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The Regulation of Apology in Healthcare:

Learning from GMC V Dr Pandian 2023

Abstract

The MTPS case involving Dr Nithya Santhanalakshmi Shunmugavel Pandian has sparked significant debate within the medical profession, particularly regarding the disciplinary process and its implications for international medical graduates, gender dynamics, and attitudes towards complaints. A noteworthy factor contributing to the strong reactions in GMC v Pandian is the 2014 implementation of a statutory duty on healthcare providers to be open and honest when medical harm occurs. This legal duty of candour complements existing ethical and professional obligations to maintain transparency and openness with colleagues and patients. This article reflects on the intriguing role of apologies, both inside and outside legal and disciplinary proceedings.

It is acknowledged that healthcare professionals often hesitate to issue apologies due to concerns about potential legal liabilities or substantial claims. In response to this challenge, legislators have introduced apology laws, creating 'safe spaces' where healthcare providers can apologise without necessarily admitting liability. Paradoxically, however, research suggests that these regulatory measures may discourage apologies and hinder honest communication regarding medical harm. Furthermore, incorporating apologies into legal frameworks may unintentionally strip apologies of their inherently humane and uncertain nature.

Keywords
Apology, healthcare regulation, GMC,

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Introduction

The recent case of the UK General Medical Council v Dr. Pandian in 2023 has sparked debates on the intricate relationship between apologies in healthcare, professional conduct, and medical ethics. The case, which revolves around allegations of professional misconduct against Dr Pandian, a junior doctor, and International Medical Graduate, provides the opportunity to reflect on the role of apologies and their complicated implications in the context of disciplinary proceedings. This article considers the nuances of the case to explore the ethical, social and legal dimensions of apologies in healthcare and reflects on the broader implications of the increased regulation of apologies for the medical profession.

GMC v Dr Pandian

On 5 May 2023, the Medical Practitioners Tribunal found Dr Pandian guilty of professional misconduct, on the balance of probabilities; on 10 May 2023 found her fitness to practice being impaired due to misconduct; and on 11 May 2023 suspended her for two months from the medical register. The allegations revolved around Dr. Pandian's having failed to carry out a physical examination on a patient and falsely recording that she carried out such an examination (Pandian MPT 11 May 2023). [1]

In its determination, the Medical Practitioners Tribunal referred to prior internal proceedings at the Kettering General Hospital Trust and to Dr Pandian's legal representatives' letter to her employer, which included an apology. The apology letter stated:

"1 - This is my routine practice that I always introduce myself before I meet a patient and I believe I did the same when I met Patient A. 2 - This is also my routine practice to document in the notes after I have completed my examination of a patient. After seeing Patient A's notes, I believe that I performed the abdominal examination and documented it in the medical notes. However, if Patient A feels that I documented this without examination then I sincerely apologise for all the distress that Patient A went through because of this." (letter of 13 Dec 2019, cited in MPT, 5 May 2023 para. 48).

During the MPT hearings, the General Medical Council (GMC) argued that Dr. P's apology "would only make sense if Dr. Pandian had not examined the patient," stating that the apology suggested an admission of guilt. However, the MPTS did not accept the GMC's interpretation, but considered Dr Pandian's clarification in her witness statement:

"I wish to make it clear that when I apologised to Patient A in my response to the initial complaint that was made to the Trust, my intention was to apologise for the distress caused to Patient A. I was not accepting any wrongdoing. I would not add a note to the patient record unless I had completed the examination. However, if the patient believed that I had done so this may have caused some distress for which I apologised." (MPTS 5 May 2023, para 49.)

The Tribunal also noted from Dr Pandian's testimony that *"she had sought advice from a consultant colleague who had advised that the normal process in these circumstances was to apologise for the distress caused to the patient."* (para 51). Whilst the MPT did not interpret Dr Pandian's apology as an admission, the GMC's attempt to use it as evidence of misconduct raises questions about the role of apologies in the conduct of healthcare and investigations of patient complaints.

Apologies, insight, and transparency

The case raises significant questions about the role of apologies and their use as evidence in patient complaints and disciplinary proceedings. It features the delicate balance between openness, accountability, and the implications of admitting to an error.

Dr Pandian's Rule 7 response to the internal complaint included, along with her apology letter, "denial of the allegations, and details of remediation, reflection and several testimonials." A letter to the GMC contained the following statements:

"Whilst Dr Pandian's practice is to document in the notes what has been done and recall that this would have been her practice on this day, there may, of course, be the possibility that on this occasion her high standards slipped due to extenuating circumstances, including workload and being on autopilot." […] "she appreciates that there is a potential possibility that her standard in maintaining good record keeping may have fallen short during this consultation. Dr Pandian accepts that if this did occur, it was a genuine error on her part and that it would have not been her intention to note inaccurate notes or in any way be dishonest." (MPT para 52)

Furthermore, the case refers to Dr. Pandian's reflection discussed during her annual appraisal (MPT para 55). These statements, and disposition to reveal her vulnerability, following the advice of legal representatives, resurfaced during the hearing, potentially to her detriment.

It is inherently human for one's high standards to occasionally slip due to extenuating circumstances or being on autopilot. And yet Dr Pandian insisted during the hearing in her oral evidence, was asked whether she does slip up, that she never does (MPT para 53). Reading the Tribunal's determination holistically, it appears that Dr P struggled to balance the demands of transparency and defensiveness. Her initial transparency was turned against her by the GMC, which suggested her apology implied guilt. In response, she distanced herself from the legal language of her initial response letter and adopted a more defensive attitude. This shift worked against her, the denial of any possibility of error making her appear less open to acknowledging the vulnerability inherent to all doctors. Consequently, her conduct was perceived as problematic by the MPT.

Considering all evidence, including note-taking protocols; the small time between examination and documentation; the examination form template; and applying the balance of probabilities, the MPT determined that Dr Pandian had not conducted a physical examination of Patient A (MPT Para 66). Furthermore, the MPT determined that Dr. Pandian knew that she had not examined when she documented otherwise (MPT para. 67. The MPT also saw Dr. Pandian's claim that she never makes mistakes as unrealistic and determined Dr Pandian's demonstrated a lack of insight (MPT Para 137).

Insight in this context can involve communication; probity; being honest about mistakes when things go wrong; and consulting with more senior colleagues. Dr Pandian had demonstrated these qualities; she apologised as advised, completed a battery of professional development courses, did ethics and probity training, and engaged in self-reflection and workplace-based assessments. One can query whether, in the circumstances, these various forms of review helped with patient safety and improved meaningful communication.

Confronted during proceedings with her apology possibly implying guilt, Dr. Pandian asserted that she does not make mistakes. Despite all her training and reflection, she insisted on her infallibility, and this led to the perception of insufficient insight and unrealistic views.

The MPT was of the view that Dr Pandian's reflection on her conduct was too general and did not address the specifics of her misconduct (MPT para 110).

The GMC's suggestion that an apology could imply guilt, in this case, sparked much discontent among doctors because it seems to conflict with its advice on 'Openness and honesty when things go wrong'.[2] The case has sparked other concerns among doctors. The case raises an array of concerns, including issues related to the differential treatment of international medical graduates and minority ethnic doctors in fitness to practice procedures; the function of note-taking and

record keeping in medical practice; the increasing and often uneven emphasis on subjective 'soft' and 'communication skills;' and gendered and hierarchical structures endemic to the profession. It is noteworthy that in this account of a sub-optimal care episode at Kettering Hospital, a junior doctor is foregrounded instead of more senior colleagues. The sole focus is on Dr. Pandian, while her consultant supervisor, who also did not examine the patient on that day, remains unexamined.

The dissection of minute details of Dr. Pandian's professional life and self-reflection on her practice stands in stark contrast with the resounding silence around the practice, supervision, and advisory role of her senior colleagues.

As a side note, it's worth mentioning that the case also serves as a reminder of an unfortunate history of medical dismissal of women's health complaints as the product of anxiety. One encouraging aspect of the MPT decision is the little weight it attributed to the fact that no harm came to the patient. Having concluded that the physical examination did not take place, the tribunal noted that the patient might have had a health problem which could have been detected during the examination and that Dr. P was not to know otherwise. Considering the broad reverberations of the case, it's essential to focus on the GMC's proposed role of an apology, what this might say about apologies and admissions of error in healthcare, and how the GMC will treat apologies in fitness to practice proceedings.

Apologies in Healthcare

To understand the role of apologies in healthcare fully, we must consider the broader context. This context includes the function of apologies in legal and non-legal settings. Apologies in the medical field have evolved significantly over the years.

In *How to Do Things with Words*, British philosopher of language J. L. Austin delves into the apology as a 'performative utterance.' 'It indicates that the issuing of the utterance is the performing of an action'. [3] Apology, in this context, is often described as a 'speech act' that is, an act that accomplishes its purpose once it is communicated.

Traditionally, the speech acts of apology belonged to the realm of private interactions, while the law was the domain used to resolve institutional and professional interactions. Professionals were often discouraged from expressing apologies as it might elicit legal liability, and lawsuits or massive settlements. The theory of legal formalism has created this dichotomy, under which the apology is seen in opposition to the law and therefore neither encouraged nor enforceable by it.[4] This dichotomy does not translate into apologies being inept or fruitless. This version of apology could transform relationships through a 'script', e.g. an acknowledgement of a wrong, followed by a response. However, this exchange occurred between parties and was not dealt with by law. Whilst we live in an age when public displays of apology and contrition feature regularly in the media, apology is still often framed as such, as a 'private act,' not being externalised and dealt with via legal regulation.

Under this formal, and impoverished, conception of law, the legal process is only relevant when relationships are alienated, making apologies unnecessary. However, richer, and more contextual understandings of law (such as those put forward by legal realists), instead conceive formal and informal law as 'radiating' through relationships[5] and influencing behaviours including apologies.

The concept of apologising does not feature massively in historical medical ethics texts. It is completely absent from the Hippocratic Oath. Nineteenth-century medical ethics paternalism stipulated not to discourage patients, and to avoid negative thoughts: The American Medical Association's first Code of Ethics from 1847 recommended physicians to be watchful of their words and behaviours, and "avoid all things which tend to discourage the patient and to depress his spirits".[6]

Modern medicine has undergone profound transformations, including the scintillation of

medical knowledge, with its emphasis on detailed documentation of both successes and errors. The professional commitment to learn from mistakes and reduce failure through peer-to-peer sharing and learning, and intra-professional openness has been amply documented by historians.[7–10] Sociologist Charles Bosk[7] has studied how errors were treated by colleagues and mentors in an American hospital. Technical mistakes were seen as inevitable and easily forgiven by peers, and junior doctors were encouraged to share them and learn from them without fear of sanction. However, normative errors, such as dishonesty, were much less easily forgiven. In contrast to relative openness between peers, there has been a historical aversion to similar levels of candour towards patients.[11] Due to fragile health, or diminished cognitive abilities, patients were shielded from the experts' acknowledgement of errors.

Transformations of Apology in Healthcare

Relationships between professionals and patients have since transformed over time, moving towards more transparency and openness, with calls for partnership-based relationships. Apologising for mistakes is considered part of this transformation and the improvement of healthcare relationships. The use of apologies has developed from being an ad hoc and exceptional way to deal with inter-relationships and disputes to being gradually institutionalised and translated into concrete normative guidance, such as Good Medical Practice, the NHS Resolution guidance, and the statutory duty of candour. Through this, it transforms from being an anomaly to gradually becoming a normative act well integrated into daily professional practice. Writing in the context of public health context Alberstein and Davidovitch[4] point out that at the normalisation stage, problems of loss of faith in apologies and co-optation can emerge.

This transformation of apology into a more systematic component of ethical and professional conduct has challenged the traditional opposition between apology and law. Furthermore, contemporary ethical perspectives see apologies positively from both deontological and utilitarian standpoints. Apologies are conceived as a moral duty, the right thing to do. They are also motivated by utility concerns, as they are believed to enhance the overall quality of patient care and safety.[12] Contemporary principalist biomedical ethics [13] support truth-telling including error disclosure based on principles like respect for autonomy, non-malfeasance, and beneficence. Consideration for patient autonomy suggests patients have a right to make informed healthcare decisions, which necessitates knowledge of events affecting their health. Acknowledgement of harmful errors helps patients avoid related future injury, aligning with non-malfeasance, and improving their future health, demonstrating beneficence. In addition, the acknowledgement of errors by clinicians aligns with the principles of truth-telling and respect for persons.[14] The UK Supreme Court case *Montgomery v Lanarkshire Health Board*[15] UKSC 11 has reinforced the importance of ongoing, engaged dialogue between patients and clinicians.

Contemporary regulation of apologies

Contemporary apology laws aim to enable and encourage apologies by shielding healthcare providers from their legal consequences. These laws make healthcare providers' apologies to patients inadmissible in future potential malpractice or disciplinary claims. The idea is that by removing the legal threat of apologies, healthcare providers will be more transparent about their work including their mistakes, thus improving communication with patients and relatedly, patient experience. In turn, better communication is believed to reduce complaints by patients and their families, litigation, and references to the professional regulator, aligning with the utilitarian principles mentioned above.

However, these current approaches highlight the individualistic perspectives on medical apologies and overlook the history of collective, cultural, and organisational aspects of public health apology, which can enrich our understanding of clinical apology.[4] Public health concerns tend to emphasise prevention and future-oriented thinking. Apologies by organisations, public bodies and nation-states in public health contexts are looking into the

future, aiming to prevent harmful conduct from recurring. In addition, public apologies are often symbolic acts, essential to implement social healing and rehabilitation. Drawing analogies from public health contexts can enlarge the meaning of apology beyond efficiency concerns and anxiety over dispute settlement and admission of professional misconduct, touching upon broader notions of professional conduct and public accountability.

Regulating and bureaucratising apology

Regulated apologies, which aim to deactivate legal consequences and promote amicable resolutions, may appear as a win-win proposition at the outset. However, delving deeper into the realm of regulated and bureaucratic apologies reveals a more nuanced perspective.

Under a regulatory framework, apologies can transform into mere formalities and resemble a 'box ticking exercise' aiming to fulfil a bureaucratic function. Apologies can be 'performative' in a different way than J.L. Austin had suggested: they can become performative in the sense that those who make them can show they have been made.[16] The words can be carefully selected by lawyers to ensure that the apology does not do too much, say too much, or reveal too much. [16,17] A person could apologise for a wrong in a way that precisely frees them from the effect of committing that wrong.

The latter addresses frontally the institutional value of apology and apology's suitability for the professions and professionalism. In adversarial contexts, advice and counselling can aspire to support doctors asking for advice, but it can also be motivated "by the need to maintain the good name of the collective – the profession as a whole" [18] and can therefore be envisaged as "a form of internal, informal, social control within medicine." The multiple purposes of apologies underscore the need to disentangle apology from its role as a legal resource and foreground the relational nature of apologies.

The apology as a relational act

Understanding apologies as relational acts underscores the importance of making moments of complaint and response more meaningful and less adversarial. Apologies are never standalone utterances; they are always intimately bound to the web of relationships that precede and follow them. Apologies exist within a broader context of doctor-patient care and historical experiences with the healthcare system. Several factors come into play, such as the identity and experiences of the apologizer and the receiver of the apology, as well as the historical context of medical injustices in certain communities.

Berlinger's ethics of forgiveness highlight that disclosure and apology require more than knowledge of professional norms; they require relinquishing control and placing the reins in the hands of those at the receiving end of the apology.[14] Disclosing and apologising put clinicians somehow at the mercy of those who suffered medical harm. This act of apology in no way obligates patients and families to forgive those responsible for the harm inflicted. This is a risky endeavour, demanding vulnerability, and humility.

To translate this framework into practice, the principles of public health prevention and policymaking must be integrated into the process of apology for medical errors. This entails the active participation of all affected parties to construct a meaningful apology. In turn, apology training must not focus on a one-size-fits-all textbook approach to be followed universally. Apology awareness ought to reach beyond ordinary abstract conceptualisation and legal considerations. Whilst the focus has so far been on utterances of apology, interlocutors such as nurses, patients themselves, and their family members ought to be depicted and heard too. Apology, as Berlinger suggests, is a 'total response' that necessitates the engagement of others. Whilst this total response is risky, uncertain, and challenging, it requires virtuous action genuinely and necessarily.

Conclusion:

GMC v Dr Pandian 2023 prompts a critical examination of the role of apologies in healthcare, and their treatment during disciplinary proceedings. It draws attention to the need for healthcare professionals to navigate the complex terrain of transparency, accountability, and legal implications carefully. This case can catalyze discussions on how apologies are perceived and utilised in healthcare, and more speculatively, an opportunity to reconsider the broader implications of apologies for the medical profession and the conduct of care.

The evolving landscape of medical ethics, which now places a greater emphasis on truth-telling, patient-centred care, and open communication, calls for a nuanced understanding of the role of apologies in healthcare. The regulatory framework has deactivated some of the legal risks of apologies for healthcare professionals, but in doing so it has not necessarily encouraged more honesty in doctor-patient relationships. Regulating apologies may have bureaucratised apologies and stripped them of their inherently relational and uncertain nature.

References

1. Dr Nithya Santhanalakshmi SHUNMUGAVEL PANDIAN May 23. https://www.mpts-uk.org/hearings-and-decisions/medical-practitioners-tribunals/dr-nithya-santhanalakshmi-shunmugavel-pandian--may-23.
2. Openness and honesty when things go wrong: The professional duty of candour. https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/candour---openness-and-honesty-when-things-go-wrong.
3. Austin, J. L. *How to Do Things with Words: Second Edition*. (Harvard University Press, 1975).
4. Alberstein, M. & Davidovitch, N. Apologies in the Healthcare System: From Clinical Medicine to Public Health. *Law Contemp. Probl.* **74**, 151–175 (2011).
5. Fokas, E. & Anagnostou, D. The “Radiating Effects” of the ECtHR on Social Mobilizations Around Religion and Education in Europe: An Analytical Frame. *Polit. Relig.* **12**, S9–S30 (2019).
6. Ross, N. E. & Newman, W. J. The Role of Apology Laws in Medical Malpractice. *J. Am. Acad. Psychiatry Law* **49**, 406–414 (2021).
7. Williamson, R. Forgive and Remember: Managing Medical Failure, 2nd edition. *J. R. Soc. Med.* **97**, 147–148 (2004).
8. Medicine in the Making of Modern Britain, 1700-1920. *Routledge & CRC Press* https://www.routledge.com/Medicine-in-the-Making-of-Modern-Britain-1700-1920/Lawrence/p/book/9780415091688.
9. Wilde, S. Truth, trust, and confidence in surgery, 1890-1910: patient autonomy, communication, and consent. *Bull. Hist. Med.* **83**, 302–330 (2009).
10. Kelly, C. & Quick, O. The legal duty of candour in healthcare: the lessons of history? *North. Irel. Leg. Q.* **70**, 77–92 (2019).
11. Katz, J. *The Silent World of Doctor and Patient*. (Johns Hopkins University Press, 1984).
12. Mastroianni, A. C., Mello, M. M., Sommer, S., Hardy, M. & Gallagher, T. H. The flaws in state ‘apology’ and ‘disclosure’ laws dilute their intended impact on malpractice suits. *Health Aff. Proj. Hope* **29**, 1611–1619 (2010).
13. Beauchamp, T. L. & Childress, J. F. *Principles of Biomedical Ethics*. (Oxford University Press, 2001).
14. Berlinger, N. *After Harm: Medical Error and the Ethics of Forgiveness*. (Johns Hopkins University Press, 2005).
15. Court, T. S. Montgomery (Appellant) v Lanarkshire Health Board (Respondent) (Scotland) - The Supreme Court. https://www.supremecourt.uk/cases/uksc-2013-0136.html.
16. The Cultural Politics of Emotion. *Edinburgh University Press Books* https://edinburghuniversitypress.com/the-cultural-politics-of-emotion-772.html.
17. Taft, L. Apology Subverted: The Commodification of Apology. *Yale Law J.* **109**, 1135–1160 (2000).
18. Allsop, J. & Mulcahy, L. Maintaining Professional Identity: Doctors’ Responses to Complaints. *Sociol. Health Illn.* **20**, 802–824 (1998).