Letter to the Editor

Letter to the Editor: On Patient Safety: Do You Say “I’m Sorry” to Patients?

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To the Editor,

Many thanks to Dr. Lee [2] for his thoughtful article about physician apologies. His piece complements earlier editorials in *Clinical Orthopaedics and Related Research*® [3, 4] about the impact of physicians’ words to patients. The unifying theme among these publications is that—surprise—people like to be treated with respect, empathy, and courtesy.

(RE: Lee M. On Patient Safety: Do You Say “I’m Sorry” to Patients? *Clin Orthop Relat Res*. 2016;474:2359–2361).

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Empathy—the recognition that someone is a fellow human being—is essential to trust and cooperation. Indeed, after a surgical error, an apology from the surgeon to the patient can help both parties to heal [5].

Unfortunately, the converse is also true: The absence of empathy can exacerbate the harm that has already occurred. I witnessed a case of surgical errors compounded by poor communication from an orthopaedic surgeon. Following a set of serious complications that could only have occurred as a result of the procedure, including neurological and vascular injury due to implant malposition, the surgeon did not disclose the errors. When the errors came to light, the surgeon did not apologize. Instead, the surgeon discharged the patient from the orthopaedic service without referral to another surgeon. Only when the case reached the attention of the institu-

tion’s leadership did the patient receive an apology. A staff member who was not involved in the patient’s care issued a perfunctory apology, but the operating surgeon did not apologize. No one at the institution made any attempt at remediation or resolution, nor did they arrange for interim care or a referral.

A simple “I’m sorry” from the surgeon—the physician whom the patient had entrusted to perform a highly complex operation—might have restored the dignity of both parties. When a physician injures a patient and then denies that person the right to basic empathy, (s)he dehumanizes both of them.

“Transparency—especially when things go wrong—is increasingly considered necessary to improving the quality of healthcare,” Allen Kachalia MD, JD wrote in the *New England Journal of Medicine*. “By being candid with both patients and clinicians, health care organizations can promote their leaders’ accountability for safer systems, better engage clinicians in improvement efforts, and engender greater patient trust” [1].

In the aftermath of a medical error, surely communication should be regarded as a tool and not an obstacle.

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