The Art of Truth Telling: Handling Failure With Disclosure And Apology

Executive Summary

- How the leader handles failures determines how people perceive the true character of the leader.
- The power of transparency and apology is an option that leaders haven’t universally embraced as rapidly as clinicians.
- However, there is a plethora of information that tells us there is almost magic in the power of the process of truth telling and apology.
- There are sentinel events and near misses associated with leadership and management, as well as the clinical process of health care.

As leaders, we would like to believe that we don’t make mistakes. Leaders are not immune from errors and failures any more than clinicians. Every leader and manager faces failure in varying forms throughout their careers. Failure is inevitable but is also a daunting opportunity to learn and grow. It is more common now to listen to clinicians discuss their errors openly in root cause analysis, but it is uncommon for leaders to openly expose their errors to the transparency of a root cause analysis.

How the leader handles failures determines how people perceive the true character of the leader. We have the choice every day of handling our mistakes openly and honestly and offering an apology, or we can be fearful to disclose, remain silent, and create a perception of lack of integrity. The choice is ours. The power of transparency and apology is an option that leaders haven’t universally embraced as rapidly as clinicians. However, there is a plethora of information that tells us there is almost magic in the power of the process of truth telling and apology.

The Failures of Leaders and Managers

As leaders, we have many opportunities to err. For example, budgetary and staffing error can happen by the slip of a pen or a keystroke. We can communi-
cate what we believe to be the truth, only to find out later that we lacked the right information. We can offend people inadvertently by our communications. We can make an incorrect decision about a project and implement a program that later fails with costly consequences to retention and turnover. And we can decide to choose a wrong product. We can also be faulted for not using the available evidence when we make decisions (a major failure). We may make decisions that put patient care at high risk, such as not using evidence for staffing decisions or patient and staff safety programs. Leaders and managers must also take responsibility for errors that happen on their watch, for which they may not have knowledge, but for which they are ultimately responsible. And the list goes on.

We can arbitrarily categorize the failure of leaders and managers into three areas: failure by omission, failure by commission, and failures of the people for whom they are responsible. Failure of omission occurs when leaders do not act or communicate important information. They know about a situation, but fail to speak up or intervene. We know of situations where leaders are afraid to speak up to their peers, staff, or boss because they fear the consequences. Their silence leads to a lack of trust and integrity. Leaders miss an opportunity to demonstrate courage, integrity, and living by their values when this happens. Failing to deal with a difficult employee or intervene in a toxic environment leads to failure when the leader chooses to employ the “head in the sand” response. Failure by commission indicates that a purposeful act has caused the failure with consequences to an employee, patient, or to the organization. A ban on overtime that results in inadequate staffing and patient harm is an unintended consequence resulting from a leader’s commission of an act. The third type of failure is that for which the leader has no direct involvement but is accountable because it is within her/his area of responsibility. Serious patient errors, such as the death of an employee by accidental electrocution from a faulty electrical connection, disclosure of confidential patient records by a staff member, or embezzlement are examples of failures for which leaders must take responsibility, even though they are not directly involved and had no prior knowledge.

Nurse leaders must take the lead from clinical practice and move from an era of cover-up and nondisclosure to a culture where errors can be discussed openly with staff, patients, and families. We have learned how to handle mistakes with patients...
much better through disclosure and apology. Isn’t it time to apply that same science to the mistakes of leadership?

**Responding to Failure**

Recognizing and responding to failure are never easy. The best defense is a strong and thoughtful process, articulated and rehearsed, that the leader can follow when failure occurs. The Harvard teaching institutions have developed a consensus statement for use at the Harvard hospitals (Massachusetts Coalition for the Prevention of Medical Error [MCPME], 2006) that provides a template for helping leaders to respond consistently and ethically to medical errors. Their premise is that “Prompt compassionate and honest communication with the patient and family following an incident is essential” (MCPME, 2006, p. 6). Their recommendations are a four-step process to tell the patient and family what happened, to take responsibility, to apologize, and to explain what will be done to prevent future events. In spite of the fear of attorneys that disclosure and apology will lead to escalated malpractice claims, the MCPME offers evidence to the contrary. The power of the apology opens up a new world of positive negotiations and healing on the part of the patient and the family as well as the caregiver.

**The Power of Apology**

Elton John reminds us in one of his songs that “sorry” seems to be the hardest word for us to say. In health care, we have been uncomfortable with disclosure, admitting our mistakes to patients and families, and apologizing. The approach can spill over to leadership and make it difficult to disclose bad financial outcomes, failure of projects, etc. to our staff, peers, and bosses. Just as we are learning that disclosure and apology are strong forces with patients, it is also true in leadership.

Lazare (2004) reminds us that there are cultural perceptions about apologies. The Japanese perceive apologies as acts of submissiveness and humility while Americans perceive them as sincere acts that signal a new beginning. Lazare (2004) posits four parts of the process of apology: acknowledgment, remorse, explanation, and offering reparation or reconciliation. An apology can be the opening act of an opportunity for negotiation when these steps are followed.

Apology as a potent social force can promote dialogue, tolerance, and cooperation between groups, according to Barkan and Karn (2006). If we applied this to interactions between doctors and nurses, new graduates and experienced nurses, and unions and managers, we could open new avenues of mutual understanding by taking wrongs seriously.

Blanchard (2003) tells the story of a leader who believes he must apologize for the unanticipated poor financial performance of his company, and then teaches this process to a new leader. Blanchard names the apology as the fourth essential secret of effective management. His thesis is that the act of an apology increases employee morale and the perception of the leader’s integrity (Blanchard, 2003).

Finally, Woods and Star (2004) apply the power of the apology to prevent lawsuits and promote healthy healing in physicians, patients, and families. Pandya and Shell (2005) examined characteristics of 25 top business leaders and concluded that truth telling was one of the key attributes of the top leaders. They provide examples such as the contamination of Tylenol® where the leaders’ ability to quickly and swiftly admit to the error, take action swiftly, and apologize made a positive difference for the company. This is not a new example. Why haven’t we incorporated this mistake protocol successfully throughout health care?

**Care of the Leader**

Leaders are not supposed to make mistakes. We set them up as perfect. When leaders falter, it not only shakes the faith of their people but also of the leader. Just as clinicians suffer from post-traumatic stress syndrome, so do leaders. Learning to use the four-stage protocol of handling error provides the clinician and leader with a roadmap for guidance through a difficult journey. Just as no clinician should suffer alone when bad things happen to patients, leaders and managers should also have that support and turn the failure into a learning experience. Disclosure and apology works for leaders as well as clinicians.

**Summary**

There are sentinel events and near misses associated with leadership and management, as well as the clinical process of health care. We should hold ourselves accountable to the same level of rigor and analysis of these events and near misses as we expect from clinicians. Research and analysis will continue to help us understand the science behind the power of truth telling and apology.

**REFERENCES**


