.⁶⁶ Central to an ethic of care is its approach to how selves are constituted and understood: we come to know ourselves through the care we provide for others and from the care we receive. This approach emphasises dependent and interdependent relationships of care and caring across a variety of contexts, and de-emphasises individualistic conceptions of the self (in the political realm, scholars typically arrange care ethics and liberal individualism as being in opposition). Care ethics elevates the importance of relationality and can be analytically engaged across different facets of public and private life, including psychological development, justice, and politics.⁶⁷ Indeed, one of Gilligan's major contributions in *In a Different Voice* is showing how a legitimate moral worldview is ingrained in care and caring:

When assertion [of the self as being a legitimate target of care] no longer seems dangerous, the concept of relationships changes from a bond of continuing dependence to a dynamic of interdependence. Then the notion of care expands from the paralyzing injunction not to hurt others to an injunction to act responsively toward self and others and thus to sustain connection. A consciousness of the dynamics of human relationships then becomes central to moral understanding, joining the heart and the eye in an ethic that ties the activity of thought to the activity of care.⁶⁸

Gilligan succeeds in showing that ethical development and behaviour towards others and the self does not have to solely rely on a (typically) masculine ethic of justice. In an ethic of justice, ethical interaction with others is rigidly and abstractly defined in terms of individualization and rational self-maximization, while caring for others in a dependent/interdependent manner is perceived as threatening to the rights-based framework from which the ethic of justice is derived. In turning away from an ethic of justice, a strength in caring for others can be determined, and the scope of what ethical development and behaviour can be is broadened. Care ethics has a variety of scholarly interpretations, but as Robinson argues, a cluster of principles for an ethic of care can be established:

While accounts of the nature of the ethics of care differ, it is possible to isolate a number of key attributes of the ‘substance’ of care ethics that distinguish it from other approaches to ethics. In a succinct and clear statement, Virginia Held argues that the ethics of care focuses on the ‘compelling moral salience of attending to and meeting the needs of particular others for whom we take responsibility’. Joan Tronto’s now well-known formulation highlights the importance in care ethics not of moral principles as such but of *practices* as constitutive of morality. These include attentiveness, responsibility, nurturance, compassion, and meeting others’ needs.⁶⁹

The applicability of care ethics to a study of medical apology is not without its challenges. Ranasinghe argues that because care ethics has many interpretations, meanings, and expressions, disorder arises when care ethics is applied in real-world circumstances.⁷⁰ Greenhalgh argues that an ethic of care is not immune to dynamics of power in relationships, and can be distorted or skewed to center the doctor’s happiness with medical relationships as the primary area of concern, rather than the mutual relationship of dependency that involves the patients’ concerns.⁷¹

The ethics of care is also precarious in its engagement with empathy. In his book *The Ethics of Care and Empathy*, Michael Slote seeks to show that empathy is a crucial component of an ethic of care. Empathy, Slote argues, permits an ethic of care to be relevant to analysts and actors in the public sphere with regards to notions of justice, an area that is atypical for care ethics.⁷² Slote puts forward a standard of an empathic ethic of care:

Our accumulating examples and discussion make it possible, I think, to offer a general criterion of right and wrong action based in the notion of empathic caring or concern for others. Rather than say (as I said, roughly, in Chapter 1), that actions are wrong if, and only if, they reflect or exhibit or express a deficiency of caring motivation, one can claim that actions are morally wrong and contrary to moral obligation if, and only if, they reflect or exhibit or express an absence (or lack) of fully developed empathic concern for (or caring about) others on the part of the agent.⁷³

Slote defends the demanding nature of such a criterion,⁷⁴ arguing that we have “moral obligations to help strangers and people we only know about”⁷⁵ but that it is uncertain how pressing these obligations are. An empathic ethic of care as Slote describes it would struggle to engage with medical relationships, due a phenomenon that Maria Marini⁷⁶ and Danielle Ofri⁷⁷ document, where empathy withers in the later stages of medical education (Ofri refers to this phenomenon as a ‘shredding of empathy’). From Slote’s empathic ethic of care, this diminishing of empathy would make moral judgments impossible if medical personnel had no or limited empathy by which their care could be judged against.

However, I argue that an ethic of care remains useful in addressing harmed medical relationships, despite the challenges raised by Slote, Greenhalgh, and Ranasinghe. Slote’s empathic ethic of care does not engage with the concept of dependence, despite dependence being a dominating force in medical relationships. Slote’s empathic ethic of care establishes connections to others through empathic concern for human well-being and grants a metric through which actions or non-actions can be judged. However, Slote’s empathic ethic of care

leaves little room for the input of context when evaluating caring responses, despite attention to context being central to an ethic of care. Further, Slote argues that an empathic ethic of care may permit paternal interventions on the behaviour of others out of empathic concern.⁷⁸ I argue that paternalism is already reflected in the distorted ethic of care that is a result of the perceived expectation of perfection and a part of a culture of silence, through both paternal interventions and non-interventions (recall the ‘paradox of care’ raised by Groopman, where physicians make a paternal decision to *not* inform patients of upsetting diagnoses).

Despite my critiques of Slote’s empathic ethic of care, and the observations of Ofri regarding the diminishing of empathy during medical education, empathy still plays a crucial role in medical relationships, especially after an error, in informing the moral intuition of medical personnel. As well, my critiques are not to condemn an empathic ethic of care as an unattainable ideal. If anything, my critiques should be understood to reinforce the claim in my introduction that medical relationships, their circumstances, and their emphases are distinct and present unique ethical quandaries. Further, the distortion and disordering potential of an ethic of care raised, respectively, by Greenhalgh and Ranasinghe gesture towards the importance of context in relational circumstances. In Greenhalgh’s circumstances, it is the context of the uneven distribution of power between patient and doctor that negatively distorts their relationship. In Ranasinghe’s case, it is the social and geographic circumstances of emergency shelters that amplify the disordering effect of care ethics. I interpret Greenhalgh and Ranasinghe’s observations as legitimate criticisms that nonetheless point to a strength of care ethics by highlighting the importance of context, which is often de-emphasized or ignored by rights-based approaches to relationships rather than revealing weaknesses that are unique to care ethics.

1.2.2: Four Subsidiary Arguments in Support of Replacing a Culture of Silence

In this section, I provide four subsidiary arguments in support of my claim that the culture of silence ought to be replaced by a medical culture that embraces apology in order to draw from the benefits that an ethic of care offers to medical practice. I make four subsidiary arguments to support this claim. The first argument is that because medical relationships involve overlapping emphases of care and multiple contexts in which an error can occur, a good medical culture should be able to respond in consideration of these features in the instance of an error.

Medical relationships involve multiple overlapping emphases of care. The commonly attributed focus of the relationship between HCPs and patients is a physical one, that is, patients rely on HCPs for physical care. The impact of medical errors on the physical well-being of patients is indeed a major concern. However, HCPs and patients are also relationally involved on emotional and psychological levels. As such, these are also areas that medical errors have an impact on. As Nora Jacobson argues in her text *Dignity and Health*, ‘dignity’⁷⁹ in health care settings is one answer to the question of ‘besides bodies, what is being harmed when something goes wrong in a health care setting?’ Indeed, Jacobson documents the precious and precarious situation of dignity in health care settings, arguing that dignity can be violated through medical conduct in many ways,⁸⁰ across intersecting contexts of power and vulnerability,⁸¹ many of which overlap with the circumstances of medical errors.

Dignity violations, as Jacobson argues, are individually focused in that it is an individual who finds their dignity violated.⁸² However, the violation of dignity can occur by way of the violation of a sense of belonging in larger social institutions, systems, and concepts, such as citizenship, personhood, and humanity. Medical culture ought to be able to address these violations as they occur in an instance of medical error, and ought to address them through

robust and satisfactory apologies in order to preserve dignity and relationships of care. Medical relationships are embedded in institutional and systemic enterprises, and a medical culture that embraces apology must be able to address a wide variety of contexts in which an error can occur, even when they occur in unexpected circumstances. An example of an unexpected circumstance is the violation of confidentiality; in a 2012 paper, Avrahami recorded the narratives of doctors who have made medical mistakes, including one in which a doctor mistakenly revealed confidential information to the parents of a patient, causing the patient to end their relationship with the doctor due to the violation of trust.⁸³ This example shows that mistakes that damage relationships do not necessarily have to be mistakes physically affecting the bodies of patients, and shows that the scope of medical errors is wide. I suggest that a medical culture that values apology would make the relationship the center of ethical action and the focus of repair and in doing so, a wide variety circumstances of harm can be addressed. Interpreting and addressing errors through their impact on the relationship between actors is an area in which care ethics excels and would benefit a medical culture that embraces apology due to the emphasis that care ethics places on paying attention to context, maintaining relationships, and repairing relationships as necessary.

My second subsidiary argument is that a medical culture that embraces apology ought to replace a culture of silence to draw from the normative benefits of care ethics, because the normativity of care ethics can help maintain an apology-favoring culture. A medical culture that favours apology can draw from the normative ethical principles of care at various stages in medical relationships to different effects. A medical culture that promotes apology can promote an ethic of care prefiguratively by way of ethically reconsidering how medical relationships are learned and taught (such as improved training on errors and apologies during medical school),

during instances of error and apology (such as using the principle of response as an orienting goal when forming and performing an apology), and after the apology process (using the principle of relationship maintenance to promote reflection, healing, and adjustment of behaviour to refine the care that is provided). As well, because of its status as a normative ethic, care ethics can be used as an investigative ethic to appraise and analyze the adequacy or appropriateness of apologies after medical errors.

Third, a culture of silence ought to be replaced by a culture that favours apology in order to interrogate dynamics of power that exist on interpersonal and institutional levels within medicine. Power in medical circumstances can be utilized to silence or dismiss legitimate complaints of suffering or wrongdoing. A healthcare provider or physician who does not apologize or provides an apology that only recognizes harms conditionally, silences or otherwise dismisses the suffering of the patient, dismisses the reality of the situation and effaces the role power plays in the relationship. On the surface, this dismissal suggests a latent power inequality that permits the healthcare provider or physician to do so. However, experiences of dismissal, suffering, and care requires a deeper analysis to establish more robustly the distribution of power between actors in medical relationships. To accomplish this goal, I utilize a narrative study of nurses' experiences with intrusive care. The study, by Peter et al., suggests that interpersonal interactions in medical settings between patients, families, nurses, and doctors are organized hierarchically. Power routinely manifests in the use of status to supersede the caring judgments and decisions of other healthcare providers, patients, and families, impacting the provision of care overall. In Peter et al.'s study, this overriding occurs in four ways. In one, doctors actively impugn the knowledge of nurses:

Participant 5 described a situation in which she attempted to stop the continued medical treatment of an aged man in an emergency room who had arrested a number of times and whose ribs were breaking as a result of cardiopulmonary resuscitation (CPR)...[d]espite this nurse's judgment that this patient would die even with intervention, the physician carried on believing his own knowledge to be superior to hers. In this case, the aggressive care continued to be administered until the patient was eventually declared dead.⁸⁴

In another, a nurse relates that medical decisions of family members were overridden by other nurses and medical teams:

Participant 13 described a situation in which the family of a woman in her 80s insisted that "everything" be done, relating a common understanding of family responsibility found in the narratives...[t]he team in this narrative wanted to stop all aggressive care, but the family, with their understanding of familial responsibility, insisted that she continue to be treated in such a manner. In other narratives, conflict arose when families decided to continue aggressive care because they believed that other measures such as Eastern remedies (Participant 15) and God's power (Participants 8 and 11) would eventually heal their family member even if allopathic medicine could not.⁸⁵

Third, senior nursing and physician staff are shown to be capable of delegating undesirable caring roles to lower-⁸⁶ or higher-status personnel, typically to communicate unpleasant information to patients and families:

Participant 3 described a situation in which a man in his 80s had cancer with metastases to his lungs whose family wanted surgery and full code status for him. The nurses had difficulty with this plan, but many found it difficult to approach the family to discuss the condition of the patient. Instead, communication was "delegated" to one nurse in the unit who had the skill. This "delegation" to the experienced and skilled nurse to talk about dying and death was present in a number of the narratives.⁸⁷

Finally, the wishes of patients themselves, even if they correspond with nursing staff, are subject to hierarchical power of dismissal:

Participant 1 told a story of a young man with advanced cancer who was expressing the desire to die, but was convinced to accept intubation for a couple of days to see whether another round of chemotherapy would prolong his survival...[t]his participant's efforts to convince the physicians to stop treatment did not succeed because their hope was to wait and see whether the treatment would improve the patient's condition. The lack of medical certainty regarding the effectiveness of the treatment increased the time needed for the patient to die.⁸⁸

These narratives reveal several things about the presence of power in medical relationships.

First is that there is a clear hierarchical structure and corresponding flow of power that is on

display in typical medical circumstances. The stratification of power finds doctors near the top, then nurses, and then patients and families, though there are also granular differences, such as differences between junior and senior nursing staff. Additionally, the hierarchical order presented here is certainly subject to shifts from the intersections of race, class, and gender. Second, these narratives show not just that the decision-making capacity of patients and families are dismissed but also that patients and families are themselves consistently disempowered over matters of life, death, and the care they wish to receive. Finally, these narratives show that drawing upon an interpretive intersectional framework that appreciates disparities of power approach enriches the view that an ethic of care lens has on medical relationships.

Peter et al.'s study reveals divisions and uneven concentrations of power in medical relationships, and it is these uneven concentrations of power that are favorable to the larger pattern of a culture of silence and a hesitance to take responsibility for errors amongst medical personnel. I reason that the power to dispute and dispel decisions as important to safe medical care as intrusive practices could certainly be used to dismiss legitimate complaints of wrongdoing and calls for apology. Power within medical relationships is a resource capable being leveraged to dismiss or ignore suffering and calls for apology, and redirect taking of responsibility that forms the basis of an apology. These uneven concentrations of power are by extension barriers to the promotion of an ethic of care in medical relationships: apology as a caring response to harms and as reparative action for damaged relationships must surmount the division of power that can be used to dismiss the harms being apologized for. As MacDonald and Levasseur argue, an ethic of care can challenge the typical power-laden division between physician and patient. For MacDonald and Levasseur, apologies can be caring in the sense that through an apology, the damaged relationship between care provider and patient is addressable,

the needs to repair it are identified, and contextual action is taken to ensure the harm does not occur again.⁸⁹

Medical apologies can also be negatively impacted by a lack of standing. Smith's concept of standing helps to better see how hierarchically-organized power dynamics impact apologies, and further supports my claim that a medical culture that is favourable to apology should replace a culture of silence. The appropriateness, quality, and efficacy of an apology can be negatively impacted if the apology is provided by a person or party without the proper standing to apologize. The interaction of care and apology is complicated by the notion of standing as apologies can be provided without standing, but from a place of care. A medical culture that embraces apology and that draws from an ethic of care can protect itself against apologies provided out of standing somewhat, by highlighting differentials of power that come into play as apologies occur. This interpretation is supported by Curtain, who draws a distinction between caring for something or someone and caring *about*⁹⁰ them: 'caring for' something or someone requires an intersectional consideration of circumstances and actors to be effective, something that 'caring about' cannot accomplish due to a lack of information and engagement with dynamics of power. I argue that this for-about distinction recalls the perfectionist drive discussed in the introduction, wherein the distorted, duty-based ethic of care arises from 'caring about' the perceived expectation of perfection on the part of the patient, as opposed to 'caring for' the deeper sense of connection imparted from being part of a medical relationship. As this perfectionist drive is a part of a culture of silence, I argue that a medical culture that favours apologies must adopt an intersectional framework to interrogate medical dynamics of power. As Curtain argues, 'caring about' can develop into 'caring for' by way of contextual intersectional engagement.⁹¹

As a feminist-influenced ethic, care ethics offers an interpretive lens through which dynamics of power in relationships can be examined, in terms of how power is exerted, transferred, or transformed, and would benefit a medical culture that favours apology. This point requires expansion due to the particularity of the argument. Gilligan argues throughout her text that the way women interpret and experience relationships, and how their moral development is understood, is framed by a masculinist morality, with distinct normative ethical guidelines. This framing means that the way that power, specifically the power of judging ethical decisions made by others, differs depending on the frame of reference of the person passing judgment.⁹² Gilligan concludes that given a masculinist morality that views caring as a weakness and passes judgment on actions leveraged from an ethic of care accordingly, women “are ideally situated to observe the potential in human connection both for care and oppression.”⁹³

Important to note is that Gilligan touches on the possibility of a role for men and masculinities in an understanding of life that privileges care and caring only briefly in her text,⁹⁴ but concludes that the languages and expressions are not necessarily bound to biological sex and are instead attached to social ideas of masculinity and femininity.⁹⁵ Essentialist critiques have been leveraged against Gilligan by other feminist and ethics of care scholars, resulting in more contemporary research that gestures towards the growing inclusion of men and masculinities in care ethics.⁹⁶ I interpret care ethics as a gender-inclusive ethic in the circumstance of a medical culture that draws from the benefits that care ethics offers, in the sense that any HCP can care regardless of gender, though I make this interpretation with the caveat that the gendered dynamics of power that exist within medicine would require a deep and enduring commitment to dispel.

As Gilligan argues, responsibility is a key element of an ethic of care.⁹⁷ Identifying responsible actors and realizing responsibility towards others is also key for apologies; recall Smith's thoughts on responsibility in collective apologies,⁹⁸ as well as the role of responsibility towards others and as something that should be accepted by offending parties in the categorical apology.⁹⁹ This shared emphasis on responsibility strengthens the argument that care ethics would benefit a medical culture that is favourable to apology. Gilligan argues that in relationships of disparate power distribution, power is utilized to either maintain the inequality through self-justification, or to dispel it.¹⁰⁰ I suggest that this observation maps onto the damming and flow of power in the unique relationship between medical personnel, patients, and families. As was shown in Peter et al.'s study, the relationships between medical personnel, patients, and families are relationships with uneven distributions of power. An example of the use of power to help dispel inequalities in health contexts would be an HCP providing a satisfactory apology to a patient. The shift in power in this example occurs in the HCP recognizing and taking responsibility for a harm done to the relationship, communicating a desire to do better, and thereby helping the patient heal after an error. The patient, at this time, can refuse to accept the apology, or forgive the offender, contributing to the repair of their relationship with their doctor. Power through apology in this sense is shifted in a confessional manner, a humbling experience in acknowledging error for the offender and an empowering experience for the victim.

The final subsidiary argument in support of my claim that a medical culture of silence should be replaced by a culture that favours apology is because an apology-favourable culture would promote an emphasis on human security in healthcare. Reframing health and healthcare relationships as security issues also elevates issues of fairness and justice that are imbricated in

systems of healthcare. Issues of fairness and justice are issues that can arise when a medical error occurs, such as when large amounts of citizens are harmed in a major health crisis, or if issues of discrimination have led or are leading to systemic harms in health care, and so are especially relevant to medical apology. An apology-favourable culture can draw benefits from an ethic of care along lines of human security and health as well. In her 2011 text, *The Ethics of Care: A Feminist Approach to Human Security*, Fiona Robinson sets out to challenge the reader to reconsider health care as a security issue. Robinson argues that a right to human security that includes and recognizes the value of relational ontologies sits in a precarious position because relational ontologies are typically undervalued by Western political institutions that privilege an atomistic ethic of justice.¹⁰¹ These power-dominant norms influence discussion and policy action on topics of human security as if actors are individual, rational self-maximizers, rather than intersubjective, relationally-bound subjects. An atomistic conception of human relationships has the effect of limiting what can be considered a human security issue, as well as limiting what responses are valid when the relationship is damaged. Robinson argues that reconceptualizing security through an ethics of care lens not only highlights dynamics of power, but also reinforces the relational nature of human interaction by shining light on issues affecting human health that may otherwise evade investigation.¹⁰² As an example, Robinson highlights HIV/AIDS epidemics as security issues negatively affecting human health and is critical of the lack of care and attention paid to them due to myopic and atomized conceptions of human security.¹⁰³

I suggest that Robinson's reconceptualization of health security can be pared down from a global scale to a scale relevant to apology in medical institutions and interpersonal relationships. Robinson's concept of security can be mapped on to health care relationships via the expectation of receiving safe medical care when it is needed. I suggest that the two-pronged

effect of re-contextualizing safe health care practices and redefining the relationships through which health care is provided resonates with the altered medical culture that favours apology. In a medical culture that favours apology, the increased presence of apologies would serve as the method of recontextualization, and that by apologizing, medical care would be rendered safer by addressing errors and fixing the conduct that led to them (I expand on this point in the next chapter). By increasing the presence of apology in medicine, an ethic of care is granted a more favourable habitat within medical relationships. In the inevitable instance of medical error, apology becomes relevant to health security due to the deleterious possibility of harm through the error, and that if left unaddressed, it will reoccur, risking the security of future patients. A medical culture that is favourable to apology can draw from an ethic of care in these circumstances by resonating with the recontextualization of health care relationships that the introduction of apology would prompt.

Conclusion

The influential 1999 report on medical error by the Institute of Medicine (now the National Academy of Medicine) is titled *To Err is Human*. The title is drawn from the first section of a well-known proverb attributed to Seneca. The first section of the proverb indicates that human subjects are united through our capacity to make mistakes without forfeiting our humanity. Less well-known and well-quoted is the conclusion of the proverb: *sed perseverare diabolicum*. Translated, this reads “to persist in error is diabolical.” This proverb in its entirety (‘to err is human, to persist in error is diabolical’) represents the general thrust of this study: mistakes are inevitable human occurrences, we are united by virtue of our shared, imperfect lives, and we are united by the possibility to improve by confronting our errors.

In this chapter, I established two key pillars for this study. The first was a broad understanding of the sociological and philosophical aspects of apology and the second was an ethic of care. I first established how the philosophical and sociological aspects of apology contribute to a study of medical apology by allowing a deeper level of inquiry. The second key concept is an ethic of care. I argued that a medical culture that promotes apology would draw from the benefits an ethic of care offers, permitting a deeper appraisal and analysis of medical relationships. I provided four subsidiary arguments in support of the replacement of a medical culture of silence with a medical culture that favours apology to draw from an ethic of care. First, I argued that the medical culture of silence should be replaced because medical relationships involve overlapping emphases of caring relationships and contexts and require deeper examinations into these relationships and contexts than the current culture of silence permits. An apology-favourable medical culture draws from an ethic of care here because of the special emphasis that care ethics places on relationships. Second, I argued that a culture of silence ought to be replaced because an apology-favourable culture can draw from the normative benefits of care ethics, which would help sustain the apology-favourable culture. Third, I argued that a culture of silence ought to be replaced in order to interrogate dynamics of power within medical institutions and interpersonal relationships. These power dynamics are harmful and prohibit the use of apology. An apology-favourable culture would draw from care ethics here because care ethics is attuned to investigating dynamics of power within relationships. Finally, I argued that by replacing the culture of silence, healthcare issues that are imbricated with issues of fairness, justice, and security can be emphasized, increasing the safety of healthcare provision. From here, the benefit drawn from an ethic of care is the reconceptualization of healthcare relationships to

focus on issues of security, justice, and fairness that may otherwise not be viewed as relevant to healthcare relationships.

In this chapter, I showed that mistakes are inevitable throughout life, and that apologies are important and appropriate responses to mistakes. I oriented this argument to focus on mistakes that occur in medical settings and that harm medical relationships. In developing this argument, I showed that the culture of silence should be replaced by one that is favourable to apology, and that this culture can draw from benefits that care ethics offers to medical relationships. I made this argument acknowledging that there are fragilities and difficulties inherent in the apology process itself (such as complications involving collective apologies or standing), that there are particularities unique to medical relationships that must be addressed for a proper apology to be issued (such as unique hierarchical structures of power), and that the application of care ethics to medical relationships in promotion of apology is not without its challenges.

Notes

¹ Aaron Lazare, "Apology in Medical Practice: An Emerging Clinical Skill," *Journal of the American Medical Association* 296 no. 11 (2006), 1403: "It is no accident that physicians often resist acknowledging offenses in the medical setting or fail to adequately apologize for them. An obvious and understandable reason for such resistance is the fear of consequences, such as an angry patient, a complaint sent to the state Board of Registration, or a malpractice suit."; Jennifer Robbennolt, "Apologies and Medical Error," *Clinical Orthopedics and Related Research* 467 no. 2 (2009), 378. "Despite the potential benefits of apologizing, apologies are not frequently given and there is wide variation in physicians' tendencies to offer apologies in the wake of medical error."

² Government of Alberta, "Alberta Evidence Act," RSA 2000, c A-18, <http://canlii.ca/t/52fmm>;

Government of British Columbia, "Apology Act," SBC 2006, c 19, <http://canlii.ca/t/52pn4>;

Government of Manitoba, "Apology Act, CCSM c A98," <http://canlii.ca/t/k94m>;

Government of New Brunswick, "Health Quality and Patient Safety Act, SNB 2016, c 21," <http://canlii.ca/t/53919>;

Government of Newfoundland and Labrador, "Apology Act, SNL 2009, c A-10.1," <http://canlii.ca/t/k5xb>;

Government of Northwest Territories, "Apology Act, SNWT 2013, c 14," <http://canlii.ca/t/524p8>;

Government of Nova Scotia, "Apology Act, SNS 2008, c 34," <http://canlii.ca/t/523gt>;

Government of Nunavut, "Legal Treatment of Apologies Act, SNU 2010, c 12," <http://canlii.ca/t/kx9p>;

Government of Ontario, "Apology Act, 2009, SO 2009, c 3," <http://canlii.ca/t/jx9q>;

Government of Prince Edward Island, "Health Services Act, RSPEI 1988, c H-1.6," <http://canlii.ca/t/53646>;

Government of Saskatchewan, "The Evidence Amendment Act, 2007," SS 2007 c 24, <http://canlii.ca/t/5385t>.

³ Canada, *Debates of the Legislative Assembly*, 20 February 2006, 6 no. 6, 2350;

Canada, *Debates of the Legislative Assembly*, 27 February 2006, 6 no. 13, 2495-2496;

Canada, *Debates of the Legislative Assembly*, 28 March 2006, 8 no. 5, 3359;

Canada, *Debates of the Legislative Assembly*, 29 March 2006, 8 no. 7, 3456-3465;

Canada, *Debates of the Legislative Assembly*, 6 April 2006, 9 no. 4, 3795-3801;

Canada, *Debates of the Legislative Assembly*, 25 April 2006, 9 no. 9, 3999-4001.

⁴ Of note, 'Apology Act' legislation in Prince Edward Island and New Brunswick specifically references healthcare providers and healthcare settings, perhaps indicating a recognition of both the precarious and crucial role of apologies in medical circumstances.

⁵ Danielle Ofri, *What Patients Say, What Doctors Hear* (Boston: Beacon Press, 2017), 143; Robert Truog et al., *Talking with Patients and Families About Medical Error: A Guide for Education and Practice*, (Baltimore: John Hopkins University Press, 2011), 44; Susan B. McIver, "Not a Children's Song," in *Medical Nightmares: The Human Face of Errors*, ed. Susan McIver (Toronto: Chestnut, 2001), 73.

⁶ Aaron Lazare, *On Apology* (New York: Oxford University Press, 2004), 33-37;

Aaron Lazare and Roselle Sherman Levy, "Apologizing for Humiliations in Medical Practice," *CHEST Journal* 139 no.

4 (2011), 749; Danielle Ofri, *What Doctors Feel: How Emotions Affect the Practice of Medicine* (Boston: Beacon

Press, 2013), 56; Nancy J. Crigger, "Always Having to Say You're Sorry," *Nursing Ethics* 11 no. 6 (2004); Patrice M.

Weiss and Sandra Koch, "Medical Errors: Disclosure and Apology," *Contemporary OB/GYN* 57 no. 6 (2012), 44; Prue

Vines, "Apologising to Avoid Liability: Cynical Civility or Practical Morality," *Sydney Law Review* 27 no. 3 (2005),

484; Prue Vines, "Apologies and Civil Liability in the UK: A View from Elsewhere," *Edinburgh Law Review* 12 no. 2

(2008), 206; Robert Truog et al., *Talking with Patients and Families*, (2011), 1-2, 31-33.

⁷ Jennifer Robbennolt, "Apologies and Medical Error," 376-377: "Apologies also have positive effects on expectations and intentions for a future relationship between the parties, play a role in restoring trust, reduce emotional reactions such as anger, induce favorable physiological responses in both parties, and reduce antagonistic responses."

⁸ Nancy J. Crigger, "Always Having to Say You're Sorry," 572-574; Stuart McLennan, Simon Walker, Leigh E. Rich, "Should Health Care Providers Be Forced to Apologise After Things Go Wrong?" *Journal of Bioethical Inquiry* 11 no. 4 (2014), 433-434.

⁹ Aaron Lazare, "Apology in Medical Practice: An Emerging Clinical Skill," 1402; Rebecca Dresser, "The Limits of Apology Laws," *Hastings Center Report* 38 no. 3 (2008), 6.

¹⁰ Vivienne Nathanson, "Medical Mistakes: A View from the British Medical Association," in *Medical Mishaps: Pieces of the Puzzle* ed. Marilyn Rosenthal, Linda Mulcahy, and Sally Lloyd-Bostock (Philadelphia: Open University Press, 1999), 199-200.

¹¹ Prue Vines, "Apologies and Civil Liability in the UK: A View from Elsewhere," 224-229.

¹² Karine Levasseur and Fiona MacDonald, "Mea Culpa: Apology Legislation, Accountability and Care," *Canadian Journal of Political Science* 51, no. 4 (2018); Stuart McLennan et al, "Apologies in Medicine: Legal Protection is Not Enough," *Canadian Medical Association Journal* 187 no. 5 (2015), 158.

¹³ Robert Truog et al., *Talking with Patients*, 41.

¹⁴ Joan Tronto, *Moral Boundaries: A Political Argument for an Ethic of Care*, (New York: Routledge, 1993).

¹⁵ Jerome Groopman, *How Doctors Think*, (New York: Houghton Mifflin, 2007), 54.

¹⁶ *Ibid.* 46, 52.

¹⁷ William Osler, "Aequanimitas," Valedictory Address, 5-6 (1889),

<http://www.medicalarchives.jhmi.edu/osler/aequessay.htm>

To establish the history of the governance of emotions in medicine, consider the influential valedictorian speech "Aequanimitas," by Canadian physician William Osler. Osler, a founding member of John Hopkins Hospital, delivered the speech to graduating physicians in 1889, and calls for physicians to maintain levels of 'obtuseness,' 'imperturbability,' and 'equanimity' as emotional doctrines to guide the provision of care, while noting briefly that a measure of compassion is still key to caring. The relevant section of the speech is provided below: "Cultivate, then, gentlemen, such a judicious measure of obtuseness as will enable you to meet the exigencies of practice with firmness and courage, without, at the same time, hardening 'the human heart by which we live.' In the second place, there is a mental equivalent to this bodily endowment, which is as important in our pilgrimage as imperturbability. Let me recall to your minds the incident related of that best of men and wisest of rulers, Antoninus Pius, who, as he lay dying, in his home at Loriam in Etruria, summed up the philosophy of life in the watchword, Aequanimitas. As for him, about to pass flammantia moenia mundi, so for you, fresh from Clotho's spindle, a calm equanimity is the desirable attitude."

¹⁸ Thomas H. Gallagher, et al., "Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors," *JAMA* 289 no. 8 (2003), 1003.

¹⁹ *Ibid.* 1003.

²⁰ Suzanne Gordon and Bonnie O'Connor, "What Goes Without Saying in Patient Safety," in *First, Do Less Harm: Confronting the Inconvenient Problems in Patient Safety*, ed. Ross Koppel and Suzanne Gordon (Ithaca: Cornell University Press, 2012), 47; Thomas Gallagher et al., "Talking with Patients About Other Clinicians' Error," *The New England Journal of Medicine* 369 no. 18 (2013), 1753.

²¹ Thomas Gallagher et al., "Patients' and Physicians' Attitudes," 1003: "Most physicians concurred that they worry regularly about medical errors. In addition to fearing that an error might harm patients, physicians said their worst fears about errors included lawsuits, loss of patient trust, the patient informing friends about their bad experience, loss of colleagues' respect, and diminished self-confidence." 1003-1004: "Other physicians believed that certain patients would not want to know about an error that informing these patients of an error would diminish patients' trust in their physician."

²² Danielle Ofri, *What Doctors Feel*, 128, 132-133, 137-138; Danielle Ofri, *What Patients Say, What Doctors Hear*, 140, 144; 146; Linda Scheirton, "Proportionality and the View from Below: Analysis of Error Disclosure," *HEC Forum* 20 no. 3 (2008), 218; Linda Treiber and Jackie Jones, "Wounds that Don't Heal: Nurses' Experience with Medication Errors," in *First, Do Less Harm*, ed. Ross Koppel and Suzanne Gordon, 187; Marlynn Wei, "Doctors, Apologies, and the Law," *Student Scholarship Papers*, Paper 30 (2006), 50-52; Nancy J. Crigger, "Always Having to Say You're Sorry," 574; Steven H. Miles, *The Hippocratic Oath and the Ethics of Medicine* (New York: Oxford University Press, 2004), 118; Susan Greenhalgh, *Under the Medical Gaze: Facts and Fictions of Chronic Pain* (Berkeley: University of California Press, 2001), 32.

²³ Robert Truog et al., *Talking with Patients*, 33, 40; Ross Koppel, Suzanne Gordon, and Joel Telles, "Twenty-Seven Paradoxes, Ironies, and Challenges of Patient Safety" in *First, Do Less Harm*, ed. Ross Koppel and Suzanne Gordon, 231; Carol Youngson, "Any Nurse, Anywhere," in *Medical Nightmares*, ed. By Susan B. McIver (Toronto: Chestnut, 2001) 57-58; Vivienne Nathanson, "Medical Mistakes," in *Medical Mishaps*, 199-200.

²⁴ Jennifer Robbennolt, "Apologies and Medical Error," 379: "In particular, a desire for and history of self-regulation and an expectation (by self, peers, and patients) of perfection may make it difficult to apologize for errors. More generally, to admit that an error has occurred and apologize for it is embarrassing and injurious to one's pride and requires one to come to grips with a threat to one's self-esteem. Acknowledging an error conflicts with a striving for perfection and can result in a sense of vulnerability."

²⁵ Thomas Gallagher, Amy Waterman, Jane Garbutt et al., "US and Canadian Physicians' Attitudes and Experiences Regarding Disclosing Errors to Patients," *JAMA* 166 (2006), 1608.

²⁶ Andre Picard, *The Gift of Death* (Toronto: Harper Collins, 1995), 157-179.

²⁷ Ken Kilpatrick and Colin Freeze, "Red Cross Pleads Guilty, Offers Apology in Blood Scandal," *The Globe and Mail* (2005), <https://www.theglobeandmail.com/news/national/red-cross-pleads-guilty-offers-apology-in-blood-scandal/article18228058/>.

²⁸ R. Douglas Elliott, "So Sorry: The Legal Myths and Social Realities of the Official Apology," *C43Journal* (2017) <https://c4ejournal.net/2017/11/17/r-douglas-elliott-so-sorry-the-legal-myths-and-social-realities-of-the-official-apology-2017-c4ej-10/>.

²⁹ Canadian Broadcasting Corporation, "Judge Acquits 4 Doctors in Canada's Tainted Blood Trial," *CBC.ca*, October 1, 2007, last updated October 2, 2007, <https://www.cbc.ca/news/canada/judge-acquits-4-doctors-in-canada-s-tainted-blood-trial-1.656335>.

³⁰ Gilles Paquet and Roger Perrault, *The Tainted-Blood Tragedy in Canada: A Cascade of Governance Failures*, (Ottawa: Invenire, 2016), 37.

³¹ Nick Smith, *I Was Wrong: The Meanings of Apologies*, (Cambridge: Cambridge University Press, 2008): A categorical apology: calls for a corroborated factual record to be agreed upon by actors (28-33); calls for blame to be properly established and accepted by the correct actors (33-55); calls for a individual offenses to be identified (55-57); calls for each harm to be investigated to identify the specific shared moral principles that have been injured (57-59); calls for these moral principles be promoted by prompting the apologizer to understand that what was done was wrong (59-54); calls for the offending party to recognize the offended party as having been wronged, and as being in a relationship to the offender, and that this relationship is at stake during the apology (64-67); calls for the offender to recognize and regret that their actions caused harm (67-74); calls for the offender to commit to communicating the apology to the offended in order to reinforce the offended party's position of having been harmed (74-80); calls for the offending party to engage with the fact that a harm has been done in order to learn and prevent the action from reoccurring (80-91); calls for the offending party to truthfully engage with why they are apologizing in order to promote the shared moral principle that has been violated and to engage with the offended party (91-96); calls for the offending party to consider the emotions of the offended party, and to consider their own capacity for emotions during the apology process (96-107).

³² Einat Avrahami, "Positive Wrongdoings: Reading Doctors' Narratives on Ordinary Ethics," *Literature & Medicine* 29, no. 2 (2012), 325-354; Marlynn Wei, "Doctors, Apologies, and the Law," 107-158.

³³ Nicholas Tavuchis, *Mea Culpa: A Sociology of Apology and Reconciliation* (Stanford: Stanford University Press, 1991), 5.

³⁴ Nick Smith, *I Was Wrong*, 8.

³⁵ Nicholas Tavuchis, *Mea Culpa*, 8.

³⁶ *Ibid.* 46: Tavuchis terms this the 'essential interactional principle of apology' and notes that the dyadic nature of apology is not purely expressed in terms of individuals, but rather abstract categorization: "*the fundamental pattern of sociation in apologetic discourse is dyadic*. That is to say, its exclusive, ultimate, and ineluctable focus is upon interaction between the primordial social categories of Offender and Offended."

³⁷ *Ibid.* 7.

³⁸ *Ibid.* 19-20.

³⁹ *Ibid.* 22.

⁴⁰ *Ibid.* 48, 71.

⁴¹ Robert Truog et al., *Talking with Patients*, 1-2.

⁴² *Ibid.* 2: The wife of the patient is recorded as saying "No one ever said they were sorry. You know, that's just what happens in medicine...No one ever apologized for the condition he [her husband] was in." The son is recorded as saying "If anybody would have acknowledged some accountability, an apology, to actually reach out

and connect with us on human terms—in human language. Not legalese, not the legality of a letter, primarily a sense that they were sorry, and that there is a willingness for them to be vulnerable enough to acknowledge that there might be an imperfection in the system...Time heals, but it doesn't heal when there are so many questions that have not been answered.”

⁴³ Nicholas Tavuchis, *Mea Culpa*, 22-23, 27.

⁴⁴ Ibid. 45.

⁴⁵ Ibid. 48.

⁴⁶ Nick Smith, *I Was Wrong*, 159-160.

⁴⁷ Ibid. 162.

⁴⁸ Ibid. 165-166.

⁴⁹ Ibid. 175.

⁵⁰ Ibid. 173.

⁵¹ Ibid. 167.

⁵² Ibid. 198.

⁵³ Ibid. 199.

⁵⁴ Ibid. 199.

⁵⁵ Linda Treiber and Jackie Jones, “Wounds that Don't Heal,” in *First, Do Less Harm*, 184-185.

⁵⁶ Robert Truog et al., *Talking with Patients*, 38.

⁵⁷ Nick Smith, *I Was Wrong*, 200.

⁵⁸ Richard Joyce qtd. in Nick Smith, *I Was Wrong*, 221.

⁵⁹ Ibid. 215-216, 217.

⁶⁰ Nicholas Tavuchis, *Mea Culpa*, 119.

⁶¹ Ibid. 124: “But in between these extremes, in the ordinary and dramatic spaces of human life, a recognition, literally a reknowing of the grounds and potential of apologetic discourse, must precede its praxis.”

⁶² Julia Bess Frank, “Moses Maimonides: Rabbi of Medicine,” *Yale Journal of Biology and Medicine* 54 (1981): 84.

⁶³ Maimonides, “Oath of Maimonides,” <https://dal.ca.libguides.com/c.php?g=256990&p=1717827>.

⁶⁴ Carol Gilligan, *In a Different Voice: Psychological Theory and Women's Development* (Cambridge: Harvard University Press, 1982), 166.

⁶⁵ Ibid. 35, 79.

⁶⁶ Ibid. 149.

⁶⁷ Fiona MacDonald, “Relational Group Autonomy and The Multiculturalism Paradigm,” *Hypatia*, 25 no. 1 (2010), 203-208.

⁶⁸ Carol Gilligan, *In a Different Voice*, 149.

⁶⁹ Fiona Robinson, *The Ethics of Care: A Feminist Approach to Human Security* (Philadelphia: Temple University Press, 2011), 25.

⁷⁰ Prashan Ranasinghe, *Helter-Shelter: Security, Legality, and an Ethic of Care in an Emergency Shelter* (Toronto: University of Toronto Press, 2017), 204: Throughout the text, Ranasinghe reflects on the disordering effect of care ethics as it is differently expressed by employees of an emergency shelter, revealing a limit to the ethic: “the polysemy of an ethic of care is chiefly responsible for the disordering of the shelter, and the rules, meant as the antidote to this problem, are simply unable to counteract the extemporaneous order that constitutes the space.”

⁷¹ Susan Greenhalgh, *Under the Medical Gaze*, 308: “This self was a compliant self that sought to secure good care by creating an artificially warm and fuzzy relationship with the doctor. This relationship was built on a distorted ethic of care in which the patient concerned herself more with her doctor's happiness than with her own physical and emotional well-being...[w]hile this relationship-first strategy worked to secure her doctor's attentions, it had devastating consequences for the patient...for it left the patient unable to communicate her concerns and unprotected against her doctor's mistakes.”

⁷² Michael Slote, *The Ethics of Care and Empathy*, (New York: Routledge, 2007), 2.

⁷³ Ibid. 31.

⁷⁴ Ibid. 31-32.

⁷⁵ Ibid. 33.

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- ⁷⁶ Maria Giulia Marini, *Narrative Medicine: Bridging the Gap Between Evidence-Based Care and Medical Humanities*, (Springer International Publishing: 2016), 22: "It appears that from the third year of med school on, students start to become less empathic, but more effective in mastering the 'detached' medical gaze."
- ⁷⁷ Danielle Ofri *What Doctors Feel*, 30-34.
- ⁷⁸ Michael Slote, *The Ethics of Care and Empathy*, 85-87.
- ⁷⁹ Nora Jacobson, *Dignity and Health*, (Nashville: Vanderbilt University Press: 2012), 51: "Conceptually, violation provides 'empirical content' to dignity...that is, an understanding of dignity violation deepens our understanding of dignity itself."
- ⁸⁰ Ibid. 24-41: The purview of dignity violations in health care settings is wide and includes: rudeness (24), condescension (26), dismissal (27), disregard (28), dependence (29), restriction (30), objectification (30), intrusion (31), contempt (32), trickery (32), grouping (33), labeling (34), vilification (34), discrimination (37), exploitation (38), revulsion (39), bullying (40), and assault (41). Importantly, dignity violations are not limited to patients, and include violations of the dignity of medical personnel.
- ⁸¹ Ibid. 52.
- ⁸² Ibid. 87: "There are some nine objects of dignity violation, or that which may be damaged when dignity is violated. They are: *the body, the self, autonomy, moral agency, status, citizenship, personhood, a people, and humanity.*"
- ⁸³ Einat Avrahami, "Positive Wrongdoings," 337.
- ⁸⁴ Elizabeth Peter, Shan Mohammed, and Anne Simmonds, "Narratives of aggressive care: Knowledge, time, and responsibility." *Nursing Ethics* 21, no. 4 (2014), 467.
- ⁸⁵ Ibid. 466.
- ⁸⁶ Ibid. 465: "Physicians also deflect their responsibilities with respect to the need to respond to the dying of their patients. Participant 12 presented a narrative in which the mother of a dying young woman with breast cancer wanted her daughter's chemotherapy to be continued because she did not realize the limits or impact of further treatment: I think she expected her daughter to get well, obviously get better, to wake up, to be back to the way she was, have the chest tubes out, um, be up walking around, off the cath pump. Like, I think her expectations were quite high. . . It's really hard though because you know, with the physicians like it's hard to have the conversation, don't you think, you know, to say, we're not going to try anything anymore. I'm not a physician, but I would imagine it would be really, really challenging . . . I think it was the doctor, the oncologist, just wanting to appease the mom. Make them feel like they're doing something even though there's nothing left to have done per se. This patient needed to be resuscitated during a chemotherapy infusion and died soon after. The participant regretted that the patient died in this manner and wished that better palliative care had been given. This may have been possible with better communication regarding the futility of further treatment."
- ⁸⁷ Ibid. 464-465.
- ⁸⁸ Ibid. 463-464.
- ⁸⁹ Karine Levasseur and Fiona MacDonald, "Mea Culpa," 12.
- ⁹⁰ Deane Curtain, "Toward an Ecological Ethic of Care," *Hypatia* 6 no. 1 (1991), 67: "A distinction can be drawn between caring *about* and caring *for* that helps clarify how caring can be expanded as part of a political agenda. Caring about is a generalized form of care that may have specifiable recipients, but it occurs in a context where direct relatedness to specific others is missing...[a]s an element in a feminist political agenda, such caring about may lead to the kinds of actions that bring one into the kind of deep relatedness that can be described as caring for: caring for particular persons in the context of their histories."
- ⁹¹ Ibid. 67.
- ⁹² Carol Gilligan, *In a Different Voice*, 167.
- ⁹³ Ibid. 168 .
- ⁹⁴ Ibid. 172-173: "For a life-cycle understanding to address the development in adulthood of relationships characterized by cooperation, generosity, and care, that understanding must include the lives of women as well as men."
- ⁹⁵ Ibid. 173: "Given the evidence of different perspectives in the representation of adulthood by women and men, there is a need for research that elucidates the effects of these differences in marriage, family, and work relationships. My research suggests that men and women may speak different languages that they assume are the

same, using similar words to encode disparate experiences of self and social relationships. Because these languages share an overlapping moral vocabulary, they contain a propensity for systematic mistranslation, creating misunderstandings which impede communication and limit the potential for cooperation and care in relationships. At the same time, however, these languages articulate with one another in critical ways. Just as the language of responsibilities provides a weblike imagery of relationships to replace a hierarchical ordering that dissolves with the coming of equality, so the language of rights underlines the importance of including in the network of care not only the other but also the self.”

⁹⁶ Fiona Robinson, *The Ethics of Care*, 36-37.

⁹⁷ Carol Gilligan, *In a Different Voice*, 35, 79.

⁹⁸ Nick Smith, *I Was Wrong*, 198.

⁹⁹ *Ibid.* 33-55, 64-67.

¹⁰⁰ Carol Gilligan, *In a Different Voice*, 168: “In relationships of temporary inequality, such as parent and child or teacher and student, power ideally is used to foster the development that removes the initial disparity. In relationships of permanent inequality, power cements dominance and subordination, and oppression is rationalized by theories that ‘explain’ the need for its continuation.”

¹⁰¹ Fiona Robinson *The Ethics of Care*, 50: “Dominant approaches to rights—including rights as they are widely conceptualized and articulated by Western states, international organizations, and large Western civil society groups—are most often based on an ontology of atomistic individualism that privileges the norm of self-sufficiency and neglects the relational nature of human existence and the fundamental nature of the human need to give and receive adequate care. This ontology further privileges a masculinized understanding of power as residing in the state, thus neglecting relations of power based on gender, race, and class.”

¹⁰² *Ibid.* 54: “A critical ethics of care disrupts and challenges the dichotomy between the individual and the collective. What becomes important, then, is not articulating whether individuals, families, communities, ethnic groups, societies, states, or the world should be the referents of security; rather, the key is the ontological argument that all human beings exist at a fundamental level in relation to others. This is not a superficial empirical claim that refers to ‘connections’ between people; on the contrary, it is a philosophical claim about the constitution of subjectivity through relations.”

¹⁰³ *Ibid.* 58.

Chapter Two: The Importance of Apology Against a Culture of Silence

The purpose of this chapter is to establish the importance of medical apologies and to show that the medical culture of silence has serious negative impacts on how medical institutions, systems, and interpersonal relationships grapple with questions of responsibility and relationship repair. The first section of this chapter establishes that medical apologies benefit medical culture and are impeded by a culture of silence. I establish this claim through three subsidiary arguments, each presented in their own subsection. The first of these subsections argues that medical apologies are political, but are distinct from ‘political apologies,’ and as such are deserving of their own study. By showing that medical apologies are distinct and political apart from what is conventionally considered a political apology, I seek to show that medical apologies are embedded in institutions and culture that require collective decisions, as well as systemic and interpersonal change if apology is to be promoted, and that a culture of silence prevents this kind of change. The second subsection argues that apologizing is key to the moral and ethical growth of actors in medical spaces, and so obstacles to apology ought to be studied as far as they are impediments to moral and ethical growth.

The final subsection argues that medical apologies and disclosure are important not only for their healing and conscience-clearing potential but are also crucial for the prevention of errors and safe care for future patients. In this subsection, I argue that a culture of silence is itself a pathological harm which can be traced through contemporary medical culture to medical pedagogy. Each of these subsidiary arguments are in support of my claim a culture of silence has serious negative impacts on medical relationships, and prevents safe health care by obstructing responsibility, apology, and preventing the discussion and correction of conduct that led to the error. The second and concluding section of this chapter is dedicated to establishing the place

and roles of medical apology from the point of view of doctors, patients, and medical advocacy institutions.

2.1.1: Medical Apologies as Political Apologies

In this subsection, I aim to show that medical apologies are distinct from conventional political apologies but are still political occurrences. Medical apologies are political because they involve political elements, such as being able to be used in just and unjust ways, and because they are subject to power dynamics that hospitals, medical personnel, and institutions use to leverage over patients and families. Contemporary literature on the topic interprets the current era as an ‘age of apology’, although its primary focus is restricted to political apologies.¹ I argue that medical apologies are distinct from political apologies in two ways: first in that medical apologies take place on a smaller scale of discourse than political apologies, and second, in that affect plays a larger role in the medical apology process. The literature typifies political apologies as taking place within large arenas of discourse and are epitomized by a government or other authority-representing figure apologizing for a historical injustice or offense in an official capacity. These apologies are typically provided to suit state interests.² Thompson, in her chapter defending the notion of political apology, provides a clear and precise definition of political apology which sets the scale of discourse:

A political apology is an official apology given by a representative of a state, corporation, or other organized group to victims, or descendants of victims, for injustices committed by the group’s officials or members.³

In instances of large-scale political apologies, the matter of assigning responsibility for the violation of norms and harms done is likely to go through a complex process of consensus and decision making⁴ to resolve what is being apologized for, who, out of a group, can and should apologize, and *if* an apology is an appropriate response to a harm or injustice.

This large-scale discourse also means that emotional connection between individuals comprising collectives is less obvious in the performance of the apology itself and plays an overall smaller role in political apologies. Some scholars, such as Janna Thompson⁵ and Nick Smith, are skeptical of the import of emotions in collective apologies, noting the difficulty in cohering emotions, collectives, and responsibility. Smith argues that emotions play a ‘dubious’ role in collective apologies:

Considering that emotions play an important but nebulous role in individual apologies, we should not be surprised that collective emotions confuse matters further...[i]f I tell you that ‘I am sorry for your pain,’ at a minimum you are safe to assume that I experience – or at least I could experience – some negative emotions in response to your suffering. A president’s claim that the ‘nation sympathizes with your pain’ is dubious even in that respect.⁶

In general, the literature suggests that the opposite is true in instances of medical apology. In an instance of medical apology, affective interpersonal connection between medical personnel and patients plays a larger and much more intimate role: from inhibiting apologies from medical personnel⁷ to validating the desire for an apology from the point of view of a patient.⁸ The second notable difference is that the arena of discourse is smaller in comparison to the arena of political apologies, often taking place between doctors, patients, and families. Important to note is that the increased influence of affect does not mean that resolving responsibility for a medical error or uncovering reasons for reluctance becomes an easier task. Biological complexity, interventions and limits of biomedical technology,⁹ disagreements or conflicts of care between healthcare providers,¹⁰ and racist, sexist, and classist attitudes towards racialized, classed, and gendered patients¹¹ all contribute to error and harm potentials that are systemically high.¹²

The initial points of difference between the scale of discourse and the role of affect is not to suggest that there is not a degree of conceptual overlap between political apologies and medical apologies, or that medical apologies exist in a vacuum separate from large-scale political

apologies. Medical apologies do not strictly take place within an interpersonal realm, as healthcare providers represent medical institutions, and the relationships between HCPs and patients and families are embedded in medical-political institutions. Indeed, an example of the conceptual overlap between individual and institutional apologies is found in the apology given for the Tainted Blood Scandal.¹³ The scandal involved compounding failures of government, medical organizations, and individuals that had a severe impact on public health on large and small scales. The affective aspect of the scandal was embodied in the narratives of families, patients, and healthcare providers,¹⁴ while the burden of responsibility for the scandal was placed primarily¹⁵ upon provincial and institutional shoulders.

So far, I have established that medical apologies and political apologies are distinct in terms of their scale of discourse and involvement of affect, with the consideration that there is conceptual overlap between political and medical apologies. Next, I will show that medical apologies are political because they call upon dynamics of power between institutions, hospitals, medical professionals, and patients and families. The connective tissue between macro arenas of apology discourse (typified by political apologies performed as or for a collective) and micro arenas of apology discourse (typified by interpersonal apologies between individuals) is the politics of apology (or its absence) itself. The political nature of apologies arises not only due to imbalances and dynamics of power between individuals or collectives, and not only because this power permits individual medical personnel, hospitals, and medical institutions to decide how, when, or if an apology will be provided to patients and families, but because the increased presence of apology in medicine carries the prospect of changing systemic, institutional, and interpersonal practices in medicine. Apologies call upon individuals and collectives to recognize and take responsibility for injustices or offences, make promises to fix conduct, and engage with

victims. These are political processes because power is mobilized to promise and follow through with non-repetition, or to dismiss calls for apology. Indeed, apologies are politically important as far as notions of justice are concerned; Coicaud and Jonsson conclude that apologies function as vessels through which power is transferred, transformed, or exerted:

Apology, although a small part, is still an important part of justice...if well conducted (for the right reasons and in the right ways), can also be a significant conduit for justice. The recognition that it brings to the wrong/crime helps the victim to reconcile with oneself and, in the process, with others and the world. The reason why this is, is also why apology is currently given such importance. It has to do with the power of apology, a fairly simple tool in the end, when applied successfully.¹⁶

Despite the potential to be a 'conduit of justice,' the power mobilized through apology can be used to silence, obscure, or normalize maladaptive behaviour,¹⁷ meaning that apologies can be used in just and unjust ways, and can become conduits for injustice rather than justice. Unjust apologies involve attempts to dismiss longstanding effects from the offence, or 'turn the page' via apology (an assertion that the issue of offence has been granted closure by the apology). Unjust apologies can involve a leveraging of power to silence voices and narratives, conceal consequences of the offence, limit liability, perpetuate harm-causing behaviour, or maintain or reify unjust relationships and dynamics of power.¹⁸ Outright refusing to apologize, rejecting responsibility, dismissing the suffering of victims, or only conditionally acknowledging their suffering also shows a politically unjust leveraging of power. Indeed, in a Canadian context, Cornthassel and Holder conclude that Jane Stewart's (then the Minister of Indian and Northern Affairs) 1998 apology for harms resulting from the Indian Residential School system was instrumental in the sense that its purpose was to limit Canada's liability permanently, and in doing so, maintaining a colonial outlook on Indigenous-settler relations.¹⁹

Medical apologies are political not just because they are subject to variances in position and circumstance, but because they involve asymmetric distributions of power between medical

personnel/institutions and patients and families and present the opportunity for change. Medical apologies can be just and unjust. They can involve intimate moral engagement and interrogation of power dynamics between medical personnel and patients, or they can involve a complete dismissal of harms, or any combination of decisions and consequences. Further, the politics of medical apologies arise in ways beyond the intrinsic politics of the apology process and beyond the politics of medical institutions and culture. The politics of public healthcare and law intersect with the politics of medical culture at the junction of error and apology. In terms of law, an intersection is observable in instances of litigation post-error, such as when laws governing how apology can be utilized in court become relevant (such as in ‘Apology Act’ legislation). In terms of public health, policy reviews and inquests into error are instances of political reaction to error coinciding with apology and concerns for justice.

A contemporary example of the intersection of the politics of medical apologies with the politics of public healthcare comes from the case of Brian Sinclair, an Indigenous man who, in 2008, perished in the lobby of the Health Sciences Centre in Winnipeg, Manitoba, after being ignored for thirty-four hours and not receiving medical treatment for a bladder infection after staff assumed he was inebriated.²⁰ The response from the regional health authority²¹ included an apology, while a separate inquest provided sixty-three recommendations for change²² to the authority. As of 2018, fifty-five of the recommendations had been fully carried out.²³ The inaction of the Health Sciences Centre and their medical staff that led to the death of Mr. Sinclair is political in that their inaction involved anti-Indigenous racism, involved a medically-vulnerable individual, and involved a failure to discharge not just health care, but seemingly any sort of care. The aftermath, including the apology, the inquest, and the recommendations, including the failure to fully implement all of the recommendations, show that efforts to address

these moral and professional failures are also political in that they involve collective efforts by the responsible parties and outside political apparatuses to address them.

The politics at the intersection of medical error, harm, and apology cannot be understated, and they cannot be fully grasped without listening to the voices of those who relate their stories of injustice. Recall Robinson's reconceptualization of health care issues as security issues: health care institutions that ignore colonial consequences on Indigenous health, ignore the voices that share narratives of pain and dismissal, and cover up consequences by dismissing suffering or providing shallow, non-committal, or conditional apologies, risk the future health care of Indigenous patients unnecessarily and unjustly. The provision of apology and the resulting consequences of apology in this circumstance have become a conduit for injustice, rather than a conduit for justice. A medical culture that values apology and draws from the benefits of an ethic of care may not have been able to prevent the death of Mr. Sinclair, but such a culture would certainly prompt efforts to interrogate the power dynamics and grapple with issues of justice in medical settings.

2.1.2: Apology as a Route to Ethical and Moral Growth

The second aspect of the argument in support of medical apologies stresses that apologies help the ethical and moral growth of HCPs by presenting avenues for HCPs to engage on moral grounds with patients and families and grow from the experience. This argument underlines my central claims by suggesting that because the culture of silence inhibits apology, it is harmfully preventing moral engagement and ethical growth of actors. As Lee Taft and Prue Vines argue, opportunities for moral and ethical growth are contingent on the conscious recognition and acknowledgment of harms done.²⁴ I extend their arguments to suggest that moral and ethical growth after apologizing for errors stems from recognizing that better behaviour and conduct is

possible, and by reaffirming that medical personnel and patients are in continually evolving and dependent relationships that regularly require maintenance. Apologizing assists both the offender and the offended in recognizing and interpreting the harm done, a recognition that is crucial for the relationship to be maintained. For apologies to have a valued place in society, actors must take the emotionally- and professionally-challenging step of acknowledging the norm that has been upset, apologizing, and capitalizing on the potential for ethical and moral growth presented.

However, opportunities for moral and ethical growth through acknowledging responsibility for errors and apologizing are subject to power dynamics. These power dynamics have direct impacts on the attribution of responsibility for errors, apology, and ultimately, the safety of the patient because of how responsibility for errors may be obscured. The effect of power dynamics impinging on the attribution of responsibility is observable through several studies. A 2002 study by Blendon et al. questioned physicians and the public on what they perceived to be the causes of medical error, and what responses to error are deemed appropriate. Their study revealed a disconnect between members of the public and physicians in terms of ascribing responsibility for an error and associating the error with the harm itself. Blendon et al. found that “[p]hysicians were more likely than the public to hold the nurse responsible for the error, regardless of the outcome.”²⁵ Further, “[i]f the patient was harmed, physicians were significantly more likely [than not] to support malpractice lawsuits against the surgeon, the nurse, and the hospital”.²⁶ What Blendon et al.’s study shows is that responsibility for errors can be split into multiple different attributions, and that more powerful actors can leverage the power concentrated in their roles to evade or shift responsibility onto less powerful personnel. This evasion carries the potential to obscure the true cause of the error, directly inhibiting not only the moral and ethical

growth achievable by admitting to and taking responsibility for a mistake, but obscuring the true cause of error, making corrective and reparative actions impossible.

This point is reinforced by studies of labour and power dynamics in hospital settings. A study by A.N. Zotterman et al. on the quality of care from the point of view of nurses reveals that communicative, emotional, and advocative²⁷ burdens are placed upon district nurses (nurses who provide longer-term care to patients, occasionally outside of hospital settings) when patients have negative encounters with physicians.²⁸ Providing an apology,²⁹ maintaining the integrity of a continuum of care,³⁰ and recognizing the dignity of patients³¹ are caring labours placed primarily on the shoulders of nurses, and reveal that when care goes wrong, the expectation is that nurses will shoulder the burden of reparative and restorative actions. The nurse-patient-physician dynamic that is revealed by Zotterman et al. and Blendon et al. shows that the hierarchy of power in hospitals is one that is rendered toxic by differentials of power.³² Toxicity arises in different forms: one is managerial organization that infantilizes nurses and nursing labour, and views their labour as one that cannot take part in safety regimes.³³ Another toxic element manifests in the absence of legal protection for nurses.³⁴ The impact of a toxic workplace hierarchy on care and moral and ethical growth through apology is notable through the division of responsibility. When an error occurs, this hierarchy divides and isolates doctors and nurses, impeding opportunities for ethical growth as a caregiving team, and opening a way for patient harm to occur. As an example of isolation, Koppel and Gordon relate that nurses develop regimes of 'personal rules'³⁵ that afford them a way of making sense of an error and reconciling it with themselves. These 'personal rules' assist nurses, but as Koppel and Gordon conclude

personal rules were useful but individually based. The ‘lessons learned’ always reflected a nurse’s own personal behavior and did not address the systems in which the nurses were embedded. While double- and triple-checking medications might help avoid errors, these solutions rely on individual initiative and consume inordinate amounts of valuable time. We never found a rule that said ‘I went out and changed the system’ as a result of a mistake. Instead of fixing problems, the ‘lessons learned’ reflected personal adaptation strategies to survive.³⁶

The reflections Koppel and Gordon relate paint a picture of health care relationships between nurses and physicians that are precarious, individualizing, and isolating in the face of an error. These toxic power dynamics are uncongenial to the practice of apology and incompatible with personal growth through the refinement of these sense of responsibility towards patients that apology promotes. Exploring this phenomenon further, I find that the desire to be perfect and the resulting shame and fear at having caused an error is present in nursing staff. However, for nurses, acknowledging and taking responsibility for an error must traverse different levels of power. This point is supported by a study by Crigger and Meek, who find that reconciling a mistake as a nurse occurs in stages. The first stage in Crigger and Meek’s study is ‘reality hitting,’³⁷ and is characterized by nurses’ dissonant self-reflection and self-deprecation in light of both an error and the belief of an interruption of a standard of care:

During reality hitting, nurses quickly compared their actions to their personal ideal and the social ideal or standard of care. In other words, participants expressed and retained a personal ideal or expectation of how they should perform their work and a socially constructed ideal of what nursing discipline, law, standards, and institutional policy require. Although participants overwhelmingly described their personal ideals as more rigorous than the social ideal and standard, they nevertheless made fleeting but real comparisons between their actions and what is expected of the ideal nurse: “We are supposed to be the Florence Nightingales.” If their actual behavior fell short of either the personal or social ideal, they were shocked and made self-deprecating comments, indicating their loss of self-esteem, disbelief, and shame.³⁸

The second stage, ‘weighing,’³⁹ involves the nurse determining whether an error should be disclosed, and to what degree, based on whether the error had been noted by another nurse, and whether it had caused or had the potential to harm the patient. In determining whether an error

should be disclosed, nurses at the ‘weighing’ stage are found to fear the reaction of superiors and peers⁴⁰ and, if disclosure is to be reported, defer to the superior first.⁴¹ These first two stages reflect the desire to be perfect and the resulting negative emotions that arise in violation of the ideal of perfection.

The final two stages, ‘acting’ and ‘resolving,’⁴² involve disclosing and apologizing, and gauging the harm or near-miss in order to learn from it respectively. These stages indicate that the same appeal to perfection that motivates physicians to approach error and apology with reluctance may be present among nurses as well. is partially reflected in nurses’ motivations to approach error and apology. Recall the observations of Truog et al. and Gallagher et al.: appeals to perfection and a general caution regarding disclosure and apology are similar to the reasons cited for reluctance among physicians. The approach of Crigger and Meek reveals that disparities in power influence the decision of nurses to approach disclosing errors with additional cautions out of fear of punishment from superiors. The vital point from Crigger and Meek’s study is that the potential for ethical growth through acknowledging responsibility for errors is limited by the providers’ standing in terms of medical authority, as a hierarchy of power between healthcare providers may inhibit how errors, apology, and responsibility are approached.

The result of a hierarchy that divides care-giving teams of medical professionals is that the precarious nature of power hierarchies undermines the ability of care providers to experience ethical growth, undermines the distribution of labour, and undermines safe care for the patient. A final example of a such a toxic hierarchy occurs when the concerns of nurses are dismissed by physicians and other hospital authorities based on their status in the institution. A tragic example of the harms that are possible from this expression of a toxic hierarchy is represented in Manitoba’s Pediatric Cardiac Surgery Inquest. The Pediatric Cardiac Surgery Inquest in

Manitoba of 1995-1998 examined the deaths of twelve children between 1990 and 1994 at Winnipeg's Health Sciences Centre. The Inquest concluded that four of the twelve deaths were preventable, five were possibly preventable, two were likely not preventable, and preventability of one was not able to be determined with the evidence at hand. The findings of the Inquest indicated that systemic issues were largely to blame for the deaths of the children and that failures in communication, teamwork, leadership resulted in the poor performance of surgical staff going unrecognized. These systemic issues ultimately resulted in the deaths of patients.⁴³

The Inquest also concluded that

Throughout 1994, the experiences and observations of the nursing staff involved in this program led them to voice serious and legitimate concerns. The nurses, however, were never treated as full and equal members of the surgical program, despite the fact that this was the stated intent of the administrative changes that the program underwent in June 1994...[t]he concerns expressed by some of the cardiac surgical nurses were dismissed as stemming from an inability to deal emotionally with the deaths of some of the patients. As well, any concerns over medical issues that the nurses expressed were rejected as not having any proper basis, clearly stemming from the view that the nurses did not have the proper training and experience to hold or express such a view. In addition, while HSC doctors had a representative on the hospital's board of directors, nurses did not.⁴⁴

Besides crystallizing the dynamics of power in medical relationships, what this analysis provides is a view of the consequences of these dynamics of power as they relate to medical error. To be certain, the causes of the deaths of children that occurred in Manitoba in the early to mid-nineties are not singularly reducible to a toxic hierarchy, but the import of such a hierarchy as it is consequential to human life cannot be ignored. When caring teams are divided and isolated, the care they provide becomes a resource that is ownable⁴⁵ in that personal stakes in care become more important than the provision of care itself. This kind of toxic hierarchy, where high-status medical personnel can shift responsibility to low-status medical personnel, is also directly harmful to lower-status medical personnel, who are subjected to unwarranted attributions of responsibility. The ability to learn from mistakes and experience ethical growth through

disclosure and apology is hindered when effort is instead dedicated to excising and evading responsibility, in doing so, obscuring the true genesis of error and potentially reinforcing harmful conduct for future patients.

2.1.3: Apology as a Route to Healing and Safety

The third and last point of entry for the importance of studying medical apology is its relevance to safe medical care. This subsection underlines the main thesis by showing how the culture of silence undermines the provision of safe health care by preventing discussion and refinement of error-causing behaviour, indicating that the culture of silence is an iatrogenic harm, which is a harm that is doctor-caused. Despite institutional techniques such as morbidity and mortality conferences,⁴⁶ (theoretically, a ‘safe space’ for physicians to discuss error in a fear-free and legally-safe environment among peers and administrators, in order to refine medical practice, as well as heal after an error)⁴⁷ medical personnel are still hesitant to share details of their mistakes with other personnel and remain hesitant to disclose error and provide apologies.⁴⁸ The hesitance to share information, disclose errors, and apologize is not without consequence, and the consequence of medical personnel *not* discussing errors and providing an apology ensures that the future safety of patients in medical care is placed in jeopardy.

The primary underlying reason for reluctance is that a culture of silence governs the decision-making process of medical personnel concerning apology and disclosure; fed by power differentials in medical settings, this culture is also promoted by medical training and education. This culture is a result of the development of pedagogical regimes that ingrains in its students an ardent and stressful desire to be perfect.⁴⁹ A crucial aspect in the appeal to perfection is the assertion that the human body (and all that could go wrong with it) is knowable with complete certainty and that the physician is the vector through which this knowledge and power over the

body are mobilized. This phenomenon is termed the ‘medical gaze,’⁵⁰ and it is through this gaze that the body and regimes of healthy living become governable through the way illnesses are conceived and treated. The direct impact of the gaze on disclosure and apology following an error is visible in two ways. First, the gaze widens the emotional and communicative gap between patient and doctor by reifying the position of doctor as an omniscient force in the patient-doctor relationship. This contributes to the development of a culture of silence and inhibits the voice of the patient from being heard.⁵¹ Second, the gaze ensures that less attention and effort is paid to training and developing methods of communication with patients and maintaining medical relationships following errors, and instead redirects effort to the development of biomedical technology to further know the body, but not the patient.⁵² This property of the gaze is known as biological reductionism, and there is literature that suggests that the cleavage between knowing the patient versus knowing the disease is an ancient one embedded in Western medicine.⁵³ Privileging knowledge of the body over knowing the patient contributes to the development of a culture of silence by way of occlusion; a culture that fosters communication and response following an error has little space to be practiced and reinforced if it is not taught.

So far, I have established that the culture of silence has roots in a medical gaze established through medical pedagogy. This gaze and the resulting culture of silence is not amenable to taking responsibility for and disclosing errors, and apology. Extending this train of thought, it is reasonable to believe that by not apologizing for and disclosing errors, the error-causing conduct will continue. By permitting error-causing conduct to continue unexamined, I argue that a responsibility for putting the safe health care of patients in jeopardy can be assigned to the practice of a culture of silence by medical personnel. This completes the chain of thought

that a culture of silence is a negative iatrogenesis, or a harmful doctor-caused result. What is clear in the historical literature on negative iatrogenic effects is that societies from which Western medicine is derived have sought to hold their medical personnel accountable for errors that have been caused by *direct actions*. Plinius Secundus laments the lack of Roman laws available to “punish the ignorance of physicians”⁵⁴ who kill their patients, while the Hippocratic Oath entreats physicians to invite ill social repute and displeasure onto themselves should they fail to fulfil their oath.⁵⁵ More recently, the shift has been to consider negative iatrogenic effects in a broader scope. Illich observes that healthcare providers benefit from unjust social-structural factors, enabling them to perpetually command a harmful and entrapping societal deference,⁵⁶ where medical personnel cannot be questioned or accused of malpractice or unjust practice. Nightingale’s work on the epidemiology of infections in unsanitary hospitals⁵⁷ places blame on the *inaction* of medical personnel to disinfect themselves and their equipment. Illich’s and Nightingale’s considerations of negative iatrogeneses situates my argument that a culture of silence is an iatrogenic harm not through direct action, but through inaction following error, and an unwillingness to permit interrogation of power dynamics in medical relationships.

It should be clarified at this point that my argument is not that apologizing will help heal past harms, and it is not that they are panaceas to harm. As Tavuchis argues, apologies cannot undo the past. My argument for medical apology is that apologizing for medical errors assists in healing the relationship between healthcare providers and patients that have been harmed by the error. The stakes of medical error are such that not apologizing for medical mistakes due to a culture of silence imbued with a medical gaze might introduce additional harms along intersecting axes of identity and oppression, beyond failing to confront the conditions of the error. As some members of society experience unjust burdens of racism, sexism, classism, and

trans/homophobia embedded in health care systems, the failure to apologize for errors risks making health care experiences for those with unique health care needs (which are often not satisfactorily or safely met)⁵⁸ even more unsafe and unsatisfactory. In a Canadian context, Mule argues that a neoliberal regime of individualization in health care systems has led to a regime of responsabilizing⁵⁹ the patient for their own maladies (specifically, by limiting LGBTQ+ health care concerns to a focus on HIV/AIDS),⁶⁰ a key logic for the medical gaze. These examples go to show that while an apology cannot hope to help heal the past, or completely fix injustices embedded in health care practices, not apologizing is a harm unto itself, and risks aggravating medical injustice.

The difference between historical and contemporary medicine on which I wish to capitalize is that apology in its namesake age can be reconciled with healthcare in the face of error to undermine the culture of silence and improve the provision of care. What I have discussed in this section in terms of harmful iatrogenesis is that the power-laden nature of the harms of a culture of silence have historical and pedagogical elements. The arguments for medical apology that I have provided are aimed to turn the medical gaze and the culture of silence upon itself by pathologizing the connection between its historical regimes of education and the current and potential future harms and negative impacts that the culture of silence has on medical relationships.

The Place of Apology Within Contemporary Medicine

This concluding section will outline the place of apology in contemporary medicine from the point of view of patients, doctors, nurses, and medical advocacy groups. The purpose of this section is to support the main thesis by outlining how the culture of silence is supported by medical advocacy organizations that promote skepticism about medical apology, is practiced by

HCPs due to training that emphasizes apology as being threatening and stands in opposition to what patients desire following an error. This section will begin with the thoughts of the medical advocacy groups. First, the advice of associations advocating for physicians in both general guidance and legal capacities (the Canadian Medical Association and the Canadian Medical Protective Association, respectively) will be examined, before moving on to associations responsible for bioethical education (the Royal College of Physicians and Surgeons of Canada). Views on apology from the Canadian Nurses Protective Society and the Canadian Patient Safety Institute will be the final advocacy organizations examined. This section will conclude with the input of HCPs, physicians, and patients with regards to apology.

2.2.1: Apology from the Point of View of Healthcare Advocacy Groups

The Canadian Medical Association's⁶¹ offers advice on medical-legal matters, provides legal support, professional development programs, and advocates for new, positive developments in national health policy. It is non-profit and voluntary in association, and their membership primarily includes physicians (though their subsidiary, Saegis, offer similar support to other healthcare providers).⁶² The Canadian Medical Association's (CMA) stance on disclosure and apology appears clear at first: if harm is done to the patient, disclosure should promptly occur,⁶³ and if appropriate, an apology should be offered to the patient. However, the CMA promotes apology in ways that are amenable to a culture of silence in that legal responsibility is suggested as being precarious:

Apologize to the patient, as appropriate. The nature of an apology for a poor clinical outcome will depend on the reason for the outcome. It is always appropriate to say you are sorry for the circumstances or condition of the patient. Avoid statements that express or imply legal responsibility, such as negligence or fault. Legal responsibility is not usually clear, and courts and medical regulatory authorities (Colleges) make these determinations.⁶⁴

The CMA's advice advocates for apologies that address circumstance and condition but does not advocate for apologies that speak to responsibility. Instead, the CMA advises physicians that responsibility is determinable by outside authorities. Aspects of a culture of silence are present in this advice, being the fear of litigation, and an encouragement to delay or otherwise avoid taking responsibility.

Like CMA, the Canadian Medical Protective Association (CMPA) recognizes and promotes the importance of apology for the conditions and circumstances of the patient after an error, but stresses even more the fear of litigation and the undesirability of admitting to error, creating medical conditions favorable to silence.⁶⁵ The CMPA does not compel apologies, and states that if the error can be traced to personnel, apology remains a possibility, and not a guarantee.⁶⁶ Factors that would make an apology inappropriate are if the harm can be traced to an 'inherent risk'⁶⁷ of a procedure, or if the harm resulted from a patient's underlying condition.⁶⁸

The CMA and CMPA⁶⁹ have restrictive outlooks on what language can be used by a physician or healthcare provider to address an error. These restrictions limit how responsibility can be assigned to actors, and stem from a fear of litigation and an apprehensiveness towards responsibility, which are key aspects of a culture of silence. Because these restrictions are advocated by powerful medical organizations, they lend legitimacy to a culture of silence. To apply a concept from Smith, these instructions and injunctions seem designed to extend the chain of causality so as to blur and shift responsibility away from physicians.⁷⁰ Smith terms this phenomenon 'institutional doublespeak,'⁷¹ and in the context of medical apology, it means shifting the chain of causality away from individuals, making precise determination of where responsibility for harm lies difficult. The chain of causality can also be twisted to bind the

patient: if responsibility can be traced to an ‘inherent risk’, or if ‘underlying condition’ in the procedure is a possibility, the patient is included in a context of responsibility for their own harm. Overall, the provisions against language in these guidelines limit the ways in which responsibility can be attached to the error and its consequences, and, because of their overall discouraging nature towards apology, work to discursively cleave responsibility from the harm, or extend it away from the most relevant context, the relationship between patient and healthcare provider.

The Royal College of Physicians and Surgeons of Canada stands out among other physician advocacy organizations in terms of acknowledging the relationship between the fluid state of medical relationships, the culture of silence, and ‘Apology Act’ legislation. The RCPSC does not straightforwardly advocate for apology but advocates for disclosure following a medical error and notes that disclosure is particularly beneficial to the enduring patient-physician relationship.⁷² The RCPSC recognizes that ‘Apology Act’ legislation shields the apologizer from litigation, but also recognizes that a fear of litigation pervades medical culture and inhibits disclosure and apology, while noting the rarity of instances of litigation following adverse events.⁷³

From a patient advocacy perspective, the Canadian Patient Safety Institute finds apology to be a key element of the disclosure process,⁷⁴ and, in a move unique in health organizations so far, explicitly recognizes the impact of sincerity in apology and provides recommendations for apologetic behavior beyond the words chosen.⁷⁵ The CPSI also recognizes the importance of ‘Apology Act’ legislation and its purported strength in shielding the apologizer; however, similar to the CMPA, the CPSI provides a list of words to be avoided,⁷⁶ indicating that a culture of silence permeates between medical advocacy organizations. The CPSI avoids the use of the word

‘error’ to describe harmful events to avoid confusion with potentially litigious language,⁷⁷ and to pay greater tribute to the complexity of the harmful event, believing that ‘error’ only singularly describes the conditions of the event.⁷⁸

Finally, the Canadian Nurses Protective Society operates in a comparable manner to the CMPA, offering legal advice, support, and financial assistance that is tailored to nursing.⁷⁹ The healing potential of an apology for the patients, families, and health care professionals is recognized by the CNPS,⁸⁰ as is the import of ‘Apology Act’ legislation. However, regarding apologies, the CNPS does not provide clear advice. Though the CNPS provides a ‘Best Practices Regarding Apologies’ section on their website, the section does not provide information on how to apologize. Instead, the section outlines the risks inherent in apologizing, and implores nurses to engage emotionally with patients and avoid assuming or directing blame. This section reflects the apprehensiveness towards apology that is consistent with other medical advocacy organizations:

Best practices regarding apologies

- the legislative requirements and your employer’s framework for critical incident investigations and disclosures should guide your actions during and after an adverse event
- in collaboration with other members of the treatment team, it is part of the nursing role to help your patient understand what is happening to him or her when a critical incident or adverse event is unfolding. Do not speculate to the patient about information that is unknown to you. Regret or sympathy may be expressed at this time but care providers should refrain from accepting or assigning blame
- understand the possible implications for yourself prior to apologizing to a patient, if you are asked to do so⁸¹

A theme consistent through the advice and recommendations provided by the advocacy groups discussed here is that while apology is recognized to play a significant role in medical relationships after an error occurs, a culture of silence overrules the role of apology and establishes instead that apologies are precarious things to avoid. Consequently, apology and

disclosure from the point of view of medical advocacy organizations are presented as legally-precarious options for physicians and HCPs, despite a recognition of ‘Apology Act’ legislation, and despite a recognition of the healing potential of apology. The primary concern of medical advocacy organizations seems to be to protect providers from litigation, and not to establish and educate providers on the benefits of apology. To the degree that apology is recognized as a worthwhile response to error, apology is noted to be legally threatening, but also a method of disarming litigious desires, indicating that apology is an instrument of protection, rather than a method of healing and maintaining relationships. Finally, there is no measure of advice for providers as to how to apologize; instead, all that is provided is apology in a negative sense, a list of words and phrases not to say. Overall, as evidenced by the threatening way in which apology is presented, the emphasis on avoiding responsibility, and the lack of information on how to navigate post-error medical relationships, the culture of silence permeates medical advocacy organizations via the presentation and reinforcing of apology as a legally precarious option and provides a measure of legitimization for silence.

2.2.2: Apology from the Point of View of Medical Personnel

In this section, I underline the main thesis by showing how the culture of silence is encouraged by the downplaying of emotions and empathy during medical education. In this section, I will investigate the roots that the culture of silence has in medical education that is inadequate in preparing medical personnel for making and responding to mistakes. I will address the emotional aspect of the culture of silence first. Emotions play dynamic roles in the culture of silence and can inhibit the possibility of apology. Negative emotions felt by medical personnel after an error is made arise from complaints from patients,⁸² arise from the shock of hurting another, and arise as a consequence of a violation of the ideal, perfect medical provider.⁸³ Lazare identifies three

emotions experienced by HCPs that influence the decision to apologize: empathy, guilt, and shame,⁸⁴ of which the latter is the most damaging and maladaptive to the refinement of medical practice and apprehensive to the provision of apology.⁸⁵ So far, what is indicated is that there are emotionally challenging barriers that medical personnel must transcend before realizing an apology. Shame, as a particularly difficult barrier to transcend, promotes silence and leads to an aversion to patient engagement.

Empathy and empathic training do play a role in medical education,⁸⁶ but the continuation of empathy is challenged in several ways. First, medical institutions are not immune to the effects of structural discrimination, and so patients of certain socioeconomic statuses are treated with disdain.⁸⁷ Second, biomedical perfectionism prevents empathy by instilling in medical students an omniscient conception of what proportions of pain and suffering that patients ought to feel and display.⁸⁸ Lastly, medical students lose or have their sense of empathy diminished as they progress along their educational route, a loss that is directly reflected from the manner of their education.⁸⁹

Groopman argues that overconfident mindsets militate against the empathic conditions that are favourable to apologizing.⁹⁰ For Groopman, denial of the reality of errors is prevalent within medical culture and is a result of the overwhelming pressure to be perfect. Further, Groopman argues that this denial is both “adaptive and maladaptive, it guides and misguides;”⁹¹ I suggest that this denial further entrenches the culture of silence in medicine, embedding not just an apprehensiveness towards apology. Groopman concludes with a personal reflection on engaging with patients who believe they are suffering, which not only highlights medical perfectionism and paternalism within medical practice, but also indicates the possibility of undoing perfection and empathically engaging with patients: “I have learned to refrain from

replying, ‘nothing is wrong with you’...why? First, it denies the fallibility of physicians. Second, it splits the mind from the body.’⁹²

The culture of silence is also reinforced by gaps in medical education. Communicating errors with patients is not taught to healthcare providers in great detail, and the emotional aspect of effective communication is viewed with suspicion.⁹³ Truog et al. highlight what they term a ‘disclosure gap’ between pedagogy and practice, a consequence of the absence of error communication.⁹⁴ Medical personnel are *aware* of the desire of patients to receive an apology post-error, but struggle to accommodate given the lack of training.⁹⁵ The culture of silence is reinforced by this gap in education. The gap in education and resulting culture of silence is not straightforward. Some healthcare providers and physicians advocate for methods to include apology within disclosure processes, such as emphasizing communication techniques that prioritize identifications and explanations of harms, developing an awareness of context to tell when apology and disclosure are appropriate, and using communications coaches.⁹⁶ Other recommendations promote the confrontation of errors on organizational, administrative, or systemic planes.⁹⁷ While these techniques are potentially worthwhile, my concern is that they may still reinforce a culture of silence. Identifying errors as being the result of administrative or systemic failures is important to hold medical institutions and the culture of silence to account. However, I suggest that if systemic failures are identified, the solutions ought to address not just organizational and administrative facets of medical institutions, but also directly speak to intimate relationships of care and the unique contexts within. As well, an institutional focus anchors effort on diminishing errors, and not on developing affective and practical skills relevant to providing apologies *after* the error. The question of how to develop a regime that appropriately assigns responsibility detached from feelings of shame and guilt is an open one.⁹⁸

In confronting silence, Truog et al. recommend that doctors should maintain an emphasis on values that are foundational to health care relationships⁹⁹ to ensure that a continuum of care is stable in the event of an error. To accomplish this goal, they argue that a dissociation from the mastering of the body is key for the doctor.¹⁰⁰ I suggest that this recommendation is a step towards disempowering the medical gaze, medical perfectionism, and the culture of silence that results. Maintaining an appreciation of empathy (a core relational value) is, for Truog et al., accomplished through practice, and not through education. However, Groopman and Ofri document the damage that is done to empathic capacity during medical education, reminding us that Truog et al.'s recommendation addresses aspects of medical education that are deeply embedded, and that confronting these embedded aspects will require sustained engagement with actors over time. The *maintenance* of empathy assumes that empathy as a core relational value is already emphasised, taught, and practiced during medical education, indicating that there is a gap between teaching empathy and maintaining it. It is perhaps in this gap that the culture of silence flourishes.

To conclude this section, I want to emphasize that the culture of silence has roots that extend from what is taught and reinforced in medical pedagogy, namely, perfectionism, the medical gaze, and the mind-body dichotomy, and a continuing absence of education on matters of error communication and empathy. While there are techniques that may counter the effects of a culture of silence on disclosure, I want to stress the concern that addressing errors only in an institutional or organizational light would leave out addressing key aspects of the affective patient-doctor relationships. Other techniques, such as striving to maintain empathy in order to communicate errors to patients, are worthwhile, but do not confront the withering of empathy and replacement of empathy with certainty that is documented in medical education. It is

important to establish that the reluctance of medical personnel to apologize *does not* indicate moral or ethical failings of character. The evidence given for apology reluctance should not be interpreted as a condemnation or demonization of doctors and nurses as unempathic or uncaring figures in society. This thesis is an exercise in sympathy and a study of circumstances. The circumstances contributing to hesitance towards apology do involve significant amounts of power, and these circumstances are pedagogically, relationally and ethically complex. The goal of this study is not to entreat physicians and healthcare providers to conceive of apology as a debt to be repaid, as a tool of defense, or as penance, but as a powerful aspect of caring and growth in circumstances where caring is especially important.

2.2.3: Apology from the Point of View of Patients and Families

In this section, I underline the main thesis by showing how a culture of silence stands in opposition of the desires of patients who have experienced medical errors. Important to note is that there are three prominent difficulties in discussing the role of apology from the patients' perspective. First is that patient accounts of errors and apology are typically presented through the point of view of medical personnel. A second difficulty of addressing the realm of medical errors from the point of view of the patient is encountered in the broad scope of what errors can be.¹⁰¹ This broadness means that in the absence of disclosure, a patient might not know enough to determine what the error is, or that a mistake has even been made.¹⁰² A third difficulty is encountered in the absence of literature on the needs of patients' post-error.¹⁰³ These difficulties gesture towards a critical gap in knowledge between patient experiences and healthcare provider experiences following medical error, one with serious consequences on the provision of care. Patients and families generally desire the disclosing of and apology for medical errors, a fact that HCPs acknowledge.¹⁰⁴ Accounts of medical apology show that patients desire increased

accountability, better communication, continuity of care, and better overall meetings and interactions with their healthcare providers.¹⁰⁵ This point is supported with quantitative data: data gathered from a study in the U.K. between 1989 and 1990 indicates that patients do indeed desire an apology and full disclosure post-error.¹⁰⁶ This data is represented in the tables below:

Table 8.1 Statement of What the Complainant Wants¹⁰⁷

Specific Remedy for this Complainant/Patient	No.	(%)
Arrange/help arrange treatment	10	2.9
Expenses/charges paid/compensation	9	2.6
Other specific request, eg., to see notes, transport, letter written to GP	11	3.2
Punish/reprimand/sack/discipline	7	2.0
Apology	6	1.8
Ensure will not recur for this complainant/patient	5	1.5
Meeting arranged/interview	5	1.5
Remedy for others/future		
Suggested specific changes in policy/procedure	17	5.0
Ensure will not recur/improve/stop it happening (for the future)	25	7.3
Ensure others will not suffer in future	13	3.8
Use the feedback/pass on information to someone who can do something	15	4.4
Investigation/Explanation		
Answer questions/provide information	38	11.1

Investigate/look into/find out	32	9.4
Treat as formal complaint	8	2.3
'Vague' Request		
Put right/resolve matter/sort out	32	9.4
Let me have your comments/reply	45	13.2
'Help' (unspecified)	13	3.8
Give attention to problem	9	2.6
No Statement	98	28.7
Total no. of letters analysed	342	

Table 8.2 Purpose(s) in Making a Medical Negligence Claim¹⁰⁸

Purpose	Most Important		2nd Most Important		3rd Most Important	
	No.	(%)*	No.	(%)*	No.	(%)*
Compensation	12	14	13	15	9	10
Unspecified						
To meet financial needs	9	10	11	13	7	8
As redress/make pay	2	2	-	-	1	1
Make doctor/hospital admit mistake	19	22	5	6	6	7
Justice/put matters right (no mention of compensation)	4	5	4	5	1	1
Explanation, find 'the truth'	19	22	5	6	6	7
Prevent reoccurrence	10	12	12	14	19	22

Apology	3	3	9	10	3	3
Obtain treatment	6	7	1	1	4	5
Damage caused/negligence	3	3	5	6	3	3
Publicize what happened	-	-	3	3	1	1
Other	1	1	5	6	4	5
Column Total	88		73		64	

* Percentage of the sample of 88 who answered this question: not all respondents named three purposes.

The data suggest that patients who have experienced harm as a result of medical error do have a desire to receive disclosure (see row thirteen in table 8.1, and rows four and six in table 8.2) and an apology for the harms caused (see row three in table 8.1, and row eight in table 8.2). What is also revealed through this data is that publication of the error (row eleven, table 8.2), knowing the truth of what happened (row six, table 8.2), receiving financial recompense (row two, table 8.1, rows two and three, table 8.2), and even punishment (row four, table 8.1) are all considered by patients as appropriate response to error—in some cases, more appropriate than apologies.

The data suggest several things. The first is that disclosure and apology are not the only things patients desire post-error. Second, the data suggest that there are some particularly severe errors, for which apologies might not be appropriate. Finally, many of the elements that are associated with apology (apologies as truth-telling events, as instruments of justice, as tools of communicating what went wrong) are able to be performed separately from apology, indicating that perhaps there is skepticism on the part of the patient as to the effectiveness of an apology, or that an apology is only conceived to serve in a limited capacity. Indeed, some patients are

skeptical of how effective an apology would be in mending a frayed relationship with their healthcare provider.¹⁰⁹

These data also show that medical apologies are not *overvalued* by complainants: ‘apology’ (row five, table 8.1) as a request from complainants is not as requested as compared to calls for more information (row twelve, table 8.1), to calling for investigation (row thirteen, table 8.1), or having the complaint recognized or otherwise acknowledged through communication from the healthcare institutions (row sixteen, table 8.1). Recognition of the error and communicating with the complainant from the healthcare institution play a major role in the purpose of making a complaint, as table 8.2 shows. The difference in importance between rows four and six (‘Make doctor/hospital admit mistake’ and ‘Explanation, find ‘the truth’ respectively) to row eight, ‘apology’ also suggest that apologies are not overvalued.

Patients in the study also expressed empathic sentiments through the desire to see that the error is prevented for future patients (see rows six, ten, and eleven in table 8.1, and row seven in table 8.2). From a political perspective, these data show the uneven and messy conditions of power between patient, physician, and nurse post-error. The differing desires of patients following an error, from disciplinary, to empathic, to establishing a factual record of the error, reflects both the initial condition of inequality of power in the medical relationship, and the resulting inequality post-error. These desires also gesture towards the power of apologies to address and encompass these desires. These points underline the main thesis by illuminating the scope of what the culture of silence is capable of obstructing. Indeed, the power of silence is immense, in that, the highly contextual nature of patient desires post-error can be completely ignored or dismissed.

In instances when an apology is provided, the *quality* of an apology also comes into play. In terms of fulfilment, dissatisfaction can remain high in cases where an apology is provided,¹¹⁰ and a sense of skepticism towards the efficacy of the apology can be present.¹¹¹ A regime of defensiveness is suggested by some medical personnel¹¹² to transform the patients' desire for an apology into a litigious endeavor, becoming in a sense a self-fulfilling enterprise that has a destructive effect on the relationship of care between medical personnel and patient. To some medical personnel, there is no doubt that on a large-scale, apologies are worthwhile and meaningful to families and patients post-error,¹¹³ alongside a full and honest disclosure of what went wrong.¹¹⁴ However, a general lack of information provided to the patients on *how* to go about seeking an apology or lodging a complaint is an impediment to seeking an apology.¹¹⁵ As some narratives show, the onus of asserting that something is wrong is put upon the patient or the family; however, any power they possess in a medical relationship is stifled by an administrative apparatus that, from the patients' perspective, has the power to shift responsibility to address harms to them.¹¹⁶ I suggest that a culture of silence is reflected in this power to shift and obscure responsibility, and is reflected in the power of medical personnel to do nothing to inform patients as to their options after a medical error occurs.

Conclusion

In this chapter, I presented three arguments that showed that a medical culture of silence prevents safe health care by inhibiting medical personnel, medical authorities, and medical advocacy organizations from taking responsibility for errors and apologizing. Firstly, I have shown that medical apologies are political, but differ from conventional political apologies in two ways: first, that the scale of discourse is smaller when compared to political apologies, and second, that affect plays a more involved role between the actors. The second point regarding affectual

engagement is particularly important as negative emotions experienced by medical personnel can inhibit the provision of apology. As well, the empathic capacity for emotions is inhibited somewhat during medical education, making engaging with patients and families on an emotional level (an act that is important for apology) difficult. As I suggest, the culture of silence draws from and is maintained by unemotional and biomedical regimes of education, and it negatively impacts the ways in which HCPs interact with patients and families after an error. The second argument that I have presented is that apologies are beneficial in that they present opportunities for the moral and ethical growth of medical personnel by letting them morally engage with patients, families, and other healthcare providers after an error, and that opportunities for this growth are threatened by a culture of silence. In this argument, I showed that the hierarchal organizational structure that medical personnel reside within can be an obstacle to apology, and thus an obstacle to ethical development.

The third argument I presented states that the culture of silence is a pathological iatrogenic harm unto itself because it prevents the error from being openly discussed and limits the prevention for future patients. In this argument I show that the reluctance to apologize comes alongside a reluctance to acknowledge, discuss, and correct behaviour that causes errors, all but ensuring that the error can occur again. This harm is pathological because the culture of silence that inhibits apology stems from elements in medical education, the biggest contributors being a biomedical view of human bodies, an emphasis on perfection, a lack of education on apology, a general discouragement towards emotion, and a decline in empathy. In the concluding section of this chapter, I established that the culture of silence is reinforced through the advice of medical advocacy organizations, is taught and reinforced in medical pedagogy, and is opposed to what patients desire after an error occurs.

Notes

- ¹ Bonnie McElhinny, "Reparations and Racism, Discourse and Diversity: Neoliberal Multiculturalism and the Canadian Age of Apologies," *Language and Communication* 51 (2016): 53; Tyler G. Okimoto, Michael Wenzel, Matthew J. Hornsey, "Apologies Demanded Yet Devalued: Normative Dilution in the Age of Apology," *Journal of Experimental Social Psychology* 60 (2015), 133.
- ² Janna Thompson, "Apology, Justice, and Respect: A Critical Defense of Political Apology," in *Age of Apology*, ed. Mark Gibney, Rhoda Howard-Hassmann, Jean-Marc Coicaud, Niklaus Steiner (2008), 31; Richard B. Bilder, "The Role of Apology in International Law," in *Age of Apology* ed. Mark Gibney, Rhoda Howard-Hassmann, Jean-Marc Coicaud, and Niklaus Steiner (2008), 19, 24.
- ³ Janna Thompson, "Apology, Justice, and Respect," in *Age of Apology*, 31.
- ⁴ Nick Smith, *I Was Wrong: The Meanings of Apologies* (Cambridge: Cambridge University Press, 2008), 159-160, 162, 165-167.
- ⁵ Janna Thompson, "Apology, Justice, and Respect" in *Age of Apology*, 36.
- ⁶ Nick Smith, *I Was Wrong*, 243.
- ⁷ Danielle Ofri, *What Patients Say, What Doctors Hear* (Boston: Beacon Press, 2017), 146: "The fear of a lawsuit is so pervasive that doctors worry any admission of error is tantamount to handing your head to a lawyer on a stainless steel surgical tray."
- ⁸ Ibid. 142-143: Ofri relays the import of emotion in a recollection of a mediation session between the widow of a patient who suffered a wrongful death and the physician who was attending at the time: "The mediation process allowed Mrs. Benson to ask questions about the central line and why a resident physician was doing the procedure. It allowed her to express her anger and frustration at how she had been treated...At the second mediation session, however, the chief of medicine had something to add. He mentioned that he had seen the resident that morning and asked him if he remembered the patient—it had been almost a year since the incident, after all. The physician's response was both incredulous and pained. 'Remember him? I think of him every single day. I grieve for him every day.' When this quote was relayed to the widow, the atmosphere changed immediately. Even though the doctor was not present, his emotions—particularly his remorse, his pain, and the enduring ramifications—restored an important degree of humanity to the process."
- ⁹ Ross Koppel, Stephen Davidson, Robert Wears, and Christine Sinsky, "Health Care Information Technology to the Rescue," in *First, Do Less Harm: Confronting the Inconvenient Problems in Patient Safety*, ed. Ross Koppel and Suzanne Gordon (Ithaca: Cornell University Press, 2012), 68; Ross Koppel, Suzanne Gordon, Joel Telles, "Twenty-Seven Paradoxes, Ironies, and Challenges of Patient Safety," in *First, Do Less Harm*, 230-232.
- ¹⁰ Jerome Groopman, *How Doctors Think* (New York: Houghton Mifflin, 2007), 149-150; Ross Koppel et al., "Health Care Information Technology," in *First, Do Less Harm*, 72; Carol Youngson, "Any Nurse, Anywhere," in *Medical Nightmares: The Human Face of Errors* (Toronto: Chestnut, 2001), ed. by Susan B. McIver, 55; Suzanne Gordon, "On Teams, Teamwork, and Team Intelligence," in *First, Do Less Harm*, 197-199, 204.
- ¹¹ Danielle Ofri, *What Doctors Feel: How Emotions Affect the Practice of Medicine* (Boston: Beacon Press, 2013), 18-19, 37, 39; Danielle Ofri, *What Patients Say*, 87-88, 186-189; Danielle Elliott, "Zones of Abandonment: The Cultural Politics of Public Health," in *Human Welfare, Rights, and Social Activism: Rethinking the Legacy of J.S. Woodsworth* ed. Jane Pulkingham (Toronto: University of Toronto Press, 2010), 186.
- ¹² Institute of Medicine, *To Err is Human* ed. Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson (Washington: National Academy Press, 2000), 65-66.
- ¹³ Ken Kilpatrick and Colin Freeze, "Red Cross Pleads Guilty" *The Globe and Mail.ca*, 2005, last updated 2018, <https://www.theglobeandmail.com/news/national/red-cross-pleads-guilty-offers-apology-in-blood-scandal/article18228058/>.
- ¹⁴ Andre Picard, *The Gift of Death* (Toronto: Harper Collins, 1995).
- ¹⁵ Gilles Paquet and Roger Perrault, *The Tainted-Blood Tragedy in Canada*, (Ottawa, Invenire, 2016).
- ¹⁶ Jean-Marc Coicaud and Jibecke Jonsson, "Elements of a Road Map for a Politics of Apology," in *The Age of Apology* ed. by Mark Gibney et. al, 90.
- ¹⁷ Ibid. 85: "apology is particularly vulnerable to various types of misuse and the dangers that they entail: though intended as a mechanism of accountability, apology might well contribute to circumventing

accountability...apology might lead to the normalization of crime; and, although designed to facilitate the return to relatively normal and healthy life, apology risks to reinforce alienation.”

¹⁸ Carol Gilligan, *In a Different Voice: Psychological Theory and Women's Development* (Cambridge: Harvard University Press, 1982), 168: Recall Gilligan's observation that power disparities in relationships can exist to perpetuate the disparity, or to dispel it. Similarly, Coicaud and Jonsson argue that “using apology in a non-apologetic manner in order to hold onto power is another way for politics to hijack apology”; Jean-Marc Coicaud and Jibecke Jonsson, “Elements of a Road Map for a Politics of Apology,” in *The Age of Apology* ed. Mark Gibney et al., 86.

¹⁹ Jeff Corntassel and Cindy Holder, “Who's Sorry Now? Government Apologies, Truth Commissions, and Indigenous Self-Determination in Australia, Canada, Guatemala, and Peru,” *Human Rights Review* 9 no. 4 (2008), 486.

²⁰ “Nurse Thought Brian Sinclair Was Intoxicated, Inquest Told,” *CBC.ca*, 10 October 2010, <https://www.cbc.ca/news/canada/manitoba/nurse-thought-brian-sinclair-was-intoxicated-inquest-told-1.1959602>

²¹ Arlene Wilgosh, “WRHA President's Staff Note about Brian Sinclair Inquest,” *CBC.ca*, 2013, <https://www.cbc.ca/news/canada/manitoba/wrha-president-s-staff-note-about-brian-sinclair-inquest-1.1349159>.

²² Provincial Implementation Team, “The Provincial Implementation Team Report on the Recommendations of the Brian Sinclair Inquest Report: 90 Day Report,” 2015: 17.

²³ Jane Gerster, “A Man Was Ignored in an ER 10 Years Ago. It Could Happen Again,” *CBC.ca*, 2018, <https://globalnews.ca/news/4445582/brian-sinclair-health-care-racism/>.

²⁴ Lee Taft, “Apology Subverted: The Commodification of Apology,” *The Yale Law Journal*, 109, no. 5 (2000), 1143; Prue Vines, “Apologising to Avoid Liability: Cynical Civility or Practical Morality,” *Sydney Law Review* 27 no. 3 (2005), 486.

²⁵ Robert Blendon et al., “Views of Practicing Physicians and the Public on Medical Errors,” *New England Journal of Medicine* 347 no.24 (2002), 1936.

²⁶ *Ibid.* 1937.

²⁷ A.N. Zotterman et al., “District Nurses' Views on Quality of Primary Healthcare Encounters,” *Scandinavian Journal of Caring Sciences*, 29 no. 3 (2014), 423.

²⁸ *Ibid.* 421: “The DNs [District Nurses] described that patients often turned to them when they are having problems. One reason for this reliance was due to a negative encounter with the physician. The DNs reported asking the physician to improve the communication in the patient-physician relationships.”

²⁹ *Ibid.* 422: “The DNs described that good quality care and good encounters included the ability to admit that meetings had turned out poorly. An apology to a person that experienced a poor encounter was important for the DNs. They claimed that patients appreciated an apology and explanation from healthcare personnel and that it was vital for improvement of the nurse-patient relationship.”

³⁰ *Ibid.* 422.

³¹ *Ibid.* 422: “the importance of good quality care and good encounters within healthcare include patients' feelings of dignity and being genuinely cared for when meeting with healthcare personnel.

³² Suzanne Gordon, “On Teams, Teamwork, and Team Intelligence,” in *First, Do Less Harm*, ed. by Ross Koppel and Suzanne Gordon, 204.

³³ Peter Lazes, Suzanne Gordon, and Sameh Samy, “Excluded Actors in Patient Safety,” in *First, Do Less Harm*, ed. by Ross Koppel and Suzanne Gordon, 110: The authors note that nurses are often excluded from the development of safety regimes, due to the perception that their role in a hospital is not as important as that of the physician in terms of their contribution to patient care. Relating a nurse's perspective on the matter, Koppel and Gordon write “[o]ne nurse at a northeastern teaching hospital described upper-level management's efforts to encourage hand washing in her institution. A hand washing initiative was designed and implemented at the top, and then a managerial hand washing ‘champion’ walked around the units rewarding staff members with a box of Skittles if he saw them comply with hand washing policies. ‘It was like we were a bunch of children whom they could pacify by giving out a box of cheap candy.’”

³⁴ Carol Youngson, “Any Nurse, Anywhere,” in *Medical Nightmares*, ed. by Susan B. McIver, 53-59: In this chapter, Youngson, a nurse who worked at Winnipeg's Health Sciences Centre in the early- to mid-nineties, recounts a story of being ignored by her hospital's department heads over concerns of high rates of newborn infant deaths after or

during cardiac surgery. In her story, Youngson recounts that after taking part in what would come to be known as the 'Pediatric Cardiac Surgery Inquest' that "[i]n the fall of 1995, the Health Sciences Centre decided that the evidence provided by the nursing staff could prove to be a conflict of interest for the centre. We nurses were advised by the HSC that we should seek our own legal council. In other words, our employer had set us legally adrift."

³⁵ Ross Koppel and Suzanne Gordon, *First, Do Less Harm*, ed. by Ross Koppel and Suzanne Gordon, 191.

³⁶ *Ibid.* 193.

³⁷ Nancy Crigger and Vicki Meek, "Toward a Theory of Self-Reconciliation Following Mistakes in Nursing Practice," *Journal of Nursing Scholarship* 39 no. 2 (2007), 180.

³⁸ *Ibid.* 180.

³⁹ *Ibid.* 180-181.

⁴⁰ *Ibid.* 181: "Participants voiced concern about how managers or peers would react to mistakes. Many of them voiced an expectation of punitive responses."

⁴¹ *Ibid.* 181: "If participants decided as a result of the weighing process to report a mistake, many of them made the disclosure to their immediate supervisor or the physician. In some instances, the patient was not told of the error...[t]he nurse or healthcare provider believes that he or she has taken the proper ethical steps by disclosing the error to all but the patient and family."

⁴² *Ibid.* 181.

⁴³ Murray Sinclair, "The Report of the Manitoba Pediatric Cardiac Surgery Inquest: An Inquiry into Twelve Deaths at the Winnipeg Health Sciences Centre in 1994," *Provincial Court of Manitoba*, (1994), www.pediatriccardiacinquest.mb.ca, 465.

⁴⁴ *Ibid.* 477.

⁴⁵ Linda Treiber and Jackie Jones, "Wounds That Don't Heal: Nurses' Experience with Medication Errors," in *First, Do Less Harm*, ed. by Ross Koppel and Suzanne Gordon, 198: "their [nurses] sense of insult and injury—particularly from doctors—and their attempt to claim their own 'caring' corner of the health care universe may lead some nurses, just like everyone else, to make bad communication even worse."

⁴⁶ Marlynn Wei, "Doctors, Apologies, and the Law," *Student Scholarship Papers*, Paper 30 (2006), 23-26.

⁴⁷ Robert Truog et al., *Talking with Patients and Families About Medical Error: A Guide for Education and Practice*, (Baltimore: John Hopkins University Press, 2011), 44.

⁴⁸ Aaron Lazare, "Apology in Medical Practice: An Emerging Clinical Skill," *JAMA* 296 no. 11 (2006), 1403: "It is no accident that physicians often resist acknowledging offenses in the medical setting or fail to adequately apologize for them. An obvious and understandable reason for such resistance is the fear of consequences, such as an angry patient, a complaint sent to the state Board of Registration, or a malpractice suit."; Jennifer Robbennolt, "Apologies and Medical Error," *Clinical Orthopedics and Related Research* 467 no. 2 (2009), 378: "Despite the potential benefits of apologizing, apologies are not frequently given and there is wide variation in physicians' tendencies to offer apologies in the wake of medical error."

⁴⁹ Lucien Leape, "Error in Medicine," in *Medical Mishaps: Pieces of the Puzzle*, ed. Marilynn Rosenthal, Linda Mulcahy, and Sally Lloyd-Bostock (Philadelphia: Open University Press, 1999), 22: "Physicians are socialized in medical school and residency to strive for an error-free practice. There is a powerful emphasis on perfection, both in diagnosis and treatment. In everyday hospital practice, the message is equally clear: mistakes are unacceptable. Physicians are expected to function without error, an expectation that physicians translate into the need to be infallible. One result is that physicians, not unlike test pilots, come to view an error as a failure of character – you weren't careful enough, you didn't try hard enough."

⁵⁰ Michel Foucault, *The Birth of the Clinic*, translated by A.M. Sheridan (London: Tavistock Publications, 1973), 137-150; Susan Greenhalgh, *Under the Medical Gaze: Facts and Fictions of Chronic Pain* (Berkeley: University of California Press, 2001), 26-28; The history of this assertion is catalogued in various texts on the history of medicine, most notably in a discursive manner in Foucault's *The Birth of the Clinic*, and a qualitative manner, in Greenhalgh's *Under the Medical Gaze*. Notably, Foucault identifies three geographic and grammatic elements that grants social continuity, or an image for the gaze to resolve. The geographic and grammatic elements come in the form of a linear scientific method of observing symptoms and interrogating patients in a controlled environment (137), an esoteric, grammatic categorization of disease (138), and the creation and adherence to rigid ideals of health,

bodies, and disease (139), ensuring that bodies and ailments can always be objectively knowable. These elements combine to simultaneously elevate the position of clinician to a height of medical power and reduce the bodies of patients to sites of epistemological knowledge, the reliance on which Foucault argues is precarious (145-150). Greenhalgh relates her experiences with medical misdiagnosis through the effects the medical gaze leveraged on her body and the relationship between her and her doctor. These effects characterize the gaze as transformative (the patient does not enter a clinic as a patient, they are transformed into one by a doctor's observation), penetrating (the gaze can travel through the geography of the hospital, to follow a patient home for example), reductive (the patient is reduced to the sum of their symptoms), revelatory (the gaze reveals, or tells truths about the patients' body to the patients themselves), and objectively presenting (the gaze relies on scientific and evidence-based medicine to present itself as a neutral, unquestionable presentation of medical symptoms).

⁵¹ Maria Giulia Marini, *Narrative Medicine: Bridging the Gap between Evidence-Based Care and Medical Humanities* (Spring International Publishing, 2016), 22: In this text, Marini explores the gap between evidence-based medicine and narrative-based medicine, and finds that the medical gaze plays a role in subduing empathy in medical students: "It appears that from the third year of med school on, students start to become less empathic, but more effective in mastering the 'detached' medical gaze. It is this gaze that Foucault described in his famous essay '*Naissance de la Clinique*', the '*regard medical*' that prevents carers from having emotional approaches to patients, and rather endorses a detachment and more *distant care*."

⁵² Danielle Ofri, *What Patients Say*, 189-190: Ofri relates a narrative of a treating a former drug addict and prison inmate, Jose Santiago. Initially, the patient was diagnosed as HIV positive through a battery of tests and advised to follow medical regimens to treat the illness, eventually ending under Dr. Ofri's care. The patient showed remarkable nonprogression of the illness. After over a year of treatment, another test revealed that the patient suffered a false positive and did not have HIV. Stereotyping, and a reliance on biomedical testing had locked Mr. Santiago into a specific illness. Ofri writes "In one respect, Mr. Santiago was a medical success—he's started out with a slew of grave medical issues and ended up with just two manageable ones. But in another respect, Mr. Santiago represented a failure of the medical system. In addition to the stereotypes into which we pigeonholed him—with potent consequences—there was a staggering lack of communication. I realized that I was probably just as guilty as the doctors before me who'd misdiagnosed him with HIV...I recognize that I didn't make as much effort to get to know him as I usually do with my patients. Maybe my biases got the better of me; I let the florid tattoos, the prison time, and the drug history keep me at a distance. But there was a whole person inside there, someone with remarkable fortitude."

⁵³ Mehmet Turgut, "Ancient Medical Schools in Knidos and Kos," *Child's Nervous System* 27, no. 2 (2011), 197; Turgut, in an examination of the ancient schools of medicine on the Turkish and Greek islands of Knidos and Kos, argues that the Koan school of medicine (the Hippocratean school) "emphasised the 'patient' rather than the disease," in a reversal of the practice of the Knidean school.

⁵⁴ Plinius Secundus, *Naturalis Historia Book XXIX Chapter 8 – Evils Attendant Upon the Practice of Medicine*, c. 79 A.D.: "And then besides, there is no law in existence whereby to punish the ignorance of physicians, no instance before us of capital punishment inflicted. It is at the expense of our perils that they learn, and they experimentalize by putting us to death, a physician being the only person that can kill another with sovereign impunity. Nay, even more than this, all the blame is thrown upon the sick man only; he is accused of disobedience forthwith, and it is the person who is dead and gone that is put upon his trial."

⁵⁵ Hippocratic Corpus, c. 500-400 B.C: The concluding section of the Hippocratic Oath is presented here: "If I render this Oath fulfilled, and if I do not blur and confound it may it be granted to me to enjoy the benefits both of life and of Techne, being held in good repute among all human beings for time eternal. If, however, I transgress, and perjure myself, the opposite of these."

⁵⁶ Ivan Illich, *Medical Nemesis* (London: Calder & Boyars, 1975).

⁵⁷ Florence Nightingale, *Notes on Hospitals* 3rd Edition (London: Harvard University Library, 1863).

⁵⁸ Soma Navidson, "Unlearning: Improving Trans Care by Reorienting Medical and Nursing Discourse," in *The Remedy: Queer and Trans Voices on Health and Health Care* ed. by Zena Sharman (Vancouver: Arsenal Pulp Press, 2016), 32; Kristen L. Eckstrand, "Using Medical Education to Advance Health of LGBT Individuals," in *The Remedy* ed. by Zena Sharman, 64; Eli Erlick, "Depathologizing Trans," in *The Remedy* ed. by Zena Sharman, 220.

⁵⁹ Nick J. Mule, "Much to be Desired: LGBT Health Inequalities and Inequities in Canada," in *Lesbian, Gay, Bisexual and Trans Health Inequalities: International Perspectives in Social Work* ed. by Julie Fish and Kate Karban (Chicago: University of Chicago Press, 2015), 28.

⁶⁰ Ibid. 38.

⁶¹ "What We Do," *Canadian Medical Protective Association*, <https://www.cmpa-acpm.ca/en/about/what-we-do>.

⁶² "Programs for Physicians and Healthcare Professionals," *Saegis*, <https://saegis.solutions/en/saegis-solutions/programs-healthcare-professionals>.

⁶³ "CMA Code of Ethics," *Canadian Medical Association*, 2004, https://www.cma.ca/Assets/assets-library/document/en/advocacy/policy-research/CMA_Policy_Code_of_ethics_of_the_Canadian_Medical_Association_Update_2004_PD04-06-e.pdf.

"Take all reasonable steps to prevent harm to patients; should harm occur, disclose it to the patient."

⁶⁴ Canadian Medical Association, "New in Practice," 2016, 71.

⁶⁵ Canadian Medical Protective Association, "Disclosing Harm from Healthcare Delivery," 2017, 9: "At every disclosure meeting, a statement of being sorry for the circumstances or the condition of the patient is important and appropriate. Physicians should not hesitate to express their regret or sympathy to the patient. This is not an admission of error or liability. Genuine concern by a caring physician will be appreciated by most patients and families. The failure to be empathetic and apologize is a leading driver of complaints and legal actions."

⁶⁶ Ibid. 10: "[if] a careful analysis determines [that] the harm was related to system failures or provider performance, an apology should be considered by the responsible provider or responsible organization."

⁶⁷ Ibid. 10.

⁶⁸ Ibid. 10.

⁶⁹ Canadian Medical Protective Association, "Disclosing Harm from Healthcare Delivery," 2017, 10: The CMPA recommends that "[p]hysicians should avoid words that express or imply legal responsibility, such as negligence, liable, fault, or 'failing to meet the standard of care'."

⁷⁰ Nick Smith, *I Was Wrong*, 199: "When accepting praise, we shorten causal chains. When deflecting blame, we extend them indefinitely and even question whether moral responsibility makes sense given any number of metaphysical conundrums."

⁷¹ Ibid. 199.

⁷² Maggie Constantine, "Disclosure of Adverse Events," *Royal College of Physicians and Surgeons of Canada*, <http://www.royalcollege.ca/rcsite/bioethics/cases/section-2/disclosure-adverse-events-e>:

"[the] need for disclosure of information is not only important to the process of informed consent for the patient, but also fundamental to the ongoing relationship between physician and patient...the relationship between patient and physician is partly based upon a commitment of trust and openness on the part of the physician. With regard to medical error or adverse events, where the non-disclosure of such events can lead to a breakdown of the patient-physician relationship, this need for disclosure is particularly important. Suspicions of cover-up and of being lied to may result, which has been shown to increase the rates of malpractice cases."

⁷³ Pam Marshall and Rob Robson, "Conflict Resolution," *Royal College of Physicians and Surgeons of Canada*, <http://www.royalcollege.ca/rcsite/bioethics/primers/conflict-resolution-e>:

"One of the factors that appears to be behind physician hesitation about fuller disclosure or more transparent and honest discussions with patients is the fear of litigation. As has been pointed out by Lucian Leape, there is no evidence that disclosure, or even an apology when appropriate, leads to increased risk of litigation. In Canada, the more serious challenge for those who would urge caution when it comes to a more robust process of conflict resolution in health care (which necessarily involves honest exchanges between patients and physicians) is the steady drop in the total number of law suits naming physicians to levels previously seen in the early to mid-1980s."

⁷⁴ Canadian Patient Safety Institute, "Canadian Disclosure Guidelines: Being Open with Patients and Families," 2011, 20: "Apology as part of disclosure is consistent with patient-centered care, honesty and transparency, and intuitively the right thing to do."

⁷⁵ Ibid. 19: "An apology is not meaningful unless it is sincere; when apologizing, those apologizing should make sure they convey their sincerity both in the words they choose, as well as in their non-verbal behavior, including body language, facial expressions, gestures, and tone, pitch and pace of voice."

⁷⁶ Ibid. 19: "An apology to patients by healthcare providers or organizations should not be taken as an admission of legal liability. In fact, in most provinces, recent legislation expressly prevents apologies from being taken as an admission of legal liability. In any event, using words such as 'negligence,' 'fault,' or 'failing to meet the standard of care,' should be avoided."

⁷⁷ Ibid. 12: "the use of the term 'error' in disclosure might be misunderstood or confused to mean that the care provided was substandard or negligent in law."

⁷⁸ Ibid. 12: "These guidelines purposely avoid the use of the term error. Patient safety incidents are known to most often result from a complex interplay of factors...[a] single failure rarely leads to harm."

⁷⁹ Canadian Nurses Protective Society, "About us," <https://www.cnps.ca/index.php?m=10&page=2>.

⁸⁰ Canadian Nurses Protective Society, "Legal Status of an Apology," <https://www.cnps.ca/index.php?page=239>: "A meaningful apology can assist patients, affected families, and health care professionals to heal after the event" Paragraph 5.

⁸¹ Ibid. <https://www.cnps.ca/index.php?page=239>.

⁸² Judith Allsop and Linda Mulcahy, "Doctors' Responses to Patient Complaints," *Medical Mishaps*, ed. Marilyn Rosenthal, Linda Mulcahy, and Sally Lloyd-Bostock, 129.

⁸³ Danielle Ofri, *What Patients Say*, 150.

⁸⁴ Aaron Lazare, *On Apology*, (New York: Oxford University Press, 2004), 94.

⁸⁵ Danielle Ofri, *What Doctors Feel*, 133, 137-138.

⁸⁶ Ibid. 10.

⁸⁷ Ibid. 10, 18,19, 39.

⁸⁸ Ibid. 10.

⁸⁹ Ibid. 30-34.

⁹⁰ Jerome Groopman, *What Doctors Think*, 149-150.

⁹¹ Ibid. 152.

⁹² Ibid. 264.

⁹³ Robert Truog et al., *Talking with Patients*, 6.

⁹⁴ Ibid. 38-39, 40, 41, 42.

⁹⁵ Ibid. 133.

⁹⁶ Ibid. 74, 77, 86.

⁹⁷ Institute of Medicine, *To Err is Human*, 65-66.

⁹⁸ Danielle Ofri, *What Doctors Feel*, 132-133.

⁹⁹ Robert Truog et al., *Talking with Patients*, 65.

¹⁰⁰ Ibid. 64-65.

¹⁰¹ Judith Allsop and Linda Mulcahy, "Doctors' Responses to Patient Complaints," in *Medical Mishaps*, ed. by Marilyn Rosenthal et al., 103-117.

¹⁰² Ibid. 133.

¹⁰³ Robert Truog et al. *Talking with Patients*, 133: "While the existing literature highlights patients' desire for disclosure of adverse events and errors, little is known about the range and variation of patients' needs at these times."

¹⁰⁴ Ibid. 31.

¹⁰⁵ Anonymous, "Mum," in *Medical Nightmares*, ed. Susan B. McIver, 36.

¹⁰⁶ Sally Lloyd-Bostock, "Calling Doctors and Hospitals to Account," in *Medical Mishaps*, ed. by Marilyn Rosenthal et al. 114, 118.

¹⁰⁷ Ibid. 112.

¹⁰⁸ Ibid. 113.

¹⁰⁹ Sally Lloyd-Bostock, "Calling Doctors and Hospitals to Account," in *Medical Mishaps* ed. by Marilyn Rosenthal et al., 114; Robert Truog et al., *Talking with Patients*, 31; Donald B. Wightman, "Brad," in *Medical Nightmares*, ed. by Susan B. McIver, 44.

¹¹⁰ Linda Mulcahy, "Mediation of Medical Negligence Actions: An Option for the Future?" in *Medical Mishaps*, ed. by Marilyn Rosenthal et al., 158.

¹¹¹ Sally Lloyd-Bostock, "Calling Doctors and Hospitals to Account," in *Medical Mishaps*, ed. by Marilyn Rosenthal et al., 114.

¹¹² Nicholas Nicol, "The Right to Redress: Complaints and Principles of Grievance Procedures," in *Medical Mishaps*, ed. by Marilyn Rosenthal et al., 243.

¹¹³ Robert Truog et al., *Talking with Patients*, 1-2.

¹¹⁴ *Ibid.* 31, table on 33.

¹¹⁵ Arnold Simanowitz, "The Patient's Perspective," in *Medical Mishaps* ed. By Marilyn Rosenthal et al., 230-231: "when something goes wrong, there is still an onus on patients to seek information in a situation where they may not even be aware that a mishap has occurred. There is no obligation on a doctor, or indeed on the trust, to seek out and inform patients of the position and to offer and give them, and their families, all the necessary financial, emotional and medical support which their maltreatment has caused them to require.";

Robert Truog et al., *Talking with Patients*, 6.

¹¹⁶ Anonymous, "Denise," in *Medical Nightmares*, ed. by Susan B. McIver, 65: "From my experience, public relations at the hospital is about blaming the patient for the hospital's problems rather than finding out what could be done better."

Chapter Three: The Tainted Blood Scandal

“The Red Cross acknowledges with profound sadness that people were infected by tainted blood in the 1980s and deeply regrets not developing and adopting measures more quickly to reduce the risk of infection. We were part of a system that failed and we are very sorry for what happened. Our thoughts continue to be with those who were affected and their families.”¹ – Statement from the Canadian Red Cross website

“The Canadian Red Cross society is deeply sorry for the injury and death . . . [sic] for the suffering caused to families and loved ones of those who were harmed. We accept responsibility through our plea for having distributed harmful products for those that rely on us for their health.”² – Apology provided by Red Cross CEO Dr. Pierre Duplessis in 2005, following a plea arrangement for violating the Food and Drug Act

These epigraphs include a statement and an apology the Red Cross has offered for its role in the Tainted Blood Scandal. The first epigraph is not an apology, as it places the Red Cross in a ‘system that failed,’ meaning that the Red Cross is not apologizing for their role as an actor implicated in responsibility for the scandal, but rather apologizing for an undefined system. An affective acknowledgement of infection is present but is separated from ‘what happened.’ ‘What happened’ is a nebulous statement, as are the specifics of what role the Red Cross played in the ‘system that failed.’ The second epigraph is an apology, and more clearly identifies the ‘injury and death’ caused by the provision of contaminated blood, clearly identifies the harm to relationships caused by the scandal, and clearly states an acceptance of responsibility. What stands out is that the acceptance of responsibility is dependent on a legal plea and is not coupled with a general acceptance of responsibility through action and inaction. Overall, the first epigraph is not an apology, and is unclear and ineffective; when judged by criteria to establish the authenticity of political apologies as proposed by James,³ the Red Cross’ statement lacks specificity as to what the wrongs were, does not promise nonrepetition, and has a shallow engagement with victims. Additionally, the Red Cross apology is mired by the faults common to collective categorical apologies as identified by Smith,⁴ especially in that it offers sympathy as a substitute for accepting responsibility, taking advantage of the complexities of causation in

institutional settings as a means of deflecting blame.⁵ The first epigraph does not fulfil the definition of apology used in this thesis, that being an apology as an expression of regret and acknowledged responsibility by an offender or offenders to an offended party or parties for an identified harm or harms done, that includes a promise to alter harm-causing behaviour for the future. The second apology is clearer in terms of identifying harms, but still does not fulfil the criteria discussed above, and only engages with responsibility after a legal judgment, rather than on grounds that a moral offense was performed. The theme this epigraph communicates is that key actors involved in providing contaminated blood engaged consistently in apology processes in ways that avoided taking responsibility.

The scandal as a case study supports my main argument by showing that a culture of silence is embedded in the pattern of behaviour of medical authorities and medical personnel during the scandal. Further, I aim to show through this case study that because the culture of silence has inhibited the Red Cross from providing a robust apology and left victims and their relationship with health authorities and healthcare providers in a state of disrepair, it has precluded these particular medical relationships from benefiting from an ethic of care. This chapter engages the earlier claims of this thesis by arguing first that the conduct and responses to the scandal taken by individuals, organizations, and authorities while contaminated blood was being provided were direct efforts to avoid or obscure responsibility. My second argument is that recent efforts by Gilles Paquet and Roger Perrault to complicate and dismiss the role of responsibility of the Red Cross reveal a culture of silence that continues to affect institutional engagement with the history of the scandal and precludes any care ethics intervention that may help repair damaged medical relationships.

Throughout this chapter, I refer to the provision of contaminated blood and blood product as a ‘scandal,’ though with some qualifications. Though it is commonly known and referred to as a tragedy, its scandalous nature is revealed as far as the unacceptable negligence of relevant health authorities and individuals is shown. Efforts to dismiss and obscure responsibility for the provision of contaminated blood only worsened the scandalous nature of the affair. Certainly, the medical uncertainty surrounding the viral nature of HIV/AIDS, including its transmissibility, lends some credence to an understanding of the provision of contaminated blood as an unavoidable circumstance. However, the use of ‘tragedy,’ as far as ‘tragedy’ refers to an unavoidable, pre-ordained event, to describe the provision of contaminated blood and blood product elides the responsibility that is imbricated in the actions and inactions of health authorities and individuals in decision-making capacities during the scandal.

This chapter is presented in three sections. The first section relies primarily on Andre Picard’s 1995 text *The Gift of Death* to provide an empirical overview and history of the scandal from a journalistic perspective. In the second section, I continue an empirical examination of the scandal and establish the role of responsibility and apology by examining responses to the scandal. These responses include the Commission of Inquiry on the Blood System in Canada, commonly known as the Krever Inquiry, which began in 1993 and concluded in 1997. The third section relies on *The Tainted-Blood Tragedy in Canada*, a 2016 text by Gilles Paquet and Dr. Roger Perrault, the former head of the Red Cross during the scandal. Paquet and Perrault argue that a combination of the exceedingly complex nature of the scandal and a lack of public understanding on how decisions are made by authorities in the face of medical catastrophes (or other similarly complex problems) has inhibited a proper understanding of the scandal. Further, they argue that such an improper understanding has resulted in unfair attributions of

responsibility for the scandal to individuals. In this section, I argue that Paquet and Perrault's breakdown of responses to the scandal is an example of the culture of silence presiding over the history of the scandal by dismissing attributions of responsibility by the media, blood activists, the Krever Inquiry, and victims.

The initial infectious period of Canada's Tainted Blood Scandal began in the early 1980s and ended in the late 1980s. It is estimated that 30 000 patients across Canada were infected with hepatitis C virus and 2 000 patients were infected with human immunodeficiency virus (HIV) from receiving contaminated blood and blood product. Though hemophiliacs formed a large fraction of those infected, many patients who required a transfusion treatment were also infected. The aim of this concluding chapter is not to lay blame on any individual, and neither is it intended as a comprehensive review of the failures of the various authorities, individuals, and organizations associated with the scandal. The purpose of the chapter is instead to interrogate the responses and non-responses to the scandal and identify how these responses and non-responses reveal a culture of silence and evasiveness towards apology. The purpose of exploring a health catastrophe like the scandal through lenses of responsibility, care, and apology is threefold. The first purpose is to examine the culture of silence as it observable in both historical and contemporary circumstances of the scandal. The second purpose is to show how these circumstances reflect a culture of silence in more general health care contexts that discourage the open discussion of errors and apology. The third purpose of this chapter is to show that if medical culture is to derive the benefits that care ethics offers medical relationships, medical culture needs to be more open towards the prospect of apology in order to elevate an ethic of care in medical relationships.

3.1.1: The Scandal: A Brief Timeline

For a timeline of the events leading up to the scandal, I rely on Picard's authoritative 1995 book, *The Gift of Death*. Picard argued that several factors led to and exacerbated the contaminated blood supply in Canada. Three prominent factors were an initial lack of scientific understanding about HIV,⁶ a moralized conception of the nature of the virus and of people who donated blood,⁷ and an undergoverned, privatized blood supply system and blood-product production practice.⁸ Below, I provide a brief timeline of the scandal, starting in 1981 and concluding in 1989. The scope of the scandal is large and would be difficult to robustly sum up; the focus of this section is on particular actions and inactions that I suggest highlight the attempts of the Red Cross, public health officials, and medical personnel to avoid responsibility for the infection of patients and members of the public. Though there are prominent economic factors that contributed to the scandal prior to 1981 (such as competition between the Red Cross and Connaught Laboratories to construct a fractionation lab in the late 1970s, something that Picard identifies as a major contributor to the provision of tainted blood)⁹ I have selected 1981 as a starting point because it marks the year when American healthcare officials first recognized the possibility that a viral agent was responsible for an notable increase in previously rare diseases and immune disorders in gay men. Not long after, the American Center for Disease Control recognized that the disease was not limited to gay men, leading to creation of the term 'Acquired Immune Deficiency Syndrome,' or AIDS in 1982.

1981-1983

The realization that blood, blood product ('blood product' refers to separated components of blood, such as platelets or plasma) could be contaminated by a viral agent was first documented in 1981. In 1982, the United States Center for Disease Control (CDC) realized that Factor VIII

blood concentrate may have been contaminated with what is now known to be HIV (blood ‘factor’ refers to a clotting factor, a crucial protein component of blood that hemophiliacs lack; without Factor VIII protein, blood platelets do not form properly, preventing clotting). At the time, the unknown cause of previously rare diseases and disorders was termed Gay-Related Immune Deficiency or GRID, due to its noted prevalence in gay men.

Canadian health authorities took note of a warning issued in 1982 by the American CDC that blood and blood product was at risk of contamination. The CDC coordinated with Canadian health authorities to alert the Canadian Red Cross that hemophiliacs were at risk.¹⁰ At this point in time, reports trickled through the medical community of patients of all ages dying from symptoms similar to GRID. These patients were not limited to hemophilia patients and included people who had received transfusions in other circumstances. In response to the newly apparent threat to blood supply, medical professionals and authorities believed that by preventing the invectively termed ‘4-H Club’ from donating blood (the four Hs standing for hemophiliacs, homosexuals, heroin addicts, and Haitians),¹¹ the blood supply would be protected. However, this regime of prevention was not put into practice for reasons that are unclear.

In 1983, the Red Cross was advised to question those deemed to be high-risk donors (primarily gay men) at the time of donation. This regime of questioning was also not implemented. During the Krever Inquiry, when the Red Cross was questioned as to why this regime of questioning was not practiced, the Red Cross answered that “it was ‘concerned that it might offend donors.’”¹² This answer in essence blames gay community sentiment for the scandal. The actions of the Red Cross in the case of blaming the gay community reveal a culture of silence through efforts to shift responsibility for inaction onto the gay community during the scandal.

Canadian health authorities (these being the Canadian Medical Association and the Red Cross) worked to dispute the connection between AIDS, blood, and blood product by distributing pamphlets and issuing official advice that the connections were unproven and scientifically unsound.¹³ In addition to emphasizing deference and appeal to scientific certainty, Picard argued that Canadian blood authorities relied on a moralized understanding of AIDS and, through this understanding, defended the decision to do nothing in the face of mounting evidence of an epidemic because ‘bad’ people did not donate blood.¹⁴ This reasoning revealed a moralized expectation of the public to take responsibility for limiting the contamination of the blood supply and exempts the Red Cross from its responsibility to the public. Between these years, there were several other instances that suggest an avoidance of responsibility for a burgeoning disaster. The Red Cross was informed that a risk was present due to a virus; moralized regimes of questioning and prevention were suggested and not implemented; efforts were directed to dispute the scientific connection between AIDS and blood; and blame for failing to question donors was in effect shifted onto the gay community.

1984

In 1984, a meeting between representatives of “users, the manufacturers and the regulators of blood products,”¹⁵ as well as provincial representatives was held. During this meeting, a conclusion was reached that indicated a danger lurked in non-heat-treated blood product, and that heat-treating blood product ought to become the new safe standard for blood product treatment.¹⁶ However, the decision reached was that the switch to heat-treated product would wait until the backstock of non-heat-treated contaminated blood concentrate was worked through. Picard referred to this as a ‘consensus for inaction’¹⁷ and identified it as a major causal factor that exacerbated the distribution of contaminated product. Picard showed that, although the decision

to work through the backstock was influenced by bureaucracy and a lack of pushback from ministerial officials, the head of the Red Cross and the Canadian Blood Committee (CBC) made the key decision to avoid action:

The switch from non-heat-treated to heat-treated concentrate, he said, [‘he’ referring to Dr. Roger Perrault, head of the Red Cross at the time] would start May 1, 1985, and would take eight weeks. The delay was necessary, he said, to ‘deal with the inventory’, because neither the consensus conference nor the CBC had requested that it be written off. The executive committee of the Canadian Blood Committee approved the decision. They decided at the same meeting that the matter should remain quiet “to avoid the creation of concerns in hemophiliacs’ minds”. It was an odd approach to public health: people were going to be infusing AIDS-contaminated blood concentrate, and the principal concern of the deputy ministers of health was that they were not to worry about it.¹⁸

Here, I argue that this ‘consensus for inaction’ shows a clear avoidance of responsibility on the part of the CBC, the Red Cross, and public health officials. The decision to continue using blood and blood product that evidence confirmed was contaminated shows that the aforementioned actors in the provision of tainted blood.

1985

In the face of mounting numbers of patient deaths and infections, the fear of litigation was growing in the Red Cross.¹⁹ A program called ‘Operation 300’ was created to contact donors to test their blood for AIDS, and was designed with the purpose of limiting ‘the legal liability of the Red Cross.’²⁰ The program revealed conclusively that many hemophiliacs and other blood-transfused patients were infected.²¹ The Red Cross, “following legal advice, told donors the bare minimum about the implications of testing, and worried that outside doctors would tell all.”²²

The Red Cross began the trace-back program in mid-1985. The Red Cross recommended that the documentation of Operation 300 ought to be destroyed,²³ and only focused on tracing donors, and not tracing recipients. The damage wrought from an epidemiological myopia of a ‘wait-and-see’ approach combined with inaction when faced with evidence that the blood supply

was contaminated meant that recipients who were unaware of their infection passed the disease on in the interim to their children and sexual partners. When the parameters of Operation 300 were expanded to include recipients, the Red Cross and public health officials each claimed that the other organizations had the responsibility for contacting recipients.²⁴ I argue that these actions show an unwillingness of both the Red Cross and public health officials to act responsibly towards patients and the public due to a fear of litigation. The political dispute between the Red Cross and Ontario provincial health authorities shows a deliberate shifting of responsibility, and the order to destroy records further identifies the Red Cross as an actor avoiding responsibility in the face of scandal.

1987-1989

By mid-year of 1988, the Canadian Hemophiliac Society (CHS) compiled a summary of the scandal and provided it to federal authorities. The summary implicated the government in the scandal and asked for government compensation for the provision of tainted blood.²⁵ This summary included a CHS-built formula to be recommended to the federal government, which was to be used to decide who would be entitled to what compensation. This formula was rejected, and the amount of compensation was gradually reduced. According to Picard, the federal government considered “a lump-sum payment for ‘pain-and-suffering’”²⁶ to be out of the question, because such a payment “‘implied wrongdoing,’”²⁷ indicating an effort to dispute the attributions of responsibility levied against the Red Cross and public health officials. Additionally, the denial of pain-and-suffering denies the harmful effects of the scandal among members of the public.

The measure of compensation finally reached was titled the ‘Extraordinary Assistance Plan’ (hereafter the EAP), which would set aside \$150 million dollars for relief. On this plan,

victims would receive \$30,000 dollars a year for four years (the length of time the federal government expected it would take HIV-infected victims to perish), for a total sum of \$120,000. Victims would voluntarily sign up for the EAP and in doing so, waive their right to sue provincial and federal governments. The Red Cross was not included in the waiver signed by victims, in order to ensure that provinces could be assigned responsibility for the scandal: “[Perrin] Beatty [the federal Minister of National Health and Welfare at the time] refused to include the Red Cross in the waiver because it would absolve the provinces, who paid for the blood program, of financial responsibility.”²⁸ Silence became the adopted culture of the provinces, when, after a meeting between provincial health ministers, a decision was reached to remain silent towards the demands of blood activists and victims. Picard wrote that “the idea was that, if no province bowed to the demands of the victims of tainted blood, none would have to offer apologies or compensation.”²⁹ In this final section, I argue that silence is clear not just in the response to the pressure leveraged by blood activists, but also that responsibility was minimized in the limitations put upon victims in terms of litigation and compensation.

Case Study Conclusions

Picard attributed the avoidance of responsibility primarily to homophobia,³⁰ while I agree that homophobia was certainly present, not just in the responsabilization of the gay community but in context of general AIDS stigma and homophobia of the time, I think that the circumstances reflect a more general evasiveness towards accepting responsibility that is endemic to medical culture. Picard argued that “far too many doctors dealing with the new disease were too proud to refer their patients to specialists, and too patronizing and ethically wanting to tell patients of their diagnosis”³¹ which I suggest supports my claim that a general hesitance against imperfect medical care is a key factor underpinning a culture of silence that inhibits communication with

patients. To be sure, the argument can be made that AIDS stigma prevented doctors from sharing a diagnosis of AIDS with patients, which gestures to the homophobia that Picard suggests. However, solely blaming AIDS and Hepatitis C stigma for the avoidance of responsibility entrenches too easily the avoidance of responsibility in a particular timeframe, as opposed to seeing it as a pattern of conduct embedded in a culture (though I do not dismiss the continuing impact of AIDS and general disease stigma).

Picard called for an official apology and argued that the absence of an apology for the scandal would prevent the re-establishing of public trust in the blood system, and would not to speak to the issue of justice for victims:

refusing to apologize and refusing to investigate the possibility of criminal charges would leave a dark cloud over the blood system. It would leave doubt in the minds of the public, doubt that would hamper the rebuilding of trust in the volunteer donor system – doubt that justice had been done.³²

I strongly agree with Picard on this point. Particularly, Picard's suggestion speaks to the possibility of repairing dependent medical relationships, and in doing so, is congenial to the benefits medical culture could draw from an ethic of care through providing an apology.

The connecting feature linking medical personnel, the Red Cross, and public health officials during and after the scandal is a culture of silence that is revealed through an avoidance of responsibility. In 1982, the CMA and the Red Cross attempted to dispute and disrupt the connection between AIDS, blood, and blood product, in an effort to deny the reality that something was wrong with the blood supply. Further in 1982, a moralized conception of donors and the nature of HIV, in combination with decision making made to avoid offending the gay community shifted responsibility for protecting patients and the public away from the Red cross, and onto the gay community. In 1985, Operation 300 was implemented to limit the legal liability

of the Red Cross, reflecting a growing fear of litigation and a further evasiveness to responsibility. The development of the EAP passed through a regime of political wrangling by the federal government that twice took measures to limit how responsibility could be assigned for the scandal. First, the federal government rejected the CHS formula for compensation because it included funds for pain and suffering, language the government rejected because of the implied wrongdoing. Second, the federal government limited the construction of the EAP waiver to exclude the Red Cross, in order to preserve the financial responsibility of the provinces. These compensatory measures worked to dispute the nature of the scandal by limiting how the harms could be understood and responsibility attributed. Further, these measures worked to isolate and separate the Red Cross and provincial health ministries, despite them being connected through their combined silence during the scandal.

3.2.1: Responses to the Scandal: The Commission of Inquiry on the Blood System in Canada

In this section, I analyze the various responses to the scandal in order to further show how the Red Cross and other authorities strived to avoid responsibility. Responses to the scandal are varied in terms of their calls for retributive and/or restorative actions. A common element in each response is a call for responsibility to be taken or assigned for the scandal. The voices of victims are clear: responsibility must be assigned and assigned through legal mechanisms.³³ These calls for responsibility did not dissipate following the acquittal of Dr. Perrault and others.³⁴ The question of responsibility was also confronted by the largest and most involved response to the scandal, the Commission of Inquiry on the Blood System in Canada, commonly known as the Krever Inquiry, named for its head, Justice Horace Krever. The first moves towards an inquiry on the scandal came in late 1992, when the matter was raised in the House of Commons. The

Inquiry was formally recommended in parliament on 16 September 1993.³⁵ The Inquiry mandate instructed Justice Horace Krever to do a complete review of the blood system of Canada, including its regulatory and organizational matters, and the events that led to contamination.³⁶

Krever made clear the investigatory purpose of the Inquiry during the first days of public hearings, writing that:

It [the Inquiry] is not and it will not be a witch hunt. It is not concerned with criminal or civil liability. I shall make findings of fact. It will be for others, not for the commission, to decide what actions if any are warranted by those findings. I shall not make recommendations about prosecution or civil liability. I shall not permit the hearings to be used for ulterior purposes, such as a preliminary inquiry, or Examination for Discovery, or in aid of existing or future criminal or civil litigation. As I interpret the terms of reference, the focus of the Inquiry is to determine whether Canada's blood supply is as safe as it could be and whether the blood system is sound enough that no future tragedy will occur. For those purposes it is essential to determine what caused or contributed to the contamination of the blood system in Canada in the early 1980s. We intend to get to the bottom of that issue, let there be no mistake about that.³⁷

The following four contributions from the Krever Inquiry are particularly relevant to this thesis. First, the Inquiry identified structural elements of the Canadian blood system that have directly contributed to harms. In identifying these elements, the Inquiry shows that responsibility can be attributed to actors, even though this was not the purpose of the Inquiry. Second, the Inquiry identified that hesitation, inaction, and silence during the scandal were the predominant modes of conduct on the part of health care authorities and the Red Cross once it was known that the blood supply was likely contaminated. Third, the Inquiry mooted apology as a possible response to victims after the scandal but did not explicitly recommend one. Finally, the Inquiry concluded with several recommendations to change the blood supply system in Canada, several in particular to clarify lines of responsibility.

The Inquiry on Responsibility

Part of the Inquiry's focus was on the unclear nature of organizational responsibility during the scandal and its potential consequences for patient care. In 1994, Justice Krever appointed a Safety Audit Committee to determine the relationships between the Red Cross and the Canadian Blood Agency in order to ascertain their respective responsibilities. The Committee

concluded that responsibility for the blood system is fragmented...the various functions integral to the supply of blood, such as regulation, funding, and planning, are undertaken by different stakeholders. The respective functions, authority, and accountability of each party are not well defined...this lack of definition may affect accountability within the system, and ultimately its safety.³⁸

While clearly outlining that responsibility was unclear, the Committee succeeded in establishing the threat to patient safety, thereby removing any doubt that clear responsibility is directly connected to safe health care. Despite the difficulty of attributing responsibility that the Committee's findings may suggest, I argue that the Inquiry's findings on blood donor records and patient information establishes that though there were organizational and ethical obstacles to sharing information, the Red Cross, public health officials, HCPs, and hospitals are not excused from failing to properly trace donors and inform recipients.³⁹

In establishing that physicians, health care authorities, and the Red Cross did not have clear lines of responsibility towards each other and to patients, the Inquiry moved towards establishing the consequences for patient care. The Inquiry showed that unclear lines of responsibility towards patients contributed to a lack of communication among physicians, hospitals, and the Red Cross. The Inquiry took a normative stance in judging the actions of the Red Cross, public health officials, and hospitals, and stated that the failure to do so resulted in further infections. Further, the Inquiry all but condemns the inaction by these actors in establishing the urgent epidemic nature of the infection:

The notification of persons potentially infected with HIV through blood components ought to have been a high priority of the Red Cross, hospitals, and public health officials. Without knowledge of their infection, these persons were denied the opportunity of preventing infection of their sexual partners and of any children who might be conceived. They were also denied the opportunity of seeking treatment. Every infected person unaware of his or her condition could, moreover, infect others by donating blood. Given what was known about the infectivity of HIV through blood components and the latency period of the disease at that time, there should have been no doubt, from the summer of 1984 onwards, that there was a significant number of persons who had been infected with HIV from blood transfusions and who were unaware of their condition. Despite the clear urgency to inform those persons and to protect others who might be infected through them, the measures that were adopted were neither timely nor effective. This was an urgency that was apparent at the time.⁴⁰

The stance of the Inquiry in determining the urgent nature of the infections, as well as the failure of HCPs, public health, and the Red Cross to act on what should have been a priority establishes that responsibility can be assigned to these actors. The Inquiry further reveals that responsibility for notifying patients was shifted amongst authorities. In most provinces, public health officials imposed responsibility for notification of illness on physicians. In Alberta, provincial health authorities opined during testimony that “it was the responsibility of the attending physician and not public health to have informed the wives of hemophiliacs that they were at risk of secondary infection. Public health did not follow-up to ensure that spouses were notified.”⁴¹ Health authorities and testifying physicians stated that the intimacy of the doctor-patient relationship was particularly appropriate for tracing patient histories, and that the closeness of the relationships imparted a legal and ethical responsibility to further question their patients as to their sexual histories, drug use histories, and other aspects of life that would make them susceptible to AIDS. The testifying physicians also argued that the Royal College of Physicians and Surgeons had a responsibility to ensure that physicians were performing this duty, and that physicians should defer to this health authority should they encounter difficulty.⁴² I suggest that this testimony and the Inquiry’s finding support my argument that responsibility was viewed as

undesirable by actors, and as something that could be shifted amongst other actors implicated in the scandal. Additionally, the Inquiry's finding also shows that though complex, moral culpability and blameworthiness is attributable to actors for inaction.

The Inquiry on Apology

The fear that an apology would encourage litigation is noted in the Inquiry. The Red Cross, bound by its insurance policies to avoid making statements that could imply liability, initially refused to apologize to victims because it feared it would be held liable.⁴³ Eventually, the Red Cross would apologize, as shown in this chapter's second epigraph. Apologies were not universally dismissed. Internationally, the Inquiry noted that 'the Japanese government made a formal and public apology to persons infected.'⁴⁴ The apology in Japan was nuanced; executives of the Green Cross knelt and apologized to victims directly, while other involved corporations provided conditional apologies without an acceptance of responsibility.⁴⁵ Importantly, the apologies provided in Japan were a result of government investigation and civil suit, and were included alongside monetary civil compensation packages to victims.⁴⁶ Indeed, the government of Japan was the only government to apologize to victims.⁴⁷ The Krever Inquiry did not address the possibility that an apology ought to be a part of compensation packages during its examination of possible methods of compensating Canadian victims. I suggest that the culture of silence is clearly observable in the Red Cross' defence against apology through a fear of litigation, and not as an opportunity for relationship repair and the refinement of conduct. The Red Cross' defence against apologizing for the scandal reflects the fear of litigation and limited view of apology that is a key logic of a culture of silence.

The Inquiry's Recommendations: The Interim Report

Justice Krever submitted an interim report to the cabinet in early 1995. This interim report provided a series of forty-three recommendations that addressed many facets of Canada's blood system.⁴⁸ Krever eventually expanded the number of recommendations and refined them in the final Inquiry. I argue that because the interim recommendations and the final recommendations reveal gaps in responsibility between actors, they further implicate the Red Cross, hospitals, provinces, and HCPs as actors that can have culpability and share responsibility assigned to them. In the Interim Report, recommendations 32⁴⁹ and 33⁵⁰ urged the Red Cross to re-examine its record-keeping and trace-back programs for deficiencies. Recommendations 34,⁵¹ 35,⁵² and 37⁵³ urged hospitals to improve their record-keeping, and to take a more active role in contacting and facilitating contact with patients who, at the time, may have been infected. Recommendation 36⁵⁴ urged provincial and territorial governments to assist hospitals and physicians with the tasks of record-keeping and trace-backs. Recommendations 38,⁵⁵ 39,⁵⁶ and 40⁵⁷ tasked physicians and physician-governing bodies with asking questions of their patients regarding their personal histories of blood donation and blood recipiency. Recommendation 28 urged physicians to "allow the participate in a meaningful way in the decisions relating to the administration of blood and blood products."⁵⁸

The Inquiry's Recommendations: The Final Inquiry

The recommendations of the final Inquiry were mostly concerned with preventing future catastrophe through changing the administration and organization of the Canadian blood system. The first recommendation urged provinces and territories to create no-fault compensation schemes: "without delay, the provinces and territories devise statutory no-fault schemes for compensating persons who suffer serious, adverse consequences as a result of the administration

of blood components or blood products.”⁵⁹ Krever’s reasoning for recommending a no-fault scheme as opposed to an optional tort scheme stems from an averseness to creating a tiered justice system: Krever argued that a tort scheme would create a justice system where only some could afford to go to court.⁶⁰ The Inquiry’s final recommendations called also for the Canadian blood system to be unified and managed under one national, independent operator,⁶¹ whose administration would be publicly created through an Act of Parliament.⁶² The Inquiry called for clarity of authority through recommendation eight, which stated that “the authority for the operation of the blood supply system be clearly defined.”⁶³ The detail of recommendation eight is crucial, because it served to address the nebulous lines of responsibility revealed throughout the Inquiry and the Interim Report through a call for clear identification of the actor who will discharge safe health care to the public:

The decision maker or decision makers, whose identity must be clearly known, must be answerable for the decisions, and must be subject to appropriate sanctions for any failure to discharge the function satisfactorily. Decisions that affect safety are often difficult decisions. Frequently, they must be made in the face of incomplete data and can have repercussions in cost, supply, harm, and public dissatisfaction.⁶⁴

The recommendations of the final Inquiry clearly show that while attributing responsibility for the scandal is a complex issue, it is not an indeterminate one. However, per the fact-finding charge of Krever, the Inquiry was focused primarily on recommendations, and not on explicitly assigning blame to actors. Krever concluded that the decision-making process of authorities during the early days of the scandal lacked a focus on the urgent nature of health care crises:

The slowness in taking appropriate measures to prevent the contamination of the blood supply was in large measure the result of the rejection, or at least the non-acceptance, of an important tenet in the philosophy of public health: action to reduce risk should not await scientific certainty. When there was reasonable evidence that serious infectious diseases could be transmitted by blood, the principal actors in the blood supply system in Canada refrained from taking essential preventative measures until causation had been proved with scientific certainty. The result was a national public health disaster.⁶⁵

I argue that this conclusion further shows that the inaction of authorities implicates them as responsible for the continuation of harms during the scandal.

The Inquiry resulted in the suspension of the Red Cross from managing the Canadian blood system, and the creation of Canadian Blood Services and Hema-Quebec by federal authorities. Krever strikes an optimistic and empathetic tone in the final part of the report:

To the extent that we have indeed learned the lessons from the tragedy of the 1980s and reform the system as recommended in this Report, the likelihood that the tragedy will happen again will be markedly reduced. Low as the risk may be of infection with HIV and the hepatitis C virus from today's blood supply, it is almost certain that infection will occur. When it does, the few members of our society to whom the risk accrues and to whom the harm results must be treated more compassionately than their predecessors were, and they must be given suitable compensation without the necessity of proving fault.⁶⁶

Key in this passage is the call for an empathic response to victims. The call for empathy in this final passage is a noble effort to combat the social stigmas of illness, but it carries little impact with regards to altering the relationships between medical personnel and patients, as the Inquiry does nothing distinct to motivate medical personnel or health authorities to engage more empathically with patients.

My judgment of the Inquiry is that it succeeded in identifying where lines of responsibility were unclear and provided novel recommendations to dismantle and rebuild the Canadian blood system. However, I do not believe that the Inquiry explicitly showed how authorities and relevant actors capitalized on these unclear lines of responsibility to evade causal responsibility and moral blameworthiness. Indeed, Krever refers to the provision of contaminated blood as a 'tragedy' (recall that 'tragedy' refers to an event that is unavoidable or otherwise fated to occur) in both his statement of purpose of the Inquiry, and in the concluding paragraph remarking on the lessons learned from the catastrophe. I suggest that this indicates that

the sense in the Inquiry was that the provision of contaminated blood was unavoidable, perhaps due to the unclear lines of responsibility, whereas I am arguing that the accounts of the Krever Inquiry and Picard indicate that causal responsibility and moral blameworthiness is attributable to actors after the fact. Considering that the Inquiry was primarily a fact-finding mission, this is unsurprising. However, I have argued throughout this section that while determining responsibility for the scandal through the Inquiry's account is complex and difficult, there are enough points raised that show that actors can be implicated in responsibility for the scandal. Further, I argue that there is enough evidence shown in the Inquiry that reveals that there have been directed efforts by implicated actors to dispute, dismiss, and shift responsibility, indicating that responsibility is undesirable, reflecting a key logic of a culture of silence.

3.3.1: Pathologies of Governance

This section studies the 2016 text *The Tainted-Blood Tragedy in Canada: A Cascade of Governance Failures* by Gilles Paquet and Roger Perrault. In this section I argue that the arguments Paquet and Perrault leverage against the public understanding of the scandal, including public attributions of causal responsibility and moral blameworthiness, exemplify the culture of silence to the degree that responsibility is said to be hopelessly complex. Their suggestion that hopeless complexity prevents actors from having causal responsibility and moral blameworthiness attributed to them permits actors to evade responsibility by suggesting that clear lines of responsibility can never be conclusively outlined, and that any attempts to do so will end in vain. Important to note at the outset is that Dr. Perrault was the head of the Red Cross during the scandal, and as such held significant decision-making authority. He has faced significant social and legal backlash for his role during the scandal. Dr. Perrault, among others, has been investigated, tried, and exonerated for any criminal wrongdoing during the scandal.

As I argued in the last section, though the purpose of the Krever Inquiry was fact-finding rather than blame-attributing, its findings showed that the Red Cross, hospitals, public health officials, and HCPs acted imprudently in the face of catastrophe, and that the possibility of causal responsibility and moral blameworthiness was dismissed through an appeal to the complexity of the affair. My account of the scandal conflicts with Paquet and Perrault's dispute of the prevailing public understanding of the scandal and public attributions of responsibility. Paquet and Perrault's argument against the public understanding of the scandal is complex; in the first part of this section, I unpack Paquet and Perrault's argument, before moving into my critique of their argument in which I show that their arguments are reflective of a culture of silence.

Paquet and Perrault argue that the public understanding of the scandal (and to some degree, the integrity of the Inquiry itself) has been unfairly and irrationally skewed to produce a 'logic of indictment seeking.'⁶⁷ They argue that indictment seeking is the result of four social logics that describe a general lack of public knowledge on socio-technical systems, a general lack of public knowledge on the risks of making decisions when faced with uncertainty, a general public entitlement to demand that accidents are the result of someone's negligence, and a general disconnection between medical personnel and political representatives. Paquet and Perrault characterize these four logics as 'pathologies of governance,' which result in emotional and irrational⁶⁸ responses by the public, the media, victims, and politicians. Paquet and Perrault argue that these logics are practiced at the cost of a fair consideration of all the facts of the scandal, with which they argue disputes the contemporary narrative of the scandal and attributions of responsibility. Other key aspects of their argument are that a regime of appeals to emotion (stemming primarily from the Canadian Hemophiliac Society),⁶⁹ a lack of public

knowledge on how complex systems of governance work, a lack of public knowledge of how to respond to dangerous events, a lack of public knowledge on how to assign responsibility in complex circumstances, and a general adherence to a ‘culture of blaming’⁷⁰ have all convened to inhibit a proper interpretation of the scandal.

Paquet and Perrault argue that a logic of indictment seeking has conspired to transform the provision of contaminated blood from “crisis into tragedies, tragedies into scandals, and scandals into miscarriages of justice.”⁷¹ They argue that these pathologies of governance have resulted in unnecessary suffering by those accused of wrongdoing (such as Dr. Perrault) and the closing off of learning potential for how health systems may need redesigning following crises.⁷² Paquet and Perrault do not explicitly assign responsibility for the scandal; they instead argue that responsibility is nebulous, and that a combination of the imperfect internal dynamics of the Canadian Red Cross,⁷³ tensions between provincial governments and the federal government,⁷⁴ the tense relationship between the Canadian Blood Agency and the Red Cross,⁷⁵ and an attitude of precaution⁷⁶ inhibits a clear understanding of who was responsible for the blood system. Paquet and Perrault argue that the efforts of the Canadian Hemophiliac Society and blood activists created social conditions where the general public believed that there must be criminal charges levied against individuals,⁷⁷ and that these conditions have been created through a misuse of the contexts and circumstances listed above. For example, Paquet and Perrault suggest that “the precautionary principle has become part of the arsenal of interest groups, which have argued that not only should responsibility be personalized, but that lack of clairvoyance should be criminally indictable.”⁷⁸ Paquet and Perrault argue that advocacy groups, the CHS in particular, have misused⁷⁹ and misunderstood the nature of the complex circumstances of the

scandal. Further, Paquet and Perrault find that because the Inquiry did not explicitly clear the names of individuals targeted by the CHS,⁸⁰ the CHS has been successful in their efforts.

The final aspect of Paquet and Perrault's argument is that it is an example of faulty reasoning to expect that due to the scandal's occurrence, responsibility *must* be attributable to a person:

this presumption denies the possibility of any tragedy orphaned of a personalized responsibility – i.e., any possibility of systemic failure and systemic responsibility – and feeds a determination to establish a link between the tragedy and person or persons to be held responsible for it – whatever the circumstances.⁸¹

I put forward that this critique is representative of Paquet and Perrault's argument, and I begin my critique of Paquet and Perrault's argument with this claim at the center. I make three arguments about this claim in response. First, I argue that while this claim is initially logically persuasive, it de-emphasizes the connection between personal and systemic responsibility by framing the circumstances of the scandal in an and/or logic. There is no discernable reason as to why 'systemic failure and systemic responsibility' cannot exist alongside personalized responsibility and personalized failure in the context of the scandal, especially given the depths to which the Krever Inquiry researched in the abdication of responsibility. I suggest that due to the complexity of medical errors, it is much more likely that systemic failure and systemic responsibility occurs alongside personal failure and personal responsibility, and that medical contexts are especially congenial with an approach to apologies that acknowledges *both* personal and systemic responsibility. I argue that such a view is supported by Smith's complication⁸² of collective apologies that urges an approach that involves a recognition of personal and structural responsibility, and by the characterization of health care contexts by the former Institute of Medicine as being especially conducive to error due to personal and structural factors.⁸³ Given

this consideration, it is a much more difficult affair to argue for a categorization of the Tainted Blood Scandal as a purely systemic failure, ‘orphaned of personalized responsibility.’

Further evidence for the and/or framing of the scandal as a method of de-emphasizing the connection between personal and systemic responsibility in Paquet and Perrault’s critique is found in their critique of the Canadian Hemophiliac Society’s calls for responsibility. Paquet and Perrault argue that the calls to “reduce the complex blood governance to Roger Perrault – as the agent that might be held responsible for this catastrophe – is senseless and can only lead to a futile search that cannot hope to throw light on what generated a system failure.”⁸⁴ I argue that this argument is both a misrepresentation of the actions of the CHS, and a line of thinking that suggests a precarious conclusion that serves to support a characterization of the scandal as purely systemic. As evidenced by Picard, the CHS put pressure on the federal government to launch an Inquiry into the scandal, but there is nothing to suggest that its goal was to reduce the complexity of the scandal to a single person. If anything, given the weak support offered by the federal government to victims of the scandal, the Inquiry was a way of making sense of what happened (recall Krever’s own characterization of the Inquiry). Paquet and Perrault’s suggestion that the CHS believes Perrault is the single person that may be held responsible for the scandal is a reductive proposition that de-legitimizes the activism of the CHS. Further, their argument suggests a precariousness in the inability to discover the ‘true’ systemic cause of the scandal that is unsustainably supported by their argument suggesting that the actions of the CHS are myopic, when in reality, the actions of the CHS have been misrepresented.

My second argument is that because of the application of and/or logic rather than both/and logic and the dismissal of causal responsibility that involves both personal and systemic responsibility, the potential contribution of apology to address harms, and the possibility of

medical culture drawing from the benefits that care ethics offers for relationship repair is diminished. The endeavor to assign responsibility to abstract or non-human systems rather than assigning responsibility to people makes the identification of harms unclear, obscures what is being apologized for, and limits how responsible actors can engage with and repair their relationship with patients and victims. What results is a diminishing of the potential for, and impact of, apology. The consequence of diminishing the impact of apology is that the histories and consequences of harms go unrecognized, calls for justice or reparations may not be heeded or heeded in an unsatisfactory manner, dynamics of power may remain concealed or uninvestigated, harmful behaviour may continue, and dependent medical relationships originally premised on safe care are left in disrepair. What is not disputed through Picard's analysis, the Krever Inquiry, and by Paquet and Perrault themselves, is that harms were done to people during the scandal. However, Paquet and Perrault's evasion of causal responsibility through the suggestion that only systemic causes can have responsibility attributed to them for the scandal does several things. This evasion neuters the potential for relationship repair by denying the reality of the experience of victims, and that they are the moral interlocutors for the events of the scandal. As well, this evasion of causal responsibility precludes any possibility that taking responsibility and apology may re-establish and repair the connection between medical personnel and patients and families.

My final argument is that because of the de-emphasized connection between systemic and personalized responsibility and the diminished possibility and impact of apology, Paquet and Perrault's argument regarding the impossibility of personalized responsibility for the scandal is emblematic of the culture of silence through an evasion of responsibility. The dismissal of blood activism, the denial of the coexistence of personal and systemic responsibility as evidenced by

both Picard and the Krever Inquiry, and the appeal to expertise over the public suggests a multi-pronged effort to dismiss any avenue through which responsibility could be assigned to actors in the Red Cross.

3.3.2: The Scandal as a Wicked Problem

In this section, I examine another argument that Paquet and Perrault advance. Paquet and Perrault argue that the scandal is an example of a wicked problem, and that as such, public responses to the scandal are hopelessly inadequate. I have separated this examination into its own section due to the particularity of the critique. The definition on which Paquet and Perrault rely establishes wicked problems as having a high degree of social complexity, involve multiple groups or actors, have multiple interpretations by multiple groups or actors, may involve social and personal changes, and “have no definitive solution.”⁸⁵ I do not dispute the characterization of the scandal as a wicked problem. I rely on Picard’s account of the scandal as an authoritative account, as it reveals a high degree of complexity. Further, I suggest that the elements of the Krever Inquiry also support the characterization of the scandal as a complex event. For example, recommendation eight in the Interim Report of the Krever Inquiry recognized that discharging safe health care is extremely difficult, and has characteristics of a wicked problem in that solutions to the challenges of providing safe care may be unsatisfactory, and may not have a complete picture of the problem it is addressing:

The decision maker or decision makers, whose identity must be clearly known, must be answerable for the decisions, and must be subject to appropriate sanctions for any failure to discharge the function satisfactorily. Decisions that affect safety are often difficult decisions. Frequently, they must be made in the face of incomplete data and can have repercussions in cost, supply, harm, and public dissatisfaction.⁸⁶

While I do not dispute the characterization of the scandal as a wicked problem, I am critical of the way Paquet and Perrault wield such a characterization. Their use of the notion of wicked

problems is done in such a way that suggests that personal responsibility is impossible, and that society at large shares in responsibility for poorly comprehending the scandal. Paquet and Perrault conclude that after crises in which wicked problems occur, society cannot rely solely on changes to mechanisms of governance to address them; social and personal changes are also necessary to improve the collective social capacity to engage with wicked problems:

In the Tainted Blood Tragedy and in the case of other wicked problems, we seem to have a propensity to be satisfied with tweaking the management apparatus because it is the easiest thing to do. It may help, but one cannot get rid of the problem of governance failures only by tweaking the meccano. As we have said earlier, a new approach is needed to deal with current wicked problems. Until the sort of revolution in the mind allows this new approach to be in good currency, we will remain saddled with governance failures with which we are not well equipped to deal.⁸⁷

I must point out that their conclusion has some resonance with a theme of this study, that being a re-appraisal of what social steps have to be taken in order to promote apology. Recall that Tavuchis calls for a critical ‘reknowing’ of what apologies do and how they do it, and that the Oath of Maimonides privileges the discovery of knowledge through error. However, I argue that their characterization of the scandal as a wicked problem encourages the dismissal of personalized responsibility in several ways and is inconsistent with the rest of their argument. First, throughout their argument, Paquet and Perrault exclude interpretations of the scandal from the points of view of victims, the media, politicians, and the Krever Inquiry as incorrect, harmful to innocent health authorities, and skewed by pathologies of governance. However, this exclusion suddenly changes with their conclusion of the scandal as a wicked problem, which calls for a collective, inclusive social re-engagement with the ways in which we interpret wicked problems (recall that Paquet and Perrault gesture towards a societal failure to grapple with wicked problems and call for a ‘revolution of the mind’ to occur). I argue that this exclusion/inclusion dynamic accomplishes several things. One accomplishment is that the

dynamic attributes an all-encompassing responsibility to society to grapple with wicked problems, and in doing so, suggests a dilution of responsibility for the scandal. The second is that this dynamic maintains the distribution of power in medical relationships that underlines and powers a culture of silence and an evasion of causal responsibility by dynamically altering what an error is and what resolutions are acceptable. This maintenance of relationships of asymmetric distributions of power recalls Gilligan's considerations on the potential impact that power dynamics have on relationships, especially in terms of justification of the asymmetry:

In relationships of temporary inequality, such as parent and child or teacher and student, power ideally is used to foster the development that removes the initial disparity. In relationships of permanent inequality, power cements dominance and subordination, and oppression is rationalized by theories that 'explain' the need for its continuation.⁸⁸

Third, I argue that the call for a general social re-understanding of the scandal indicates that the victims of the scandal do not know the circumstances of their injury, and so cannot properly respond to the injury in a manner that is healing, fair, or just in the eyes of medical authorities. This view reflects the medical gaze, in particular, its paternal lack of confidence in the capacity of patients to engage with and understand their malady and their healing. Including victims in the call for re-understanding disempowers them through dismissing their lived experiences of harm and leaves the relationships through which the harm was provided throughout the scandal unexamined. Finally, Paquet and Perrault's characterization of the scandal as a wicked problem is logically precarious. If, by the definition of wicked problems on which they rely, wicked problems are characterized by 'paradoxical formulations'⁸⁹ from multiple actors, have no conclusive solution, then the complex accounts of victims, journalists, activists, and the Krever Inquiry must be valid. However, Paquet and Perrault dismiss these conclusions throughout their text, leaving their conclusion of the scandal as a wicked problem in jeopardy. This argumentative weakness is important to note, because it suggests that the logical

formulations are structured in such a way as to support the overall argument that causal responsibility and moral blameworthiness is impossible to attribute.

3.3.3: Paquet and Perrault's Recommendations and Conclusions

In this final section, I address the conclusions and recommendations that Paquet and Perrault reach that I argue are efforts to reinforce a culture of silence. Paquet and Perrault advocate for a systemic enterprise to avoid further health injury. To tackle the governance of uncertainty, they recommend transdisciplinary inquiries involving multiple worldviews, diverse sources of evidence, and an honest acknowledgement of uncertain or open-ended results.⁹⁰ To counter what they perceive as scapegoating perpetuated by the media, they recommend that a regime of 'professionalization'⁹¹ be adopted by journalists, though they do not deeply engage or speculate as to what this professionalization would look like. To confront the bureaucratic inefficiencies that contributed to the scandal, they recommend a neoliberal regime of competition between blood and blood product suppliers to develop better products and drive innovation, as well as a general privatization effort of these suppliers.⁹² To correct what they perceive to be a 'promiscuity' between official inquiries and lobby groups, they recommend "better safeguards to ensure total and complete separation among those different stages (from fact finding to indictment) to assure fairness to all parties, and to eliminate the possibility that public opinion and the whims of *pouvoir social* might ever again have an impact on the decision to indict."⁹³ I argue that none of these recommendations speak to the role of the Red Cross, individual HCPs, hospitals, and public health officials had in perpetuating harms during the scandal as evidenced by Picard and the Krever Inquiry. This further suggests that Paquet and Perrault do not conceive of responsibility as being applicable to any of these actors, or at least enough to warrant an explicit recommendation.

Paquet and Perrault reach two conclusions⁹⁴ regarding the impacts of the way they argue the scandal has been interpreted by the public. The first is that the public's ignorance of the exceedingly complex nature of the scandal has so personalized the scandal that there is no socially acceptable possibility that the scandal can be interpreted any other way. Second, they conclude that because interpretations of the scandal are limited to a scope of personalized responsibility, society is left with insufficient means of addressing the systemic causes of the scandal. Their first conclusion strikes a persecutory tone and suggests that the authorities that have had responsibility assigned to them deserve social exoneration. This conclusion is antithetical to apology through a rejection of any other understanding of events other than one that dismisses responsibility, in doing so limiting moral engagement with victims and a mutual establishment of events. Their first conclusion is very near a demand for forgiveness from victims and society in general and any such demand would, foundationally, not accept an account of events that engages and promotes an alternative view. Further, this conclusion is divisive rather than reparative; it seeks to embed the expert, authoritative account as the proper interpretation of events and dismisses any comprehension of events and attributions of responsibility from victims, the media, and the Krever Inquiry. In doing so, the conclusion precludes any possibility of a re-establishing of trust and repairing relationships between health authorities and patients.

When extrapolated, their second conclusion strikes a precarious tone and suggests that society is ill-prepared to address systemic events. I suggest that this is a false precarity; I suggest that Paquet and Perrault are suggesting instead that society is ill-prepared to address systemic events in a manner that defers to and exonerates authorities, in doing so, reifying dynamics of power between providers of care and patients and leaving responsibility in a permanent state of

obscurity. To apply this logic to society would be to suggest that the accomplishments of social movements in highlighting and addressing systemic and structural inequalities and injustices are perpetually obstructed by an ineluctable desire to condense responsibility to single actors, when this is simply not the case.

Predicting criticisms of their argument against personal attributions of responsibility, Paquet and Perrault argue that fairness and sophistication of method are the qualities that suffer should one criticize an effort to dispel the notion that personalized responsibility is possible:

any systemic analysis seeking to depersonalize responsibility for toxic outcomes has tended to be regarded by journalists and academics as a cop-out: not a fair and more sophisticated effort to analyze responsibility in complex circumstances, but as an illegitimate sleight of hand to avoid assigning blame to individuals that the uninformed but very agitated *magistrats de l'immediat* have already identified as their favourite candidate for indictment.⁹⁵

I argue here that by supporting a culture of silence through dismissing calls to personalized responsibility, power has been leveraged in a manner that seeks to maintain power disparities and dismiss legitimate complaints and attributions of responsibility. In undercutting the experiences of victims and the evidence put forward by Picard and the Krever Inquiry, I argue that 'fairness' as a quality has already decayed. And so, the argument that considerations of the scandal are universally either not fair or fair by negation (fairness hinging on *not* attributing personal responsibility) is a dismissal of evidence that suggests otherwise. Further, the argued threat against sophistication of method elides the fact that sophisticated and systemic addresses of responsibility that include personalized attributions of responsibility exist and offer manners of recourse that include or promote apology and relationship repair. Presenting the circumstances of the scandal in such a manufactured precarity does not do justice to the sophistication with which the scandal has already been studied.

Through this section, I have argued that logics that support a culture of silence shape Paquet and Perrault's argument for a diffuse conception of responsibility. As I have shown, their overall argument condemns and dismisses accounts of scandal from victims, the media, the Krever Inquiry, and advocacy groups as being uninformed, irrational, harmful to comprehending wicked problems, and unjustly vilifying of individuals. As I have shown, their arguments against public attributions of causal responsibility and moral blameworthiness reflect a culture of silence. The de-emphasizing of shared responsibility leaves little room for meaningful apologies and harms the potential for medical culture to share in the benefits of care ethics to address damaged medical relationships. Paquet and Perrault then offer their own version of diffuse responsibility for the scandal as a replacement. This logic of replacement reflects the concentration of power in medical authorities that is maintained by an unwillingness to confront errors on terms other than their own. Finally, their characterization of the scandal as a wicked problem is reasonable, but the conclusions they reach with it are unreasonable. Though their arguments dismiss the accounts of the scandal from alternative points of view, they reach a conclusion where society is drawn back into discourse to confront wicked problems in a manner that is deferential to authority and that leaves responsibility in an obscured state.

In this chapter, I outlined the Tainted Blood Scandal as an example of a large-scale medical catastrophe whose negative effects on caring medical relationships were exacerbated by responses and non-responses of doctors, medical authorities, and provincial and federal governments during and after the infectious period of the scandal. These responses were aimed at avoiding responsibility and limiting liability, reflecting behaviours that are emblematic of a medical culture of silence. Accounts of the scandal from Picard and the Krever Inquiry followed indicated that responsibility is attributable to public health officials, healthcare providers, and the

Red Cross, despite their efforts to dispute responsibility. Gilles Paquet and Roger Perrault argue that the general ignorance of the public, and the emotional uproar of victims and victim advocacy groups is representative of a pathological desire to attribute personal responsibility to the scandal where they argue none exists. In exploring Paquet and Perrault's arguments, I found that they relied on questionable logical decisions and antagonistic claims towards the media, the Krever Inquiry, victims and victim advocacy groups, and the general public. Further, I argued that their arguments serve to further dispute attributions of responsibility, and as a result, are further emblematic examples of a medical culture that is evasive to responsibility and evasive to apology.

Conclusion: Against Silence, Toward Apology

In this thesis, I studied the impacts and implications of the culture of silence on medical relationships after an error occurs. I made two central arguments in this thesis. First, I argued that the culture of silence has serious negative impacts on medical relationships and the provision of safe health care by obstructing responsibility and apology and by preventing the discussion and correction of conduct that led to the error. Second, I argued that the culture of silence should be replaced by a medical culture that promotes apology, empathy, and responsibility, a culture that I argue could draw from the particular emphases that care ethics places on responding to, maintaining, and repairing relationships.

In order to advance these arguments, I first established that apology is viewed as threatening by medical personnel, and as such, medical personnel are hesitant to apologize after a medical error occurs. The reasons for this hesitance are varied. Initially, it appeared that a fear of litigation is the predominant obstacle for apology in medicine, and this may at first glance appear to be supported by qualitative studies of medical error.⁹⁶ However, the advent of ‘Apology Act’ legislation in Canada, first introduced in British Columbia in 2006, shields the apologizer from having their apology used against them as evidence of liability or guilt. Even with ‘Apology Act’ legislation, medical personnel are still resistant to apologizing, a result that suggests that more than a fear of litigation is at work.

Silence in the face of errors plays a protective role and a preservative role for medical personnel. Silence might protect medical personnel from uncomfortable emotional dissonance following an error, might seem to prevent litigation, and might even preserve the illusion of perfection in medical practice that is used to preserve medical authority as traditionally understood. But silence is also directly harmful to patient-medical personnel relationships after

an error occurs. Avoiding disclosure, not apologizing for errors and providing poor quality apologies leaves patients and families in an upsetting communicative vacuum, damages their trust in health care systems, and prevents accountability, thereby precluding the possibility for learning from mistakes and growing from apology.

In the first chapter, *Key Pillars of Thought and Arguments for an Apology-Favourable Culture*, I investigated the sociological and philosophical aspects of apology and provided arguments in support of my claim that the culture of silence should be replaced. Through this investigation, I drew on apology scholarship to define apology as an expression of regret and acknowledgement of responsibility by an offender or offenders to an offended party or parties for an identified harm or harms done which, includes a promise to alter harm-causing behaviour for the future.⁹⁷ Through the literature, I established that apologies have various properties, including an affective core, and a dyadic structure, where a minimum of two groups (offender and offended) interact. Further, the literature showed that collective apologies are particularly complex. In instances of collective apologies, responsibility can be difficult to attribute due to actors capitalizing on the complexity of institutional settings to deny or dismiss causal responsibility or moral blameworthiness. This denial and dismissal of responsibility is particularly relevant to medical settings and institutions. Individual medical personnel are reluctant to apologizing due to the culture of silence, and as medical personnel are embedded in institutions, they can capitalize on the complexity of the circumstances of the error and shift blame to systems and/or institutions or claim that causal responsibility cannot be applied due to complex circumstances.

Next, I provided four subsidiary arguments in support of my claim that the medical culture of silence ought to be replaced by a culture that is favourable to apology in order to draw

from the benefits that care ethics offers to medical relationships. First, I argued that because of the overlapping emphases of care and the complex contexts of error, medical culture should be able to respond to errors by properly addressing these contexts. Because of the relational ontology of care ethics, it is an especially appropriate ethic to appraise and respond to instances of harm that damage relationships. Second, I argued that a medical culture that favours apology should replace a culture of silence to draw from the normativity of care ethics. Because care ethics is a normative ethic, it excels at providing recommendations for conduct and behaviour that is more amenable to responding to and repairing relationships. Third, I argued that a medical culture of silence should be replaced by a medical culture that favours apology in order to interrogate dynamics of power within medical relationships. The power dynamics that unfold in medical hierarchies are obstacles to the proper attribution of responsibility and are obstacles to apology. As I showed during my examination of power dynamics between different kinds of medical personnel (varieties of nurses, doctors, hospital authorities, etc.) during their experiences with medical error and apology, dynamics of power can have a detrimental effect on the potential and efficacy of apology. Because care ethics has roots in feminist ethical analysis, it is especially attuned to revealing and addressing dynamics of power within relationships. Finally, I argued that the medical culture of silence should be replaced in order emphasize and elevate issues of fairness, justice, and security that are imbricated in healthcare relationships. A medical culture that values apology can draw from contemporary developments in care ethics, specifically, Fiona Robinson's argument that issues of human security ought to include issues of health.

In the second chapter, *The Importance of Apology Against a Culture of Silence*, I provided three subsidiary arguments in support of my claim that a culture of silence has serious negative effects on healthcare relationships and presents risks for future patients by preventing

errors from being discussed and addressed by medical personnel. First, I argued that medical apologies are political, but are distinct from political apologies in two primary ways. In their namesake age, political apologies typically involve states or representatives apologizing in an official capacity for past atrocities or historical injustices. Medical apologies occur on smaller scales of discourse and involve emotions to a greater degree, due to the greater degree of intimacy involved in relationships of medical care. Importantly, there is a degree of institutional overlap between large-scale and small-scale apologies in that, hospitals, health authorities, and medical personnel can apologize as representative of large health systems. Medical apologies involve relationships with asymmetric distributions of power and are political insofar as they speak to manners of justice, manners of speaking, hearing, being heard, manners of recording events, identifying moral transgressions and harms, and establishing responsibility. Showing that medical apologies are political is important because doing so highlights the ways that institutions, authorities, and individual medical personnel are embedded in complicated systems of health care provision that require collective decision making in order to make systemic change, something that the culture of silence prevents.

Second, I argued that apologizing is beneficial to the moral and ethical development of healthcare providers by promoting moral engagement with patients, families, and other healthcare providers after an error occurs. In medical contexts, where power asymmetries have a direct impact on human life, ethical development takes on a key role in ensuring safety and security for patients and families. Here, I established that the internal hierarchical structures of power in hospitals have a direct impact on whether or not an error will be disclosed and prompt an apology. Typically, physicians possess power over nursing staff and over patients, though there are smaller differences in the role of medical personnel, such as senior nursing staff

possessing authority over junior nursing staff. As such, qualifying what an error is, determining and assigning responsibility for errors, and communicating information to patients and families are actions that face distinct levels of power that may inhibit the sharing of information. These power dynamics, combined with a culture of silence in medical settings, compromises the efficacy of team treatment, harming not only the possibility for apology and its benefits, by jeopardizing the health and safety of patients by obscuring the true cause of the error. Finally, I argued that promoting medical apology is important because it in turn promotes safer medicine by encouraging medical personnel to immediately address errors and take steps to prevent them for future patients. The medical culture of silence not only inhibits apologies, it also discourages even private discussion of the sorts of errors that might otherwise prompt apologies. The precarity I pointed to is that if errors are not being discussed and apologized for, then it is uncertain if medical practice is being refined in order to prevent the error from reoccurring.

The second chapter also examined the place of apology in contemporary medicine from several viewpoints. Literature⁹⁸ focused on patients, families, and medical personnel who have experience with medical error highlights the confidence and trust restoring, conscience clearing, and healing effects of apology. Further, literature⁹⁹ on medical error and disclosure suggests that patients desire that medical personnel openly disclose, take responsibility and apologize for errors in order to prevent them from reoccurring to other patients. Indeed, institutional strategies, such as morbidity and mortality conferences, are designed to facilitate the fearless discussion of errors amongst medical personnel. However, the fear of litigation and difficulty of admitting responsibility for errors prevents these strategies from being effective. Other strategies play into the hierarchical dynamics of power between medical personnel. Some nurses, for example, develop highly individualized strategies of admitting and digesting the error to themselves, but

not other colleagues and coworkers, due to a fear of reprimand or being seen as incompetent. While these strategies may temporarily ease the strain of having made a mistake, they do not involve or facilitate the meaningful discussion of errors and are not congenial to apology.

The third chapter, *The Tainted Blood Scandal*, examined the tainted blood scandal as a case where the actions of the Red Cross, health authorities, and individual healthcare providers reflected a culture of silence through their efforts to dispute, dismiss, and evade attributions of responsibility. The case study addressed the provision of contaminated blood in Canada between 1981 and 1990, an event commonly referred to as the tainted blood tragedy or tainted blood scandal. The period in which contaminated blood occupied space in Canada's blood supply was between 1981 and 1990, though intergenerational infection was also a result of contamination. The health catastrophe resulted in thousands of patients being infected with hepatitis C virus and HIV. The scandal resulted in calls for criminal prosecution, civil compensation, and a public inquiry, the Commission of Inquiry on the Blood System in Canada, commonly known as the Krever Inquiry.

The Krever Inquiry did not lay blame and focused solely on fact-finding and relaying recommendations. However, accounts of the scandal from both the Krever Inquiry and Andre Picard's book *The Gift of Death* relay the circumstances of the scandal in such a way that both responsibility for the scandal and a reluctance to take responsibility on the part of health authorities, the Red Cross, and medical personnel can be inferred. Through a reading of Picard's and Krever's accounts, I argued that a culture of silence is revealed in the actions of the CMA and the Red Cross during their attempts to dispute the nature of AIDS contamination of the blood supply and in the development of the EAP and Operation 300 in order to limit the legal liability of the Red Cross. The actions and inactions of provincial governments reflect efforts to dispute

and eschew responsibility for the provision of contaminated blood and the lack of follow-up with patients and donors, in addition to limiting compensation to four years in the hopes that victims would perish by then. The moralized view of blood donors and the homophobic responsabilization of the gay community by the Red Cross further shifted and blurred responsibility for the scandal. Finally, the culture of silence was shown on the interpersonal level via the hesitance of physicians to communicate diagnoses of HIV to their patients.

The recommendations from the Krever Inquiry emphasized establishing clear lines of responsibility through record keeping and governmental oversight of the blood system. In the initial absence of apology and absence of a declaration of responsibility, victim advocacy groups and patients were left in a communicative vacuum. The Inquiry concluded that clear lines of responsibility for maintaining patient and donor records of blood product reception were absent. Among other issues, economic logics of acceleration and privatization, poor decision making by Red Cross authorities, and silence in the face of poor diagnoses by physicians all contributed to catalyzing and amplifying the overall effect of the scandal. Victims and hemophilia advocacy organizations called for responsibility through legal and civil means. Through the Extraordinary Assistance Plan, provinces compensated victims, and Dr. Roger Perrault, the head of the Red Cross at the time, was acquitted of any criminal wrongdoing in 2007.

The second part of the third chapter of this thesis argued that contemporary dismissals of attributions of responsibility for the scandal from victims, families, and blood activists further reflects a culture of silence. In their book, *The Tainted-Blood Tragedy in Canada*, Gilles Paquet and Roger Perrault argue that the public conception of the scandal is incorrect, particularly in how responsibility is attached to figures who were intimately involved with the scandal in a decision-making capacity, such as Dr. Perrault. Paquet and Perrault argue that in general, the

public has developed a sense that expects that because a catastrophe occurred, personal responsibility must be attributable, despite systemic and structural influences. Terming these beliefs as ‘pathologies of governance’ Paquet and Perrault argue that the tragedy is just that: a hopelessly complex series of events, in which personal responsibility is impossible to determine, and that any attempts to do so result in the unjust vilifying of figures (such as Perrault) and restricting the possibility of learning from the affair how to deal with future catastrophes.

Paquet and Perrault claim that the scandal is so complex and the public too ignorant to make judgments of individual responsibility, including attributions of responsibility. This claim is part of a larger argument that in most cases blame for complex institutional errors, individual causal responsibility ought not to be laid. I made three counter-arguments against Paquet and Perrault’s argument. First, I argued that their claim de-emphasizes the connection between systemic and personal responsibility, despite there being no logical reason why systemic and personal responsibility cannot co-exist. Paquet and Perrault frame the scandal in an and/or logic, based on their interpretations of the work of the Canadian Hemophiliac Society, the conclusions of the Krever Inquiry, and the public address of the scandal. Second, I argued that Paquet and Perrault’s construction of the scandal as a scandal framed in an and/or logic leaves the possibility for apology as a caring response in an unsatisfactorily limited position. By claiming that non-human systems shoulder complete responsibility for medical errors, the human element of error making, including authorities in decision-making capacities, is elided from the process, and simultaneously, the potential for human redress and refinement is also lost. In these cases, human actors can express sympathy for harms experienced, but can avoid taking responsibility for them. The absence of establishing responsibility for offences damages the efficacy and quality of apology, and limits how offences can be discussed, disclosed, and conduct refined in the future.

Finally, I argued that Paquet and Perrault's consideration of the scandal reflects the influence of medicine's prevailing culture of silence—the culture that this thesis has sought to challenge by showing that apology offers a means of transformation by elevating the ethics of care—in several ways. First, their argument strives to dispute attributions of responsibility from victims, activists, and the public, and to instead diffuse responsibility among systems rather than human actors. Second, Paquet and Perrault's text is dismissive in that the experiences and conclusions reached by actors and entities other than themselves are not seen as the legitimate claims that they are.

A peculiarity occurs in Paquet and Perrault's argument and conclusion that I argued reflects the concentration of power in medical relationships. Paquet and Perrault argue, convincingly so, that the scandal is an example of a wicked problem, involving multiple actors, sets of experiences and interpretations, and multiple valid, if contradictory, conclusions are able to be reached. However, Paquet and Perrault dismiss the resolutions of the scandal from the point of view of victims, troubling the use of the concept of wicked problems. This dismissal is an exclusionary move. Yet, in their conclusion, Paquet and Perrault propose that a general social re-understanding of the scandal must occur, in terms of abandoning entitlement thinking, logics of indictment, and pathologies of governance. Further, this re-understanding is socially far-reaching, including victims, the media, and health authorities. This is a proposal that strives to include society as a whole. This proposal reflects an asymmetric distribution of power in relationships: particularly, the power to pathologize legitimate experiences and the political critiques of authorities, actions, and inactions following a catastrophe that stems from them, to evade responsibility and re-order the narrative of the event in such a way that makes it supremely difficult to assign responsibility. The result of this re-ordering is that apology becomes unlikely,

damaged medical relationships continue to suffer, and care and empathic responses following harms do not occur.

Apology is not a panacea for harms done. There is no apology that will undo the experience of harm following a medical error. There is no guarantee that an apology will be well-received. There is no guarantee that forgiveness will follow. Despite these caveats, there is a great deal of good that can be accomplished by engaging with patients in an empathic and caring manner after an error, rather than remaining silent. There is growth that can be achieved by taking responsibility for errors, and there is a higher level of safety and security in health care that can be practiced by fearlessly discussing and apologizing for errors. Shifting from a culture of silence to a culture that promotes apology would not be easy. Apologizing for errors, especially errors that have great impacts on the minds and bodies of others, is not an easy task, but it is an honourable one. In settings where care, in all its contexts and dependencies, lies at the foundation of engagement, apology is a route to better knowledge of the self, a route to better help for the other in need, and a route to a better honouring of the relationship in which each party enriches and draws from.

Notes

- ¹ “Blood Program: 1946 Until 1997-1998,” *Canadian Red Cross*, <https://www.redcross.ca/about-us/about-the-canadian-red-cross/blood-program-1946-until-1997-1998>: para. 11.
- ² David Spurgeon, “Canadian Red Cross Apologises for Distributing HIV Infected Blood,” *BMJ* 330 no. 7504, (2005), 1349.
- ³ Matt James, “Wrestling with the Past: Apologies, Quasi-Apologies, and Non-Apologies in Canada,” In *The Age of Apology: Facing UP to the Past*, edited by Mark Gibney, Rhoda Howard-Hassman, Jean-Marc Coicaud, and Niklaus Steiner, Philadelphia: University of Pennsylvania Press, 2008, 139.
- ⁴ Nick Smith, *I Was Wrong: The Meanings of Apologies*, Cambridge: Cambridge University Press, 2008, 167.
- ⁵ *Ibid.* 173.
- ⁶ Andre Picard, *The Gift of Death*, Toronto: Harper Collins, 1995, 60.
- ⁷ *Ibid.* 57, 71, 169-170, 210.
- ⁸ *Ibid.* 35: “The Red Cross, like Connaught, had the full support of the government, which, was willing to overlook problems to support Canadian agencies. The Red Cross also had an enviable contract, unwritten and open-ended; the provinces paid the bills, the agency answered to no one. In such an arrangement lay the seeds of the disaster that would strike the Canadian blood supply less than a decade later.”; 49-50.
- ⁹ *Ibid.* 97: “the politically driven decision to build Canadian fractionation plants and rush them into production – dismissing cryoprecipitate as an alternative – is probably the single biggest factor in the infection of hundreds of hemophiliacs with the AIDS virus.”
- ¹⁰ *Ibid.* 57.
- ¹¹ *Ibid.* 71.
- ¹² Horace Krever, *Commission of Inquiry on the Blood System in Canada: Final Report: Volume 1* Commission of Inquiry on the Blood System in Canada, 1997, 226.
- ¹³ Andre Picard, *The Gift of Death*, 64-66.
- ¹⁴ *Ibid.* 72.
- ¹⁵ *Ibid.* 104.
- ¹⁶ *Ibid.* 115.
- ¹⁷ *Ibid.* 116.
- ¹⁸ *Ibid.* 116.
- ¹⁹ *Ibid.* 141-142.
- ²⁰ *Ibid.* 141.
- ²¹ “Commemoration of the Tainted Blood Tragedy,” *Canadian Hemophilia Society*, <https://www.hemophilia.ca/commemoration-of-the-tainted-blood-tragedy/>.
- ²² Andre Picard, *The Gift of Death*, 143.
- ²³ *Ibid.* 144.
- ²⁴ *Ibid.* 147; 149: “with enough investments of time and money, many recipients could be found. For the next four months, Red Cross and Ontario public health officials dickered about who should be responsible for notifying the recipients of potentially tainted blood.”
- ²⁵ *Ibid.* 164.
- ²⁶ *Ibid.* 167.
- ²⁷ *Ibid.* 167.
- ²⁸ *Ibid.* 168.
- ²⁹ *Ibid.* 169.
- ³⁰ *Ibid.* 210: “Sadly, the chief reason that this ongoing abdication of responsibility was tolerated, or at least unchallenged, by bureaucrats, public health officials and politicians alike, was homophobia.”
- ³¹ *Ibid.* 223.
- ³² *Ibid.* 224.
- ³³ “Criminal Charges in Tainted Blood Scandal,” *CBC Digital Archives*, 20 November 2002, Duration: 6:10, <https://www.cbc.ca/archives/entry/criminal-charges-in-tainted-blood-scandal>.

³⁴ “Not Guilty, Says Judge in Tainted Blood Scandal,” *CBC Digital Archives*, 1 October 2007, Duration: 2:58, <https://www.cbc.ca/archives/entry/not-guilty-says-judge>.

³⁵ Horace Krever, *Commission of Inquiry*, Vol. 1, 5.

³⁶ *Ibid.* 5.

³⁷ Horace Krever, *Commission of Inquiry* Vol. 1, 8-9.

³⁸ Horace Krever, *Commission of Inquiry on the Blood System in Canada: Final Report: Volume 3* Commission of Inquiry on the Blood System in Canada, 1997, 1023.

³⁹ Horace Krever, *Commission of Inquiry*, Vol 1, 339: “The information required in order to notify recipients was spread among several sources. The Red Cross had information about donors who had tested positive to HIV-antibody tests. It had records of any prior donations from those persons and the names of the hospitals that had received the blood components from those donations. In provinces in which the reporting of AIDS was nominal, that is, in which cases of AIDS had to be reported to the government with the name of the person infected, public health officials possessed the names of persons diagnosed with AIDS who might have been blood donors. Hospitals, in theory, at least, possessed records identifying patients who had received blood components. Physicians possessed information from which patients could be located. If all these organizations or persons had kept sufficient records and had communicated with one another, it should have been possible to trace a large number of the recipients of contaminated blood transfusions. In practice, it was much more difficult.”

⁴⁰ *Ibid.* 364.

⁴¹ *Ibid.* 587.

⁴² *Ibid.* 576-577: “The testimony of public health officials in Nova Scotia, Alberta, and Saskatchewan characterizes the positions on contact tracing taken by some provincial public health departments before testing for AIDS was available. Both Dr Wayne Sullivan, the administrator of community health services in Nova Scotia, and Dr Pierre M. Lavigne, that province’s epidemiologist, said a patient’s physician had the primary obligation to trace the contacts. The doctor-patient relationship, particularly a long-standing relationship, was conducive to disclosure by the patient of the identity of persons with whom he or she had sexual relations, shared needles, or engaged in other conduct that placed these persons at high risk of infection with AIDS. These public health officials expressed the opinion that a physician had both a legal and ethical obligation to trace the contacts of his or her patient who showed indications of AIDS. Dr Sullivan said the ultimate responsibility for ensuring physicians met that obligation rested with the College of Physicians and Surgeons. Dr Lavigne said the provincial public health service had an obligation to ensure that contact tracing was carried out by the patient’s physician. Both agreed it was incumbent on the physician to ask for help from public health officials if he or she found it difficult to trace or counsel the partner or partners of persons with AIDS.”

⁴³ Horace Krever, *Commission of Inquiry*, Vol. 3, 1038: “The availability of insurance also affects the relationship between a manufacturer of inherently risky but essential products and a person injured by those products. Insurance contracts contain a standard clause preventing an insured party from admitting liability to a potential claimant. Policies for liability insurance normally contain a standard term to the effect that “[n]o admission of liability or offer or promise of payment, whether expressed or implied, shall be made without the written consent of the insurer, which shall be entitled at its own discretion to take over and conduct in the name of the insured the defence or settlement of any claim.” The Red Cross is contractually bound by its insurance policy not to make any admission of liability whenever a claim is made. Douglas Lindores, the former secretary general and chief executive officer of the Red Cross, agreed during his testimony that one of the reasons why the Red Cross declined to apologize to persons infected through blood components or blood products was that an apology might be construed as an admission of liability.”

⁴⁴ *Ibid.* 723.

⁴⁵ *Ibid.* 894: “In mid-March 1996, before a final settlement was reached, senior executives of Green Cross made a public apology for their role in the tragedy. They knelt and pressed their foreheads to the floor before several hemophiliac victims and their families in a televised news conference. The other four corporations issued written apologies, but did not accept responsibility.”

⁴⁶ *Ibid.* 893-894.

⁴⁷ *Ibid.* 723.

⁴⁸ Horace Krever, *Commission of Inquiry on the Blood System in Canada: Final Report: Appendices* Commission of Inquiry on the Blood System in Canada, 1997. Appendix H, 1131-1135.

⁴⁹ Ibid. 1134: "That the Canadian Red Cross Society review and revise its Standard Operating Procedures for trace-back and look-back to require that all donors and recipients are identified and tested where possible; and that revision specifically prevent the closing of an investigation upon the identification of a single positive donor in the case of a trace-back, or of a single negative recipient of an earlier donation in the case of a look-back."

⁵⁰ Ibid. 1134: "That the Canadian Red Cross Society conduct a review of the look-backs and trace-backs it has conducted to the present, and that it re-open and complete any which have been closed following the identification of one positive donor in the case of a trace-back, or of one negative recipient of an earlier donation in the case of a look-back."

⁵¹ Ibid. 1134: "That hospitals record information pertaining to blood and blood components administered to patients and retain these records indefinitely, and in a manner that they may be readily retrieved for the purposes of both the Canadian Red Cross Society's trace-back and look-back programs and the direct notification of transfusion recipients by the hospital."

⁵² Ibid. 1134: "That hospitals undertake reviews of their records in order to identify former patients who received blood and blood products between 1978 and the end of 1985; and that, where such records are still in existence, the hospitals directly notify these patients that they have received a blood transfusion, inform them about the risks of HIV infection, and provide counselling about the advisability and availability of HIV testing."

⁵³ Ibid. 1134: "That hospitals undertake reviews of their records in order to identify former patients who received blood products between 1978 and May 1990; and that, where such records are still in existence, the hospitals directly notify those patients that they have received a blood transfusion, inform them about the risks of HCV infection, and provide."

⁵⁴ Ibid. 1135: "That the provinces and territories take such action as may be necessary to permit hospitals access to census information, including current addresses, in the possession of their health insurance commissions for the purpose of locating recipients of blood transfusions."

⁵⁵ Ibid. 1135: "That physicians routinely question both new and old patients to determine whether they have received blood or blood products, and that such questioning should extend to illnesses and surgical procedures which might indicate a history of blood transfusion."

⁵⁶ Ibid. 1135: "That the bodies governing physicians remind physicians of the importance of taking blood transfusion histories from their patients, and that these governing bodies take such steps as may be necessary to make the taking of blood transfusion histories a standard of practice."

⁵⁷ Ibid. 1135: "That physicians routinely ask their HIV- and HCV-positive patients about the date and location of any blood donations; and that, if a patient has made a donation that poses a potential risk to recipients, the physician request the consent of that patient to provide information concerning the blood donation to the Canadian Red Cross Society for the purpose of locating infected recipients."

⁵⁸ Ibid. 1134: "That the discussion between the physician and the patient take place well in advance of the surgical procedure or blood therapy to enable the patient to employ some of the alternatives to an allogeneic blood transfusion, such as the advance deposit of autologous blood, and to allow the patient to participate in a meaningful way in the decisions relating to the administration of blood and blood products."

⁵⁹ Horace Krever, *Commission of Inquiry*, Vol. 3, 1046.

⁶⁰ Ibid. 1044: "An optional no-fault system would serve to limit the number of tort claims, but would not avoid the unpredictable outcome of tort actions or the inconsistent financial awards for blood-related injuries. More important, it would make possible for the development of a two-tiered justice system, one for those who can afford to go to court, and the other for those who cannot."

⁶¹ Ibid. 1049-1051. Recommendation 3, 1049: "It is recommended that Canada have a national system for the collection and delivery of blood components and blood products." Recommendation 4, 1050: "It is recommended that the core functions of the national blood supply system be performed by a single operator and not be contracted out to others." Recommendation 7, 1051: "It is recommended that the operator of the blood supply system be independent and able to make decisions solely in the best interests of the system."

⁶² Ibid. 1053: Recommendation 10 "It is recommended that the blood supply system be publicly administered by a national blood service, a corporation to be created by an Act of Parliament."

⁶³ Ibid. 1052.

⁶⁴ Ibid. 1052.

⁶⁵ Ibid. 989.

⁶⁶ Ibid. 1074.

⁶⁷ Gilles Paquet and Roger Perrault, *The Tainted-Blood Tragedy in Canada: A Cascade of Governance Failures*, (Ottawa: Invenire, 2016), 14: "Once the process of investigation is launched, the 'cascading logic' of the commission of inquiry, of the police investigation that often ensues, and of the offices of attorneys general brought into the file, often develops into a logic indictment seeking. This leads commissions in inquiry, police forces and the Office of an Attorney General (wittingly or not) to develop a 'mindset focused on getting and indictment', rather than (1) establishing the facts clearly and independently, and (2) determining whether the uncovered facts, in their totality, warrant an indictment to be brought forth."

⁶⁸ Ibid. 9.

⁶⁹ Ibid. 37-38.

⁷⁰ Ibid. 12.

⁷¹ Ibid. 9.

⁷² Ibid. 15.

⁷³ Ibid. 45.

⁷⁴ Ibid. 46.

⁷⁵ Ibid. 45-47.

⁷⁶ Ibid. 48.

⁷⁷ Ibid. 50-51.

⁷⁸ Ibid. 49.

⁷⁹ Ibid. 48: Paquet and Perrault characterize the Canadian Hemophiliac Society's activism as propaganda; "Since the 1970s, it has become the new norm in many areas to hold experts criminally responsible for not having been clairvoyant. Indeed, through the activism of lobby groups, like the Canadian Hemophiliac Society, this new norm has been propagandized and widely diffused in the media."

⁸⁰ Ibid. 52.

⁸¹ Ibid. 37.

⁸² Nick Smith *I Was Wrong*, 167.

⁸³ Institute of Medicine, *To Err is Human* ed. Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson (Washington: National Academy Press, 2000), 65-66.

⁸⁴ Gilles Paquet and Roger Perrault, *The Tainted-Blood Tragedy*, 39

⁸⁵ Ibid. 59: "Wicked problems evade clear definition. Rittel and Webber have defined them by a number of characteristics synthesized by Valerie Brown and further boiled down here as follows: they have multiple interpretations from multiple interest groups; they involve trade-offs between multiple goals that are often ill-defined and unclear; they have no definitive solution; actions on this front lead to unforeseen consequences; the means-ends relationships in the actions taken are not stable; they are socially complex; they rarely sit conveniently within a discipline or organization; tackling them involves changes in personal and social behaviour; they cannot be generalized outside their particular context; their formulation rests on paradoxes and calls for open inquiries."

⁸⁶ Horace Krever, *Commission of Inquiry* Vol. 3, 1052.

⁸⁷ Gilles Paquet and Roger Perrault, *The Tainted Blood Tragedy*, 68.

⁸⁸ Carol Gilligan, *In a Different Voice: Psychological Theory and Women's Development* (Cambridge: Harvard University Press, 1982), 168.

⁸⁹ Gilles Paquet and Roger Perrault, *The Tainted Blood Tragedy*, 59.

⁹⁰ Ibid. 60.

⁹¹ Ibid. 62-63.

⁹² Ibid. 63.

⁹³ Ibid. 66.

⁹⁴ Ibid. 73.

⁹⁵ Ibid. 73.

⁹⁶ Vivienne Nathanson, "Medical Mistakes: A View from the British Medical Association," in *Medical Mishaps: Pieces of the Puzzle* ed. Marilyn Rosenthal, Linda Mulcahy, and Sally Lloyd-Bostock (Philadelphia: Open University Press, 1999), 199-200; Stuart McLennan et al. "Apologies in Medicine: Legal Protection is Not Enough," *Canadian Medical Association Journal* 187 no. 5 (2015), 158.

⁹⁷ Nick Smith, *I Was Wrong*, 28-107.

⁹⁸ Danielle Ofri, *What Patients Say, What Doctors Hear* (Boston: Beacon Press, 2017), 143; Robert Truog et al., *Talking with Patients and Families About Medical Error: A Guide for Education and Practice*, (Baltimore: John Hopkins University Press, 2011), 44; Susan B. McIver, "Not a Children's Song," in *Medical Nightmares: The Human Face of Errors*, ed. Susan B. McIver, (Toronto: University of Toronto Press, 2001), 73; Aaron Lazare, *On Apology* (New York: Oxford University Press, 2004), 33-37; Aaron Lazare and Roselle Sherman Levy, "Apologizing for Humiliations in Medical Practice," *CHEST Journal* 139 no. 4 (2011), 749; Danielle Ofri, *What Doctors Feel: How Emotions Affect the Practice of Medicine*, (Boston: Beacon Press, 2013), 56; Nancy J. Crigger, "Always Having to Say You're Sorry," *Nursing Ethics* 11 no. 6 (2004); Patrice M. Weiss and Sandra Koch, "Medical Errors: Disclosure and Apology," *Contemporary OB/GYN* 57 no. 6 (2012), 44; Prue Vines, "Apologising to Avoid Liability: Cynical Civility or Practical Morality," *Sydney Law Review* 27 no. 3 (2005), 484; Prue Vines, "Apologies and Civil Liability in the UK: A View from Elsewhere," *Edinburgh Law Review* 12 no. 2 (2008), 206; Robert Truog et al., *Talking with Patients and Families*, 1-2, 31-33; Jennifer Robbennolt, "Apologies and Medical Error," *Clinical Orthopedics and Related Research* 467 no. 2 (2009), 376-377: "Apologies also have positive effects on expectations and intentions for a future relationship between the parties, play a role in restoring trust, reduce emotional reactions such as anger, induce favorable physiological responses in both parties, and reduce antagonistic responses."

⁹⁹ Sally Lloyd-Bostock, "Calling Doctors and Hospitals to Account," in *Medical Mishaps*, ed. by Marilyn Rosenthal et al. 112-113.

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