

Mea Culpa: Apology Legislation, Accountability and Care

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Introduction

When the oncologist came in to the room he just came in and looked at my brother and said I'm sorry, we harmed you more than we helped you. It was so unexpected but it meant a lot to my brother....the apology itself was very powerful and it certainly helped my brother acquire a sense of peace.

(CBC “The Current,” 2014)

This statement from the family member of a patient in a Canadian hospital highlights the role an apology can play after a medical mistake. It also highlights the potential impact of apology legislation designed to allow medical professionals the ability to apologize for an “adverse event” by disallowing the introduction of the apology in a liability case as evidence of fault or liability. “Apology” or “Compensation” acts are now on the books in

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jurisdictions in the US, Canada, Australia and the United Kingdom (Vines, 2008).¹ In Canada, nine provinces and two territories have adopted apology legislation.² There is increasing demand from organizations including the Uniform Law Conference of Canada and the Canadian Patient Safety Institute to have all provinces and territories enact apology legislation and to educate physicians about the legislation in jurisdictions which already have the legislation on the books. The protection provided by apology legislation includes legal proceedings in the courts as well as any “proceedings before tribunals or quasi-judicial bodies, such as regulatory authority (College) disciplinary committees or coroners’ inquests” (The Canadian Medical Protective Association, 2013).

An apology is generally defined in existing Canadian legislation as “encompassing an expression of sympathy and regret and a statement that one is sorry, or any other words or actions indicating contrition or commiseration, whether or not the words or actions admit or imply an admission of fault” (The Canadian Medical Protective Association, 2013). While apology legislation itself is fairly straightforward, its potential meaning(s) and impact are much more complex, especially, as we will discuss, in a context of neoliberal funding cutbacks, restructuring and privatization (see Armstrong, 2009; Brodie, 1995; Cossman and Fudge, 2002; Polzer and Polzer, 2016). Apology legislation is not a zero-sum game whereby patients must choose between an apology *or* pursuit of a lawsuit for financial compensation. Rather, apology legislation allows for the issuing of an apology while still allowing patients the opportunity to pursue a lawsuit. What apology legislation prevents, however, is the ability to use the apology as evidence of fault in a legal proceeding.

Reception of the legislation has been mixed. While the legislation was heavily advocated for and continues to be a main point of focus for numerous patient safety groups, some observers have been highly critical about the limits and potential negative consequences that accompany this law. The strongest criticisms come from the legal scholarship. Victor Cotton, for example, argues “the idea that seriously injured patients, many of whom face major financial burdens, will simply forgive and forget about the errors that crippled them is counterintuitive. And, most clinicians remain skeptical, if not fearful, of the practice” (2012: 30). Similarly, Regehr and Guthel suggest the creation of “safe harbours” in which one can apologize without repercussions or legal vulnerability may in fact undermine the integrity and value of apology by protecting the apologizer from the consequences of taking responsibility. Apology may therefore end up as a pawn in a power game, “thus becoming part of another moral economy in which apology is used as strategy” (2002: 426). Further, apologies can also be “botched” by failing to acknowledge the mistake or wrongdoing adequately or at all. “Such botched apologies include statements such as, ‘I am sorry you’re hurt,’ rather than, ‘I am sorry I did that

Abstract. Increasingly, jurisdictions are adopting “apology legislation” that allow medical professionals to apologize to patients and family members when an adverse event occurs while disallowing the introduction of the apology in a liability case as evidence of fault or liability. While apology legislation itself is fairly straightforward, its potential meaning and impact is much more complex. This paper conceptualizes apology legislation from an accountability and ethics of care perspective. These two concepts—accountability and care—are distinct but interrelated concepts and this dual theoretical approach offers a rich analysis on the potential impact(s) of apology legislation. We argue that apology legislation is a mechanism added to the existing accountability regime that can offer important opportunities to express and practise care. As an accountability mechanism, apology legislation creates space for an accountability relationship to emerge between medical professionals and their patients. Apology legislation also addresses long-standing gaps in how we as a society think about health care and respond to patients and families in ways that challenge the dominant “consumer of services” role. It is in this sense that apology legislation has the potential to destabilize traditional notions of social citizenship. Last, we argue that empirical research is urgently needed to know to what degree apologies contribute to accountability and the transformation of health care.

Résumé. De plus en plus, les provinces et les territoires adoptent des « lois sur la présentation d’excuses » qui permettent aux professionnels de la santé d’exprimer des regrets auprès des patients et des membres de leur famille lorsqu’un événement indésirable se produit, tout en rejetant l’introduction d’excuses dans une affaire de responsabilité à titre de preuve de faute ou de négligence. Bien que la loi sur la présentation d’excuses en soi soit assez explicite, sa signification et ses répercussions potentielles sont beaucoup plus complexes. Le présent article conceptualise la législation sur la présentation d’excuses du point de vue de la responsabilité et de l’éthique des soins. Ces deux concepts - responsabilité et soins - sont des concepts distincts, mais interreliés et cette double approche théorique offre une riche analyse de l’impact potentiel de la législation sur la présentation d’excuses. Nous soutenons que la loi sur la présentation d’excuses est un mécanisme qui s’ajoute au régime de responsabilisation existant et qui peut offrir d’importantes occasions de dispenser et de pratiquer les soins. En tant que mécanisme de reddition de comptes, la loi sur la présentation d’excuses crée un espace pour qu’une relation de reddition de comptes entre les professionnels de la santé et leurs patients puisse émerger. Les lois sur la présentation d’excuses comblent également des lacunes de longue date dans la façon dont nous, en tant que société, pensons aux soins de santé et répondons aux besoins des patients et des familles d’une manière qui remet en question le rôle dominant de « consommateur de services ». C’est dans ce sens que la législation sur la présentation d’excuses peut déstabiliser les notions traditionnelles de citoyenneté sociale. Enfin, nous soutenons que la recherche empirique est nécessaire de toute urgence pour savoir dans quelle mesure les excuses contribuent à la responsabilisation et à la transformation des soins de santé.

to you” (426). This paper contributes to this debate by examining apology legislation from an accountability and ethics of care perspective. These two concepts—accountability and care—are distinct but interrelated concepts and this dual theoretical approach offers a rich analysis on the potential impact(s) of apology legislation.

Generally, accountability in the health care context refers to the effectiveness and safety of the system (for example, were standards met? Were obligations fulfilled?). At its most basic level, “care” refers to the ability of

health care institutions and providers to identify and respond to the needs of patients, but care can also be invoked to reference a particular philosophical and moral outlook that focuses on specific “contexts of action” and that challenges any absolute division of roles between care-givers and care-receivers (Sevenhuijsen, 1998: 15, 28). With this broader notion of care as ethics in mind, we assess how apology legislation is constructed as an additional accountability mechanism and whether or not such legislation contributes to caring institutions. In so doing, we depart from a theoretical standpoint developed by care theorist and policy critic Olena Hankivsky that emphasizes how “a care ethic can lead to greater social justice in social policy because it opens up new ways of seeing human beings, their social problems and their needs, and it enables us to analyze critically how government responds to these” (2004: 2).

Using the conceptual framework advanced in this paper, we make three arguments. First, we argue that apology legislation is another mechanism that works within the existing accountability regime to create space for an accountability relationship to emerge between medical professionals and their patients. Second, we argue that while apology legislation is an important starting point, much more is needed to transform health care into caring and responsive institutions beyond apology legislation, including a supportive material context in which the necessary funding and resources are ensured and a supportive cultural context in various medical institutions and practices. Finally, we argue that much more empirical research is needed, particularly involving patients and medical professionals who have received or offered an apology, to know to what degree apologies contribute to accountability and the transformation of health care.

Apology as Accountability

Accountability is part storytelling and record keeping to judge whether standards were maintained and obligations fulfilled (Bovens et al., 2014: 3). It is distinguished from the concept of “responsiveness” despite the fact that the two concepts are related (Thomas, 2001: 12). Responsiveness, as we will see later in our discussion of ethics of care “refers to the inclination and capacity of health institutions and health care providers to recognize and reflect in their actions the needs and wishes of the particular individuals they serve, as well as of society at large” (12).

Accountability emphasizes the structures that secure the accountability of government and the provision of public services through such mechanisms as elections (Bovens et al., 2014: 1–5). In this sense, accountability is concerned with democratic governance and the abuse of power. In Canada, accountability is secured through the doctrine of ministerial responsibility whereby cabinet is held to account for the performance of

government (Jarvis, 2014: 406; Thomas, 2001: 13–14). Cabinet is accountable for the “overall safety, effectiveness and responsiveness of the health care system” (Thomas, 2001: 13). To illustrate how the doctrine of ministerial accountability works in health care, consider a patient who is discharged from the emergency room and sent home via taxi only to die on their front yard never making it into their house. The minister responsible for health is held to account and expected to provide an explanation for how this incident occurred and institute reforms to prevent similar incidents from occurring (Puxley, 2015). The ability of the minister and cabinet is judged by the electorate for such incidents and may or may not be re-instated.

Of course, such issues of accountability are not limited to elected government officials, but include all those involved in the provision of services to the public. As Allen argues, “accountability is at the heart of the concept of clinical governance. Not only must health professionals strive to improve the quality of care, they must also be able to show that they are doing so” (2000: 608). The introduction of apology legislation is another mechanism to the existing accountability regime already in place for medical professionals dealing with adverse events.

The first line of accountability rests with the fiduciary responsibility of medical professionals, notably doctors, to their patients. This fiduciary responsibility is at the heart of the patient-physician relationship “because the balance of knowledge and information favours the physician, patients are reliant on their physicians and may be vulnerable. The patient must always be confident that the physician has put the needs of the patient first” (College of Physicians and Surgeons of Ontario, *nd*). It is not surprising, then, that the fiduciary responsibility requires physicians to act in the best interests of patients by respecting their dignity and autonomy (College of Physicians and Surgeons, 2015). More tangibly, the fiduciary responsibility requires physicians to prevent harm by taking reasonable courses of action but to also recognize their limitations and refer patients to specialists when appropriate (Snyder et al., 2015). There is also the obligation of informed consent that requires physicians to provide relevant information related to concerns of their patients such as providing information related to the risks and benefits of different treatment options (Snyder et al., 2015: 585). Acting in the best interest of patients also includes full disclosure when something has gone wrong (MacDonald and Attaran, 2009). Failure to do so erodes trust and violates the doctor’s responsibility to be honest, open and respectful (MacDonald and Attaran, 2009). Moreover, this erodes the ability of the patient to make informed decisions about their health and may actually place them in harm.

Disclosure is not solely an ethical and professional requirement. It is also a legal requirement rooted in common law that has been further strengthened in recent years by the “international shift” away from

secrecy to openness with Canada being a leader in working towards greater transparency (McLennan et al., 2015). By way of example of this shift, Manitoba introduced legislation in 2006 (*The Regional Health Authorities Amendment and Amendments to the Manitoba Evidence Act*) that requires no-blame critical incident reporting from the regional health authorities. Beyond disclosure, some jurisdictions may also employ patient-safety indicators, such as the number of patients who acquire an infection during their hospital stay (Stastna, 2013). Moreover, morbidity and mortality conferences are held regularly in health institutions with residency programs that provide opportunities to reflect and learn from adverse events so long as they are not rooted in culpability (Kravet et al., 2006).

However, there are concerns that some incidents are not reported or that the reporting system may not generate learning. In relation to critical incident reporting, Macrae outlines several concerns. First, the definition of what constitutes a critical incident may be quite broad thus missing opportunities to prioritize. Second, while reporting is encouraged, this may not result in learning. Macrae (2015) suggests that we should not assume that high levels of reporting necessarily mean that learning is occurring because it may only reflect a strong reporting culture. Third, reporting does not necessarily reflect safety and may not be sufficient to capture broad social, cognitive or organizational factors (for example, systemic racism against Indigenous peoples) that undermine patient safety. Last, reports may be biased because they capture the perspectives of the actors involved. Moreover, critical incident reporting may not be applied to the entire health care system. The legislation introduced in Manitoba in 2006 only applies to the regional health authorities so medical professionals outside that system are not held to the same reporting standards.

In the accountability regime, there are also professional regulatory bodies, such as the College of Physicians and Surgeons, that fulfill a self-regulatory function. In this example, the regulatory bodies, like the college, license doctors, investigate complaints of misconduct and maintain reporting systems of adverse events or errors (see Kalra et al., 2005: 308). Investigating complaints of misconduct is an integral component of the accountability regime. Citizens can file a complaint related to a number of concerns including but not limited to the behaviour of the physician, inadequate care provided by the physician, breach of confidentiality and, sexual misconduct. Processes are in place for regulatory bodies to investigate and resolve complaints which can range from providing advice on how to improve their medical practice to outright removal of a physician from practice.

As part of the accountability regime, some hospitals may also employ a “patient representative” to advocate on behalf of families, particularly when errors are not readily apparent such as ongoing delays in treatment

(Thomas, 2009). Finally, the accountability regime also affords patients, or their families, to initiate a lawsuit for financial compensation.

We can see that the accountability regime is well developed and has room to deal with adverse events. So, to what extent can apology legislation contribute to accountability? The Canadian literature in this area is sparse, but there are well-grounded concerns. Bailey and colleagues (2007: 34–35), for example, are pessimistic and dismiss the grounds upon which apology legislation has been built. They cite US case law where, in some instances, contradictory decisions have occurred whereby some court decisions determine that an apology is sufficient to determine liability, but in other instances an apology is insufficient. This causes confusion as to whether apology legislation is needed. They also cite Australian case law that supports the position that apologies do not establish liability. They argue what is really needed is better training in the legal, ethical and professional responsibilities when dealing with an adverse event (2007; see also MacDonald and Attaran, 2009). McLellan and colleagues echo this sentiment, stating “without good training and support in this process, apology legislation is unlikely to have much of an impact on the behaviour of health care staff” (2015).

Apology as a Mechanism

The introduction of apology legislation is consistent with an emerging shift in the literature that forces us to start thinking seriously about the accountability of individuals. Warren (2014) signals that there is a sense of urgency in situating accountability closer to the needs of citizens. He argues that we need to better proximate accountability to those individuals such as medical doctors who are not part of government proper per se but provide valuable public goods. With calls for a shift in how accountability is more proximate to the citizen, how then can this be achieved particularly when accountability is a multi-dimensional concept for which no universal definition can apply? While there are many ways to define this complex concept, this article draws on the work developed by Bovens (2010) in which he conceptualizes accountability as a mechanism to later understand apology legislation.³

Bovens asserts that accountability mechanisms establish a *relationship* between actors whereby one actor feels compelled to explain his or her actions and justify them to the other actor. In this way, it makes sense to think of it as a “social mechanism” whereby space is created between actors so that an accountability relationship can emerge. This is a crucial point for Bovens: Not all relationships are accountability relationships. In order for a social relationship to be deemed an accountability relationship, actors must feel an obligation to account and take ownership of their

performance; otherwise there can be no accountability relationship (2010). When viewed as a mechanism, the primary focus rests with the institutional design and whether it allows for the emergence of an accountability relationship. The emphasis relates to the configuration of institutions to allow for accountability to be secured, and not whether individuals have acted accountably (948).

Four elements comprise this approach. First, responsibilities are assigned to the various agents, generally an accountee and an accountant; second, the accountee provides an account of their performance of responsibilities to the accountant; third, the accountant questions and monitors the accountee; and last, the accountant issues consequences or rewards—formal and informal—to the accountee. The actors involved can be individuals (for example, journalists, public servants or cabinet ministers) or organizations, even institutions (for example, legislatures or the courts) according to Bovens. As a research agenda, accountability as a mechanism is more focused on “who is accountable and for what” and “to whom is accountability owed and when” and “how sanctions or rewards” are applied (Bovens, 2010: 953).

Apology legislation reflects mechanistic forms of accountability that proximates accountability at the service provider level. As a mechanism, it creates space for an accountability relationship to solidify between a patient and health care professional, notably physicians, when an adverse event occurs such as mistakenly administering a drug other than the one prescribed.

As an expression of public policy, apology legislation is thought to contribute to the transformation of health care to become less about anger and the pursuit of lawsuits, and more about empathy, forgiveness and the pursuit of understanding to overcome the culture in medicine of “sealed lips” and promote learning (Zylberman, 2009: 187). As Aucoin and Heintzman observe, accountability can be conceptualized as “continuous improvement” through learning rather than blaming (2000: 52). While apology legislation does not allow for the issuance of rewards or consequences there may be healing effects resulting from apologizing for both the health care professional and patients which should not be overlooked when considering the impact and value of an apology, although this potential impact is far from being proven in the existing literature. As Regehr and Gutheil observe, while we often assume an apology will contribute to the healing process, the therapeutic value has yet to be determined” (2002: 427). What is needed, we argue, is more empirical research that involves patients and medical professionals to determine the impact of apology legislation in these areas.

Apology legislation may not fit neatly into current conceptualizations of accountability mechanisms, but it is a mechanism nonetheless. It is an additional accountability tool that is layered onto the current accountability

regime to further develop the relationship between the patient and the medical professional. While apology legislation works with the existing medical accountability regime to further create space for an apology to occur by offering the mechanism to do so, how, if at all, does it work to change our public institutions and practices? It is to this question we now turn.

Can Institutions “Care”?

What does it mean to care? Is it a private matter or a public responsibility? Can public policy create care? These questions are central for any society and yet the notion of care remains marginal within our political theories and practices. There was, however, a “minor revolution” in the study of ethics that began in the 1980s. “The constellation of the moral universe in Western culture was enlarged by the introduction of ‘care ethics’” (Hamington and Miller, 2006: xi). First introduced by Carol Gilligan (1982: 12), “care ethics” was originally premised on the notion that two distinct moral perspectives become manifest in human development due to markedly different contexts of socialization. More specifically, Gilligan argued, the experiences of the female child are markedly distinct from the experience of the male child, “from very early [...] because they are parented by a person of the same gender [...] girls come to experience themselves as less differentiated than boys, as more continuous with and related to the external object-world, and as differently oriented to their inner-object world as well” (12). These differences in sense of self culminate in differences of perspective that shape the priorities and values of the subject through the life cycle. Thus, when the subject is female, she is likely to be working from a perspective based not on the primacy of the unencumbered individual self but rather on a self that is constituted through connections and relationships to others. Defining themselves in a “context of human relationships” leads women to judge themselves not in terms of individual self-maximization but in terms of their “ability to care.” From this standpoint, moral dilemmas are not about how to “exercise one’s rights without interfering with the rights of others” but rather about how to “lead a moral life which includes obligations to others” (8).⁴

In its earliest or “first wave” conceptualization, an ethics of care was juxtaposed to the dominant “ethic of justice” and these two ethics—justice and care—were posited as separate and distinct from one another. The ethics of justice emphasizes abstract reasoning, human separateness and some form of equality while ethics of care emphasizes context, connectedness and the maintenance of relationships (Clement, 1996: 11). The ethics of justice is premised on the primacy of personal autonomy through individual rights whereas the ethics of care is premised on individuals’ ability to recognize themselves as part of a larger whole.

While the distinction between these two ethical perspectives is helpful for analytical clarity, not all ethics of care scholars insist that the two ethics can or should be understood as opposed to one another (see, for example, Hankivsky, 2004; MacDonald, 2010; Nedelsky, 1989). As care ethics have developed, many of its advocates have taken the position that care and justice are not mutually opposed ethical approaches, but rather distinct yet related understandings of morality that can work harmoniously under certain conditions. “Such harmony has been harmed by the suppression of the voice of care, but the reclaiming of this voice could produce a healthy balance” (Hamington and Miller, 2006: xii). It is also important to emphasize here that while “first-generation” care scholars (see Gilligan, 1982; Noddings, 1984; Ruddick, 1989) emphasized that care ethics are inherently gendered, “second-wave” care scholars (see Hankivsky, 2004; Sevenhuijsen, 1998; Tronto, 1993, 2010) propose that care is “central to all human life” (Hankivsky, 2004: 11). It is this second wave of scholars who first articulated the potential of care in our theories of citizenship practice and policy paradigms.

According to “second wave” care scholar, Selma Sevenhuijsen, care ethics can and should inform our responsibilities as democratic citizens. For Sevenhuijsen, integrating values of care such as “attentiveness, responsiveness, and responsibility” into models of citizenship will produce “a dual transformational effect” whereby the concept of citizenship is more deeply developed to integrate diversity and plurality and care is “de-romantisized” and reconceptualized as a source of political virtues (1998: 15–16). Such an approach is further defended by Hamington and Miller in their notion of “socializing care” which entails the application of care ethics to reconstruct institutions, politics and social dynamics as part of a larger shift to deconstruct the boundaries between home and community (2006: xiv).

Central to any effort to “socialize care” is the concept of relational autonomy. While there is no single agreed-upon definition of relational autonomy a number of ethics of care scholars (Fox Keller, 1985; Mackenzie and Stoljar, 2000; MacDonald, 2010; Nedelsky, 1989) invoke this idea as a concept that offers the ability to successfully combine the *prima facie* oppositional claims of “the constitutiveness of social relations” and “the value of self-determination” (Nedelsky, 1989: 9) and in so doing to reconcile the insights of care ethics with the importance of individual freedom in democratic societies. As Iris Marion Young argues, relational autonomy entails both a “presumption of non-interference” but also the recognition that “agents are related in many ways they have not chosen, by virtue of economic interaction, history, proximity or unintended consequences of action” (2000: 258).

From this perspective, autonomy is still central in practising care but the notion of autonomy itself is expanded and/or enhanced to recognize that autonomy is always socially constituted. Social relations will

unavoidably include relationships of dependence. This reality is not in and of itself a problem as dependence is not only a part of the human condition but it can also be a fulfilling and nurturing part of our relationships with others.

Some scholars of medical ethics have also taken up the principles of care theory and the concept of relational autonomy in particular. Baylis and colleagues, for instance, propose “a relational concept of personhood” in their model for both clinical and research ethics. Such a concept, they argue, “allows us to see how questions of social justice are central to many aspects of personhood” by highlighting that all persons are socially constructed, “also reminds us that we are not all constructed as equals” (2008: 6).

This relational emphasis is particularly essential for health care, given recent stories that may leave some citizens with the growing perception that health care staff *do not care*, a perception that is correlated with a decline in public support for public health care (Armstrong, 2009: 96). One recent example of this growing discontent comes from Manitoba where, according to one patient, suicidal patients are discharged at 1:00 am with few supports beyond a bus ticket:

“They told me straight up they needed the room for someone else,” she said, adding there was no follow-up plan and she was given a bus ticket. It was 1:00 a.m. and she said she had no keys to her apartment, no cell phone and was given a bus ticket, despite the fact buses were not running. She didn’t know at first, that her mom was there to take her home. “It feels like people with mental health problems don’t matter. They just wait for us to have a moment of clarity and that’s when they ship you off. And it’s frustrating.” (Coubrough, 2016; see other similar examples from CBC, 2013, and Meikle, 2015, from the UK)

As Armstrong details in her account of social cohesion and the neoliberal welfare state, neoliberal restructuring of public health services translates into deficit reduction, staff reductions, amalgamation of hospitals and the imitation of corporate practices centred on market principles (2009: 96). Health professionals are also starting to speak out on how increased funding cuts to health care institutions displace caring and leaves them, and their patients vulnerable. A nurse in the British National Health Service tells *The Guardian* how her employment as a mental health nurse in the UK health care system drained her of her compassion:

When I assess that my patient is actually planning to kill herself today, I find myself sighing. I hope she hasn’t heard. I look at my home visits and decide who to cancel. I manage to get my patient to agree that she will keep herself safe until 1pm when I will be able to visit her at home. It’s only later when I am in my car and have a minute to myself that I am

able to reflect that this is not the type of nurse I want to be. This is not who I am, someone who sighs and finds it inconvenient that a patient is so low they want to end their life. Where is my compassion? (Carroll, 2015)

The narratives above speak to the need for, but also the complex challenges in creating caring institutions reminding us that care must be front and centre for the individual health care professional, caregiver and patient, and must also be part of the material environment. Does the introduction of apology legislation aid in the development of caring institutions and/or socializing care? As the next section will outline, apology legislation has the potential to aid in transforming our current policy paradigm but without additional changes in institutional culture, material resources, funding and support this act may remain a mechanism of accountability, but will not on its own lead to more caring institutions.

Apology as Care

Given our current neoliberal context of funding cuts, restructuring, and privatization, the potential impact (both direct and indirect) of an apology in a context of medical error or mistreatment is complex and yet little research exists on the topic.⁵ Lazare's work (2006) helps to fill this gap and suggests ten ways in which apology can potentially contribute benefits for those involved. These contributions include the restoration of respect and dignity to the patient and/or family to address any feeling of disrespect and humiliation, a feeling of being "cared for" by the physician or practitioner communicated through various actions including follow-up telephone calls and attending a patient's funeral when the outcome is death, a restoration of power to the patient and/or the family of the patient, some level of "suffering" by the offender, a validation that an offense has occurred, designation of fault and/or responsibility to the medical practitioner as opposed to the patient and/or family of the patient, assurance of shared values, an opportunity for dialogue in which patients and family can ask questions and express their feelings, experiences and concerns, a "promise for the future"—that is, a commitment to correction and/or prevention in future cases and finally reparations may be an important part of addressing damages in some cases (2006: 1402).⁶

These potential outcomes of apology are very consistent with ethics of care. Actions like attending the funeral of a patient challenge traditional notions of public-private division and professionalism centred on separation between physician and patient and highlight how context is of fundamental importance when determining the correct ethical action or inaction. Most significantly, the practices highlighted by Lazare are centred on the relationships between medical professional and patient as

citizens well beyond any consumer of service–supplier of service models recognize.

Apology legislation may therefore aid in challenging previous traditions in health care policy and administration by challenging the dominance of an ethics of commodification consistent with liberal notions of justice in contemporary neoliberal policy practice and evaluation. For ethics of care advocates, “there is a great danger in thinking of care as commodity, as purchased services rather than as a process” (Tronto, 2010: 164). Apology legislation addresses long-standing gaps in how we as a society think about health care and respond to patients and families in ways that challenge the dominant “consumer of services” role. It is in this sense that apology legislation has the potential to destabilize traditional notions of social citizenship.

While apology legislation has this potential to create new understandings it also appears to directly decrease actions associated with prior “tight lipped” practice. There is significant research that links apology legislation with decreases in the likelihood of litigation. Lazare explains, “Although the goals of policies regarding disclosure and apology were to enhance patient safety and fulfill an ethical commitment of honesty to patients, an outcome unexpected by many was a reduction in the number and cost of malpractice claims” (2006: 1401). This decrease in litigation lends support to the notion that “the medical malpractice litigation problem” is often “a human relations problem.” Fiesta argues:

Regardless of the physician’s care and skill, some cases will result in an unfortunate outcome. Refusing to acknowledge the poor results may be the very thing that causes a patient or a patient’s family to pursue legal action [...] Patients and family members are sometimes more upset with the physician’s lack of communication and apparent lack of concern than they are about the unfortunate outcome or medical treatment. *They might understand a bad outcome, or even a mistake, but they cannot forgive a lack of concern.* (1994: 14, italics added)

The significance of concern in medical relationships is also comprehensive in nature. As Lazare argues, the apology process should not be limited to the realm of medical errors but should include all aspects of the medical setting in which a person could be offended or humiliated (2006: 1403). Lazare also includes the relationships among health professionals—relationships that are also constituted by significant power and gender dynamics—as important targets for concern and, at times, apology, as we shift from the “ritual practice” of humiliation of medical students by their superiors. Moving away from these hierarchical humiliating practices is an essential part of creating caring institutions. Developing a culture of respect, transparency and accountability among health professionals is foundational to

developing such a culture between patients and health care providers. Apology legislation creates space and opportunity for increased expressions of care more broadly. As Hankivsky argues, “Policy texts and legal texts are, after all, ‘stories in themselves’: they include patterns of dealing with things which are often the result of political compromises and discursive traditions. They often contain fixed patterns of speaking and judging, but they can also open up unexpected discursive spaces, where new forms of thinking and judging can start” (2004: 31).

Apology legislation has the potential to create discursive spaces about care and yet the legislation itself is only one small contribution to the development of caring institutions. While apologies are important to transforming how we think about, talk about, and practice care they are also reactive rather than proactive in nature. Institutional and professional cultural factors are crucial in working to prevent medical errors or mistreatment in the first place. Liability experts suggest a link between poor communication between health professionals and patients—such as medical staff interrupting or failing to allow patients to finish speaking during initial appointments—and misdiagnoses and/or medical mistreatment (Fiesta, 1994: 14). It is also worth noting that the likelihood of both medical mistakes and subsequent litigation are correlated with the nature and scope of patient-institution relations even at what may appear to be the most trivial levels such as a call to a hospital switchboard. Fiesta explains:

Hospital staff—everyone from telephone operators to groundskeepers—shape the public’s impression of the facility [...] Case studies indicate that patients that have an unfavourable overall impression of a hospital or a staff member are more likely to consider litigation where a problem occurs in the course of treatment. Patient satisfaction surveys perennially indicate that “rudeness,” “aloofness,” “acting superior or officious,” “indifference,” “impatience” and “ignoring my presence” are among behaviours that cause unfavourable impressions. (1994: 14)

To truly create caring institutions then we need to develop comprehensive and proactive approaches to care as citizenship. Such an approach requires challenging traditional notions of professionalism as impartial, abstract, and objective. As Sevenhuijsen aptly observes, care and citizenship are often constructed as separate, if not oppositional, practice. Judgments in the public sphere are typically associated with distance, impartiality and a “general viewpoint” while care ethics such as compassion, attentiveness, empathy and specificity are depicted as belonging to a “different sphere,” that is, the sphere of “interpersonal and private relationships” (1998: 5).

Deconstructing the divide between public judgment and private care is at the centre of the necessary cultural shift at the institutional and societal level. At the same time we must not assume that increased care means

decreased conflict. As Tronto reminds us, “the reality is that care is rarely without serious problems and conflict” (2010: 167). Creating caring institutions requires that we make democratic space(s) for the politics of care that offer “explicit locus for the needs-interpretation struggle.” According to Tronto (2010: 168) that comes with providing, receiving, and debating care and our contesting and changing notions of what care means. It is also worth noting that Tronto’s work points to at least two significant dangers that accompany efforts to “emphasize care as purposive practice.” These are the dangers of “power and particularity.” More specifically, the dangers of paternalism—“in which care givers assume that they know better than care receivers what those care receivers need”—and the dangers of parochialism—“in which care givers develop preferences for care receivers who are closer to them”—are tendencies to guard against (161). Challenging traditional understandings of professionalism will require significant learning and reflection within institutions working to socialize care. Virtues such as compassion, attentiveness and reciprocity must be considered and expressed with the dangers of paternalism and parochialism in mind. The concept of relational autonomy is, we argue, a key concept in pursuing such as balance. From this perspective, public institutions, such as hospitals and other medical care facilities, should identify how best to ensure practices and processes that recognize, as Mackenzie and Stoljar argue, a context of social relationships that are always shaped by “a complex of intersecting social determinants such as race, class, gender, and ethnicity” (2004: 4).

Ensuring practices of non-domination is fundamental to practising care ethics in the administration of health care. Citizens receiving care are often in highly dependent relationships with health practitioners and policy makers leaving them particularly vulnerable to the dangers of paternalism and parochialism highlighted by Tronto. A recent case prominent in Canadian media helps to illustrate this reality. In May 2016, the CBC reported that a Quebec City man with multiple sclerosis and significantly limited mobility launched an online crowdfunding campaign in order to raise sufficient money to pay for showers in the long-term care home where he lives. While the institution does provide showers to residents, government funding will not provide more than one shower weekly.

“The government doesn’t provide enough money for hygiene,” François Marcotte, 43. [He] said [...] he’s hoping to raise enough money to afford three showers a week. “I find it sad that I have to turn to alternative sources of funding to pay for an essential service” [...] “I find it humiliating. I suffer in the heat. Each morning I wake up and I’m hot. I’m sweating. I’d like more than one shower a week.” [Marcotte is] hoping to raise \$5,200, enough to pay someone \$100 a week for two additional showers. That would make a huge difference to his quality of life, he said. “It gives

me self-confidence and comfort, but it's more than that" he said. "With MS I have a lot of spasms. The shower relaxes me. When I have showers at night I sleep better, I feel better. It's not just a question of hygiene, it's for my well-being." (CBC, 2016)

This case shows a clear deficit in both care ethics generally, such as compassion, attentiveness and responsiveness, and the principles of relational autonomy and non-domination more specifically. It also demonstrates how care cannot be fostered without the necessary material resources. Finally, this example also showcases a clear and illustrative resistance to these deficits.

By initiating a crowdfunding initiative and speaking to media Marcotte is resisting the passive subjectivity and domination current policies and practices enforce. A system that truly embraced an ethics of care would not only avoid such humiliating and dominating policies but would also work to develop a context in which the autonomy of citizens like Marcotte is supported and enhanced through the provision of necessary resources in an institutional context of dignity and respect. As Nedelsky argues, autonomy is both a capacity and a feeling:

Although I define autonomy as a capacity and not a feeling, I insist upon the feeling of autonomy as an inseparable component of the capacity for several reasons. First, I think the capacity does not exist without the feeling. Second, I think the feeling is our best guide to understanding the structure of those relationships which make autonomy possible. Third, focusing on the feelings of autonomy defines as authoritative the voices of those whose autonomy is at issue. *Their autonomy is then not a question that can be settled by others.* (1989: 25, emphasis added)

Clearly the circumstances Marcotte has revealed show that this institution fails to pass the threshold of autonomy as capacity or feeling. It also reveals many of the complex factors at play when thinking through how to transform care. While apology legislation has the potential to enhance the capacity and feeling of autonomy for patients and professionals in various scenarios, this case reminds us that there are many aspects to ethical care that fall beyond the scope of apology, most notably, material resources. It also reminds us that health care is an area already laden with complex dynamics of power and dependency that must be taken into account if a meaningful shift to care as citizenship practice is to be implemented. Apology legislation has the potential to help lead us to such a change if we conceptualize the legislation as a starting point rather than an end in and of itself.

Conclusion

The conceptual framework advanced here led to three arguments. First, apology legislation fits into our current understanding of accountability by better locating accountability at the service provider level between patients and health care professionals, notably physicians. As a mechanism that opens space for an accountability relationship to emerge between health care professionals and patients, the goals of apology legislation are to prevent lawsuits, reduce blame, promote healing and advance learning. Current notions of accountability are often punitive and adversarial with an increasing emphasis on blame and escaping blame (see Hood, 2011). Apology legislation has the potential to further advance learning. Second, apology legislation, by itself, is not sufficient in transforming health care institutions. Last, the impacts of apology legislation on promoting learning and healing need to be empirically tested. As noted, the Canadian literature on medical accountability, notably apologies, is rather scant and little is rooted in empirical research. To understand apologies, research must include the experiences of both patients and medical professionals.

While each individual apology is potentially transformative for those involved, apology legislation also has the potential to contribute to a cultural transformation of public institutions themselves if the necessary economic commitments are present. However, this rests on a much broader commitment to transforming the institution itself. While much more empirical research is needed, the conceptual work advanced in this paper argues that apology legislation is a starting point. That said, it is an important starting point and much more is needed to transform health including empirical research to ascertain what is needed beyond just apology legislation to facilitate this transformation. Is more training required to assist health care professional provide a meaningful apology? What kind of training? What other financial and material supports are necessary to support health care professionals as they enter into an apology with their patients following an adverse event? What changes are required to the institutional culture? Are new resources required? How can the institution beyond just the clinical environment be transformed to care? Moreover, empirical work that includes patients and medical professionals who themselves have received or offered an apology is urgently required to gain further insight about the possibilities to learn and the impacts on the institutional culture as a result of this new type of legislation. Apology legislation is an exciting area for analysis and empirical research. Our contribution in this paper is conceptual and provides a grounding for how we think about apology legislation from an accountability and ethics of care perspective. Both perspectives are necessary if public policy is serious about transforming health care institutions into caring and responsive institutions.

Notes

- 1 Massachusetts was the first American state to enact apology legislation in 1986 with at least 35 states having now followed suit (Beaulieu-Volk, 2014; Vines, 2008).
- 2 These are British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, New Brunswick, Nova Scotia, Prince Edward Island, Newfoundland and Labrador, Northwest Territories, and Nunavut.
- 3 Bovens also outlines another approach: accountability as a virtue that focuses its attention on the behaviour of the actor. This is different from social accountability. Ball and Osborne (2011: 1) define social accounting as the disclosure of organizational information to a broad range of stakeholders so this may include traditional financial reporting but may also involve nonfinancial reporting, such as environmental reporting. Social accounting may be provided by a for-profit corporate entity, a public agency or a non-profit organization.
- 4 It is important to note that while gender was a critical distinction in Gilligan's initial work, it is not sex or gender identity per se that determines which ethics are most dominantly invoked by individuals but rather the socialization they have experienced as children.
- 5 It is worth noting here that recent scholarship challenges the widely accepted economic premise that social spending in areas such as care services is a "drain" on the economy. Marjorie Cohen's analysis suggests just the opposite. Cohen's work reveals that in the Canadian case, it is the "reduction in government social spending as a proportion to GDP puts a drag on the economy (2017: 309). Further she argues "crucial shifts in government policy towards support for social reproduction could increase economic activity [...] But [...] these approaches would require the strong assertion on the part of the state and its willingness to shift economic priorities away from the focus on material goods and services, towards working in the interests of social development and welfare" (311).
- 6 Lazare's theoretical work is important but empirical research is urgently needed.

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