Moving Beyond 'Sorry': The Acknowledge-Repair-Prevent (ARP) Framework for Colleague Apologies in Medicine

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Abstract

Apologies to patients are institutionalized in medicine, driven by ethics, training, and apology laws aimed at reducing malpractice risk. Yet apologies among colleagues—clinicians, administrators, and staff—remain rare, despite frequent harms from hierarchy, bullying, and dismissive interactions. Drawing on personal primary care experience and workplace conflict literature, this perspective highlights the cultural and structural barriers to inter-colleague remorse. It critiques existing apology models for lacking prevention and proposes the novel Acknowledge–Repair–Prevent (ARP) framework, which incorporates restorative justice principles to shift from retributive (power-focused) dynamics to shared accountability. Implementing ARP could rebuild trust, mitigate burnout, and foster profound respect for colleagues in a demanding profession.

Keywords: ARP framework, colleague apologies, workplace conflict, restorative justice, medical hierarchy, professional accountability, healthcare burnout, physician wellness

Introduction

When clinicians err with patients, saying "sorry" upholds truth-telling, expresses compassion, and is widely viewed as an ethical obligation [1]. It shows respect and humanity toward those we serve.

But what about harms to colleagues? Administrative oversights, bullying, disrespectful comments, and failures of support injure coworkers daily—yet apologies are scarce, especially across hierarchy. In my career, physicians rarely apologize to each other; administrators, in my experience, never do. This silence persists despite innumerable ways in which words and actions harm peers: arrogance stemming from subspecialty training, public dismissal of valid concerns, or abandonment in crisis.

Patient apologies are mandated and protected; colleague apologies lack equivalent support. This perspective examines the disparity, its costs, and a practical remedy: the Acknowledge–Repair–Prevent (ARP) framework.

The Workplace Toll of Unaddressed Harm

"Healthcare conflict is prevalent and potentially damaging. In a large ICU study, over 70% of staff reported conflicts, and 70% believed recent conflicts affected quality of care, with 44% perceiving possible harm to patient survival. In a separate hospital study, clinicians judged that about 40% of described conflict situations had potential negative consequences for patient care [2]. Bullying—common in medicine—causes psychological and physical harm [3].

Examples abound. I once urgently requested an emergency subspecialty evaluation; my concern was publicly dismissed in a large group email as "stupid" and "poor judgment." Yet when the patient was finally seen by the specialist, she was immediately rushed off to surgery which thankfully went well. The clinical course proved I was right; the subspecialist even admitted this privately to others. Yet no public acknowledgment or apology to me followed. In another instance, a mentor failed to support me during a complex case, leaving me feeling not only abandoned but betrayed. The patient recovered, but the relationship did not.

Such incidents reflect hierarchy: subspecialists belittling primary care, administrators ignoring clinician burden, and mutual disparagement across roles. Unaddressed, they erode communication, morale, productivity, and collegiality—exacerbating burnout in an already strained field.

Why Patient Apologies Are Institutionalized but Colleague Apologies Are Not

Patient and physician apologies in the context of medical errors have been discussed, in part, in relation to medicolegal and malpractice incentives. Hypothetical error-disclosure vignettes show that patients' forgiveness increases when physicians use more involved, empathic disclosure styles that convey remorse [4]. Hospital-based disclosure programs have been associated with reduced malpractice claim frequency and costs [5]. In parallel, more than 30 U.S. states have enacted apology laws, many of which specifically make expressions of sympathy or regret by clinicians inadmissible as evidence, thereby protecting 'sympathy-only' statements [6,7].

No parallels exist internally. The U.S. medical liability system operates through an adversarial tort framework in which hospitals and individual clinicians may be sued, a structure that commentators argue encourages defensive practices and emphasizes individual blame rather than system-wide accountability for patient safety [8]. This climate is counterproductive because it tends to divide individuals within a system where cooperative efforts provide better patient care.

The Acknowledge-Repair-Prevent Framework

Effective apologies typically require genuine remorse, specific acknowledgment, and amends [9]. These restore immediate dignity but often ignore systemic roots or future prevention. The harmed party gains validation, yet no assurance others will be spared.

The Acknowledge–Repair–Prevent (ARP) Framework proposed here, builds on existing models while adding prevention, emphasizing restorative over retributive justice. Retributive dynamics prioritize status and power; restorative justice focuses on shared values, heals relationships, and rebuilds trust [10]. Here are the individual steps of the ARP framework:

Acknowledge: Own the specific harm fully and sincerely, without deflection. “I publicly dismissed your urgent referral as poor judgment. You were correct, and my response was disrespectful.”

Repair: Offer meaningful restitution matched to the harm. Because the dismissal was public, repair could include a direct, visible correction: “In our next team meeting, I will openly acknowledge that your referral was spot-on and thank you for advocating for the patient. I also offer to cover one of your urgent consults this month as a tangible gesture of support.”

Prevent: Commit to concrete changes preventing recurrence. “I will implement a rapid-response protocol for urgent referrals and lead team training on respectful communication.”

Prevention is the novel, crucial step: it transforms apology into lasting improvement, reassuring the harmed that their experience catalyzes change. When modeled by leaders—especially downward—ARP signals that accountability strengthens authority and fosters reverence: profound respect for colleagues as sacred in our shared mission.

Barriers and Pathways Forward

Ego, insecurity, and hierarchy block apologies—particularly downward, where vulnerability feels risky. Lack of reverence—treating colleagues with less respect than patients—compounds this. The litigious climate reinforces defensiveness. Pathways forward include:

- Leadership modeling ARP
- Training incorporating colleague scenarios
- Malpractice reform reducing blame incentives
- Cultural emphasis on “we’re in this together,” with fewer administrative layers easing posturing
- Restorative practices—facilitated contact on shared goals in mutual respect—could supplement ARP in high-conflict cases.

Conclusion

Medicine mandates compassion toward patients for ethical and pragmatic reasons. Extending it inward—through deliberate, prevention-focused apologies—could counter hierarchy and bullying, shifting from retributive silence to restorative healing. The ARP framework offers a simple, actionable path: acknowledge harm, repair damage, prevent recurrence. In a profession defined by caring, cultivating reverence for colleagues is not optional—it is essential for sustainable teams and the patients we serve together.

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