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# Doctors, Apologies, and the Law: An Analysis and Critique of Apology Laws

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**Doctors, Apologies, and the Law:  
An Analysis and Critique of Apology Laws**

Marlynn Wei<sup>1</sup>

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## **Abstract**

This article analyzes and critiques apology laws, their potential use, and effectiveness, both legally and ethically, in light of the strong professional norms that shape physicians' reaction to medical errors. Physicians are largely reluctant to disclose medical errors to patients, patients' families, and even other physicians. Some states have passed so-called apology laws in order to encourage physicians to disclose medical errors to patients. Apology laws allow defendants to exclude statements of sympathy made after accidents from evidence in a liability lawsuit. This piece examines potential barriers to physicians' disclosure of medical mistakes and demonstrates how the underlying problem may actually be rooted in professional norms—norms that will remain outside the scope of law's influence. The article also considers other legal and policy changes that could help to encourage disclosure.

## I. Introduction

Since the release of the Institute of Medicine report on medical errors in 2000,<sup>2</sup> the prevalence of errors in medicine may no longer shock either the public or the medical community. But the increased awareness of errors has not been accompanied by better strategies to prevent errors or to release them from the shroud of secrecy.<sup>3</sup> So-called “apology laws”<sup>4</sup> have been heralded as the new cure not only for high medical malpractice costs and but also rising numbers of malpractice lawsuits.<sup>5</sup> Supporters also claim that they will encourage doctors to disclose errors to patients. These laws allow defendants to exclude statements of sympathy made after accidents from evidence in a liability lawsuit. Over a dozen states, including Massachusetts,<sup>6</sup> California,<sup>7</sup> Florida,<sup>8</sup> and Texas,<sup>9</sup> have passed apology laws.<sup>10</sup>

Critics of apology laws, most notably Lee Taft, are concerned that the sympathetic statements that apology laws protect may become empty, utilitarian or self-serving rituals,

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<sup>2</sup> INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (Linda T. Kohn et al. eds., 2000) [hereinafter IOM REPORT] (concluding that between 44,000 and 98,000 patients die every year in hospitals as a result of medical error which, using the lower estimate, is more than from automobile accidents, breast cancer or AIDS).

<sup>3</sup> See generally Maxine M. Harrington, *Revisiting Medical Error: Five years after the IOM Report, Have Reporting Systems Made Measurable Difference?*, 15 HEALTH MATRIX 329 (2005) (discussing the problem of underreporting).

<sup>4</sup> See generally Jonathan R. Cohen, *Legislating Apology: The Pros and Cons*, 70 U. CIN. L. REV. 819 (2002); Jonathan R. Cohen, *Apology and Organizations: Exploring an Example from Medical Practice*, 27 FORDHAM URB. L.J. 1447 (2000); Carol B. Liebman & Chris Stern Hyman, *Medical Error Disclosure, Mediation Skills, and Malpractice Litigation* 31-56 (2005), available at <http://www.medliabilitypa.org> (discussing disclosure and apology policies in health care systems and recommending consult service for communication experts). For a discussion on use of apologies in criminal law, see Stephanos Bibas & Richard A. Bierschbach, *Integrating Remorse and Apology into Criminal Procedure*, 114 YALE L.J. 85 (2004).

<sup>5</sup> See Rachel Zimmerman, *Medical Contrition: Doctors' New Tool to Fight Lawsuits: Say "I'm sorry"*, WALL ST. J., May 18, 2004, at A1. One of the leading groups championing these apology laws is the Sorry Works! Coalition. See Sorry Works! Coalition, <http://www.sorryworks.net> (last visited May 16, 2006). The Sorry Works! protocol/full-disclosure approach was developed in the 1980s and implemented at the Veterans Administration Hospital in Lexington, Kentucky. The VA system has since adopted a similar approach nation-wide. Department of Veterans Affairs, *Disclosure of Adverse Events to Patients*, VHA Directive 2005-049, October 27, 2005, available at <http://www1.va.gov/vhaethics/download/AEPolicy.pdf>.

<sup>6</sup> MASS. GEN. LAWS CH. 233, Sec 23D.

<sup>7</sup> CAL. EVID. CODE 1160 (Supp 2004).

<sup>8</sup> FLA. STAT. ANN. CH. 90.4026 (Supp 2004).

<sup>9</sup> TEX. CIV. PRAC. & REM. CODE ANN. 18.061 (Supp 2004-05).

<sup>10</sup> Liebman & Hyman, *supra* note 4, at app. A.

leading doctors away from the higher moral purposes of apologies.<sup>11</sup> Taft makes a normative observation, and my study does not focus on this aspect. Instead, I question whether the apology system would successfully encourage apologies, given the deeply entrenched attitudes and behaviors of doctors toward disclosure. I argue that the more pressing problem in medicine is not simply the lack of apologies, but a more fundamental lack of disclosure. A narrow evidentiary rule like the apology laws will do little to change the silence that surrounds mistakes in medicine. I point to barriers embedded in long-standing professional norms and traditions of the physician-patient relationship.

## II. Apology Laws

In 1986, Massachusetts enacted a statute excluding from admissibility expressions of sympathy and benevolence after accidents. The safe harbor provision for apologizers in the Massachusetts statute provides:

Statements, writings, or benevolent gestures expressing sympathy or a general sense of benevolence relating to the pain, suffering or death of a person involved in an accident and made to such person or to the family of such person shall be inadmissible as evidence of an admission of liability in a civil action.<sup>12</sup>

In 1999, Texas passed a similar “I’m sorry” law that protects statements of regret, but does not protect “a statement . . . concerning negligence or culpable conduct . . . .”<sup>13</sup> This statute became

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<sup>11</sup> Lee Taft, *Apology Within a Moral Dialectic: A Reply to Professor Robbennolt*, 103 MICH. L. REV. 1011 (2005). First, a sympathetic statement devoid of the admission of fault or the acceptance of responsibility may not be an apology at all. Such sympathetic statements have been deemed “partial apolog[ies],” which lack the moral dimension and power of true repentance. *Id.* Just saying “I’m sorry” does not acknowledge grievances, accept responsibility for causing them, or express remorse. AARON LAZARE, ON APOLOGY 25 (2004). These statements could leave patients even more frustrated, perhaps even more so when they find out that they cannot use the statements as evidence in court. Since the apology laws exclude evidence of the apology statement for use to prove liability, one might argue that patients would be more angered that although they suspect that a mistake occurred, but that they can’t use a statement of apology as evidence against the doctor. For a discussion of the importance of trust in looking at malpractice reform proposals, see Mark A. Hall, *Can You Trust a Doctor You Can’t Sue?*, 54 DEPAUL L. REV. 303 (2005). The statutes are limited in second way: Sympathy and remorse are easily feigned. One of the reasons is that remorse is an emotion that takes place “mostly on the inside, the biting and biting again of conscience.” WILLIAM IAN MILLER, FAKING IT, 78 (2003).

<sup>12</sup> MASS. GEN. LAWS ANN. Ch. 233 § 23D (2000).

<sup>13</sup> TEX. CIV. PRAC. & REM. CODE ANN. § 18.061 (Supp. 2004-05).

the model for other states. These apology laws, with the exception of Colorado,<sup>14</sup> do not exclude from admissibility full admissions of fault by the doctor.<sup>15</sup>

### **A. Role of Apologies and Disclosure in Malpractice**

One might wonder why physicians should be worried about expressing sympathy in the first place. Apologies have been admitted as evidence against physicians in subsequent civil suits of malpractice in various forms. Prior out-of-court statements of the defendant physicians can be used against the defendant as a way of providing expert testimony that establishes a prima facie case of malpractice. In medical malpractice cases, the plaintiff must demonstrate (1) the applicable standard of care; (2) a breach of that standard of care; (3) an injury; and (4) proximate cause between the breach of duty and injury. In most cases, the plaintiffs must use expert testimony from members of the defendant's profession in order to establish the standard of care and its breach. Expert testimony does not have to come from third-party experts. Plaintiffs can establish a prima facie case with statements made by the defendant physicians. Thus, the presence of an apology in a case might make the case more likely to go to trial and may influence the strength of the plaintiff's case or the defense's willingness to settle.<sup>16</sup>

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<sup>14</sup> Edward A. Dauer, *Apology in the Aftermath of Injury: Colorado's "I'm Sorry" Law*, 34 COLO. LAW. 47 (2005).

<sup>15</sup> Oregon enacted a similar statute in 2003, excluding a licensed medical professional's statement of "apology or regret" but does not further define the terms. Oreg. Rev. Stat. § 677.082 (2003).

<sup>16</sup> Danzon and Lillard report that 50% of cases were settled prior to filing a legal suit. Most studies have found that about 40% of claims filed were dropped without payment, 50% settled out of court by payment to plaintiff, and 7-10% litigated to verdict. See PATRICIA MUNCH DANZON & LEE A. LILLARD, *THE RESOLUTION OF MEDICAL MALPRACTICE CLAIMS*, 43 (1982). Studies have found that 36% of cases were dropped by the plaintiffs or dismissed by the judge, and 58% settled out of court, and only 5.2% were tried in court. Cases fit into a pattern of three categories: "[c]ases with low defendant liability are likely to be dropped, those with high defendant liability are more likely to be settled, and a more mixed pattern is apparent for the cases decided at verdict and beyond." NEIL VIDMAR, *MEDICAL MALPRACTICE AND THE AMERICAN JURY* 37-45 (1995). Danzon and Lillard make a similar observation in their model, asserting that cases only continue to verdict where plaintiff either overestimates the award or the defendant underestimates the award or probability of losing. Thus, the following cases represent a narrow selection of cases that were not settled before the court was asked to determine whether the case was sufficient for submission to the jury. However, such cases are important because they set the precedent and guide future settlement decisions of both parties.

However, the legal liability of apologies can cut the other way. First, a physician who has apologized is a much more sympathetic defendant. If the case does go before a jury, then the jury may be less likely to award higher damages compared to a physician who appears cold and unapologetic. In fact, Dr. Lucian Leape, a leading physician-figure in the discussion of medical errors, encourages disclosure and apologies precisely for this reason:

The long, painful, shameful spectacle of the plaintiff lawyer trying to prove in public that the physician is negligent, a bad person, will not take place. The court's role will be limited to establishing just compensation. What is a jury likely to do with a physician who has been honest and also apologized? Judgments will most likely be far less costly.<sup>17</sup>

Second, the caselaw on whether physicians' statements to patients are actually admitted as admissions of fault varies widely. Physician statements have been held as evidence for an extrajudicial admission that establishes both the standard of care and its breach in some cases.<sup>18</sup>

Many of these cases include statements, as recalled by the plaintiff, that sound callous and insensitive.<sup>19</sup> But even well-intentioned and remorseful doctors have had their statements used against them in a later malpractice suit. In *Woronka*, the plaintiff filed suit for burns she received on her buttocks while giving birth.<sup>20</sup> The defendant doctor examined the patient two days later

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<sup>17</sup> Lucian L. Leape, *Understanding the Power of Apology: How Saying "I'm Sorry" Helps Heal Patients and Caregivers*, 8 NAT'L PATIENT SAFETY FOUNDATION NEWSL. 3 (2005).

<sup>18</sup> *Colbert v. Georgetown Univ.*, 623 A.2d 1244 (1993) (holding that defendant physician's admission that he had made a mistake in not performing a mastectomy 2 months earlier and that he had performed the wrong operation established a breach in the standard of care); *Robertson v. LaCroix*, 534 P.2d 17, 19 (Okla. App. 1975) (holding that physician's statement that he "just made a mistake and got over too far" during surgery was prima facie evidence of the standard of care and its breach); *Sheffield v. Runner*, 328 P.2d. 828 (1958) (finding that the case was sufficient to submit to the jury based on statements by defendant physician indicating that the patient should have been treated in the hospital and that "I should have put her in the hospital"); *Snyder v. Pantaleo*, 122 A.2d 21 (1956) (holding that defendant radiologist's statement to the deceased's family physician that the patient had a reaction when the defendant gave her an injection of the iodine compound, yet injected her with an iodine compound, was expert testimony of the standard of care and its breach); *Lashley v. Koerber*, 156 P.2d 441 (1945) (finding that the jury could reasonably conclude that the admissions of the defendant doctor's alleged statement to patient that "I know it is not your fault, . . . it is all my own" constituted breach of the standard of care).

<sup>19</sup> *Wickoff v. James*, 324 P.2d 661, 667 (1958) (finding that defendant doctor's admission to the patient's husband "Boy, I sure made a mess out of things today, didn't I Warren" and "I busted the intestine" established a prima facie case of negligence); *Zettler v. Reich*, 11 N.Y.S.2d 85 (1939) (holding that dentist's statement "Well, I did break your jaw, I guess I hit you a little too hard," in addition to an outcome unlikely in absence of negligence, was sufficient to establish prima facie case).

<sup>20</sup> *Woronka v. Sewall*, 69 N.E.2d (Mass 1946).



and allegedly said, “My God, what a mess; my God, what happened here . . . . It is a darn shame to have this happen” and sympathized with the patient for a “very hard delivery and it was a burning shame to get that on top of it, and it was because of negligence when they were upstairs.”<sup>21</sup> The doctor explained to the husband that the event should not have happened—and that the staff was going to do something to correct the problem. The court found that these statements were sufficient to present the case to the jury. In *Greenwood*,<sup>22</sup> the physician apologized and explained that he had wrongly diagnosed a tumor when the patient was actually pregnant. The doctor had accidentally aborted a fetus. The patient’s husband recalled that the physician said, “this is a terrible thing I have done, I wasn’t satisfied with the lab report, she did have signs of being pregnant. I should have had tests run again, I should have made some other tests” and “I’m sorry.”<sup>23</sup> The court found that these statements indicated a prima facie case of malpractice.

But equally as many other courts have found that apologies are insufficient evidence to establish the standard of care or its breach.<sup>24</sup> One court found that one physician’s statement that “I’m sorry, I accidentally cut the nerve to your vocal cord” was not enough to establish failure of due care.<sup>25</sup> In *Senesac*, the court found that the physician’s alleged admission that she “made a mistake, that she was sorry, and that it has never happened before,” was insufficient to establish the standard of care or its breach.<sup>26</sup> Even when physicians describe adverse events as “mistakes” or “inadvertent,” many courts have held that such out-of-court statements are not enough to

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<sup>21</sup> 69 N.E.2d 581, 582.

<sup>22</sup> *Greenwood v. Harris*, 362 P.2d 85 (1961).

<sup>23</sup> Page number

<sup>24</sup> See e.g., *Phinney v. Vinson*, 605 A.2d 849 (1992) (holding that physician who allegedly admitted that he performed an “inadequate resection” and apologized was not enough for the plaintiff to meet its burden of proof); *Jeffries v. Murdock*, 74 Or. App. 38 (1985); *Senesac v. Associates in Obstetrics & Gynecology* 449 A.3d 900 (1982).

<sup>25</sup> *Jeffries v. Murdock*, 74 Or. App. 38 (1985).

<sup>26</sup> *Senesac v. Associates in Obstetrics & Gynecology* 449 A.3d 900 (1982).

establish a prima facie case.<sup>27</sup> Therefore, the caselaw on the legal liability of apologies is not uniform or clear.

Apology laws have the potential to make this caselaw more uniform by not allowing any apologies to be admitted into evidence. The idea is that this should reassure physicians and allow them to feel safer in apologizing to patients. But to follow that logic is to ignore the much deeper problem—that the kind of apologies that these laws seek to protect are ones that are given in the context of adverse events and medical errors. It would be silly to think that apology laws are necessary to enable doctors to deliver harmless empathetic statements in the everyday situation; physicians frequently and without hesitation can say to their patients that they are sorry that their patients are experiencing pain or suffering. These are not scenarios to which the apology laws are concerned. Apology laws are supposed to help doctors speak up when medical errors occur—to push doctors to engage in apologies as part of disclosure. In this way, apology laws do not tackle the more fundamental issue that physicians struggle with apologies as part of disclosure of medical errors.

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<sup>27</sup> *Maxwell v. Women’s Clinic, P.A.* 625 P.2d 407 (1981) (holding that defendant’s statement that he “obviously messed up” was insufficient to establish breach of standard of care); *Crowley v. O’Neil*, 609 P.2d 198 (holding that defendant doctor’s use of the word “accident” did not establish negligence); *Locke v. Pachtman*, 446 Mich. 216 (1994) (holding that physician’s statement that she chose a needle “too small” does not establish prima facie case); *Collins v. Itoh*, 503 P.2d 36 (1972) (holding that defendant doctor’s admission that he removed a parathyroid gland by mistake was insufficient to establish prima facie case for plaintiff); *Sutton v. Calhoun*, 593 F.2d 127 (1979) (holding that defendant doctor’s alleged statement during a conversation with the patient’s family after surgery that he made a “mistake” was not an admission of negligence); *Smith v. Karen S. Reisig, M.D., Inc.*, 686 P.2d 285 (1984) (holding that defendant doctor’s statement in the medical record that injury to plaintiff’s bladder was “inadvertent” was not an admission of negligence); *Quickstad v. Tavenner* 264 N.W. 436 (1936) (holding that alleged admissions of defendant doctor that “he broke the needle,” that he “should have used a stronger needle,” that he “shouldn’t have done it” and “would never try it again” were not enough to support a prima facie case for the plaintiff).

## B. Definitions and Approaches to Error

Errors<sup>28</sup> can be defined along at least three different dimensions: 1) the severity or gravity of the consequence, ranging from no harm to reversible harm to serious irreversible injury, and finally death; 2) potential versus actual harm (a near miss versus actual injury); and 3) the level of agency and control, and, as a corollary, the level of avoidability. The problem of uncertainty and the complicated system of healthcare delivery makes it difficult for parties to agree where to place certain events along these different dimensions. Commentators on medical errors are also divided between two models of error: the persons and systems approach.<sup>29</sup> The “persons approach” locates the problem of error to the individual level. In contrast, the “systemic approach” focuses on errors as a result of system failures.<sup>30</sup>

Defining error and choosing an approach to error are hidden battlegrounds for different institutional interests. The medical community and advocates of the patient safety movement advance the systemic approach. They avoid placing individual blame on physicians and other health care professionals. The Institute of Medicine, stresses that “[t]he problem is not bad

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<sup>28</sup> An “adverse event,” which involves actual harm, is an overlapping category with “medical error”. An adverse event (also sometimes referred to as “harm”, “injury”, or “complication”) is “[a]n injury that was caused by medical management rather than the patient’s underlying disease.” Medical management includes both actor and non-actors. Janet Barnes et al., *When Things Go Wrong: Responding to Adverse Events*, 4 (2006) (introducing a consensus statement of the Harvard Hospitals); IOM REPORT, *supra* note 2, at 29. Some adverse events may be the result of error, some not. Medical errors, according to the Harvard Hospital statement, are the “failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim.” The definition of medical error includes events that are potential and actual harm, at various levels of severity: (1) serious error (“[a]n error that has the potential to cause permanent injury or transient but potentially life-threatening harm”); (2) minor error (“[a]n error that does not cause harm or have the potential to do so”); and (3) near miss (“[a]n error that could have caused harm but did not reach the patient because it was intercepted”). Barnes et al., *supra* note 28, at 4 (borrowing from the definitions from the American Society of Healthcare Risk Management). In contrast, other authors have defined medical errors *limited to* events that have caused serious harm. See Robert J. Blendon et al., *Views of Practicing Physicians and the Public on Medical Errors*, 347 NEW ENGL. J. MED. 1933, 1934 (2002) (defining medical error as “mistakes . . . made that result in serious harm, such as death, disability, or additional or prolonged treatment.”).

<sup>29</sup> James Reason, *Human Error: Models and Management*, 320 BRITISH MED. J. 768 (2000) (discussing the differences between the person and system approach and arguing that the system approach is much more appropriate for medicine).

<sup>30</sup> *Id.*

people; the problem is that the system needs to be safer.”<sup>31</sup> The Harvard Hospital consensus statement is more balanced and distinguishes three types of error: error by attending physician, error by others on the healthcare team, and systems failure with no individual error.<sup>32</sup>

Physicians themselves understand and categorize errors differently than policymakers, legislators, or lawyers might. Charles Bosk, a sociologist who studied surgeons in major hospitals, described how surgeons saw errors as technical, judgmental, and normative errors, with a separate category of exogenous sources of failure.<sup>33</sup> Technical errors occur when a physician performs his role carefully but his skill is inadequate. Judgmental errors are when the wrong course of treatment is chosen. Normative errors, which Bosk notes are the least acceptable to physicians, occur when the physician has failed to be conscientious about her obligations of the role as a physician other than treatment and care. Some examples of normative errors are: not calling an attending physician when their patient is in a precarious or serious situation, failing to treat fellow physicians or nursing staff politely, or failing to be honest with his colleagues or superiors. One attending explained, “the most important thing is complete intellectual honesty, a willingness to admit problems and personal deficiencies. Someone who recognizes his errors and ‘fesses up.’ Look I could teach a gorilla to operate in six months, but I can’t teach honesty and responsibility. It’s the people who have these qualities that make outstanding surgeons.”<sup>34</sup>

The lack of consensus on the definition of error, and what constitutes reportable error, frustrates many parties: physicians who must figure out when to report, hospital administrators, and policymakers who try to enact effective, consistent reporting systems.<sup>35</sup>

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<sup>31</sup> IOM REPORT, *supra* note 2, at 49.

<sup>32</sup> Janet Barnes et al., *supra* note 28, at 4.

<sup>33</sup> CHARLES L. BOSK, FORGIVE AND REMEMBER 37-70 (1979) (describing the different types of errors among surgeons).

<sup>34</sup> *Id.* at 60.

<sup>35</sup> Janet Barnes et al., *supra* note 28, at 4 (noting the confusion surrounding terms referring to bad outcomes).

## C. Groups in Favor of Disclosure

Apology laws therefore must be considered within the broader conversation of disclosure of medical errors. The problem of medical errors and the question of disclosure have been approached in many different ways. Commentators on medical errors have identified “a deep-seated tension”<sup>36</sup> between the two worldviews: malpractice law<sup>37</sup> and the patient safety movement.<sup>38</sup> I suggest a third perspective, which Bibas and Bierschbach call the “relational approach.”<sup>39</sup> This section points out that those who have a stake in all three perspectives have a strong interest in encouraging disclosure. But none of them have been successful in getting doctors to disclose.

### 1. Tort Law Approach

Tort law has different goals, depending on one’s underlying theory. Advocates of the economic analysis of tort law<sup>40</sup> assert that liability rules are justified by their promotion of efficiency, whether in the form of deterrence or insurance.<sup>41</sup> In contrast, others argue that the best account of tort law is one of corrective justice<sup>42</sup> and that “those who are responsible for the wrongful losses of other have a duty to repair them.”<sup>43</sup> Medical malpractice therefore seeks: 1) to promote economic efficiency; 2) to deter negligence by doctors; 3) to compensate patients injured by negligence; and 4) to enforce an ideal of justice.

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<sup>36</sup> David Studdert et al., *Medical Malpractice*, 350 NEW ENG. J. MED. 283, 287 (2004).

<sup>37</sup> Studdert et al., *supra* note 36 (describing malpractice law as a “punitive, individualistic, adversarial approach”)

<sup>38</sup> Randall R. Bovbjerg et al., *Paths to Reducing Medical Injury: professional Liability and Discipline vs. Patient Safety—and the Need for a Third Way*, 29 J. L. MED. & ETHICS 369, 369-71 (2001).

<sup>39</sup> Stephanos Bibas & Richard A. Bierschbach, *Integrating Remorse and Apology into Criminal Procedure*, 114 YALE L.J. 85, 89 (2004).

<sup>40</sup> WILLIAM LANDES & RICHARD A. POSNER, *THE ECONOMIC STRUCTURE OF TORT LAW* (1987); STEVEN SHAVELL, *ECONOMIC ANALYSIS OF ACCIDENT LAW* (1987).

<sup>41</sup> Jules L. Coleman, *The Structure of Tort Law*, 97 YALE L.J. 1233, 1235-36 (1988).

<sup>42</sup> Jules Coleman, *Moral Theories of Torts: Their Scope and Limits*, 2 LAW & PHIL. 5 (1983).; Richard Epstein, *A Theory of Strict Liability*, 2 J. LEGAL STUD. 151 (1973); George Fletcher, *Fairness and Utility in Tort Theory*, 85 HARV. L. REV. 537 (1972); Ernest Weinrib, *Toward a Moral Theory of Negligence Law*, 2 LAW & PHIL. 37 (1983).

<sup>43</sup> Jules L. Coleman, *The Practice of Corrective Justice*, 37 ARIZ. L. REV. 15, 15 (1995)

Supporters of the tort law system have a significant interest in pushing for disclosure. Many patients will not be aware that they deserve compensation unless a physician alerts them to the fact that a medical error has occurred. The lack of disclosure will result in less just and efficient system: Fewer injured patients will receive compensation and fewer physicians will be deterred. But critics of this approach often doubt the effectiveness of legal deterrence in medicine. They also point out that physicians will only be less likely to disclose if they must face punitive consequences. There is evidence that both supports and denies a deterrent effect compared to other nonpunitive measures.<sup>44</sup>

## 2. Patient Safety Approach

Patient safety advocates promote disclosure as fundamental to the detection of error and prevention of future errors. The overarching goal of the patient safety perspective is to prevent iatrogenic injury, or injuries caused by medical management, and reduce errors through systemic changes.<sup>45</sup> Patient safety advocates push for transparency through reporting requirements and voluntary, anonymous, and confidential reporting systems. But even these nonpunitive reporting systems have not been very successful at getting doctors to disclose.<sup>46</sup>

Other patient safety advocates urge physicians to disclose to patients.<sup>47</sup> But this plea has been largely ineffective. One reason may be that the malpractice system is in place. But another part of the problem is that, in contrast to reporting systems, the connection between disclosure to *patients* and the basic patient safety goal of reducing future errors is unclear. In other words, it

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<sup>44</sup> Bovjberg et al., *supra* note 38, at nn.16 & 21.

<sup>45</sup> For a history of the development of the patient safety movement, see Michelle M. Mello et al., *Fostering Rational Regulation of Patient Safety*, 30 J. OF HEALTH POLITICS, POL'Y & L. 375 (2005).

<sup>46</sup> See Maxine M. Harrington, *Revisiting Medical Error: Five Years After the IOM Report, Have Reporting Systems Made Measurable Difference?*, 15 Health Matrix 329, 366 (2005) (“[m]ost experts believe that the low incidence of reporting is due not to a tremendous decrease in adverse incidents or medical errors, but to widespread underreporting”).

<sup>47</sup> See e.g. Dale Ann Micalizzi, Advocate for Pediatric Patient Safety & Transparency in Medicine, presentation “A Mother’s Journey Through a Health Care System that was Meant to Comfort and Heal.” (on file with author).

does not make sense to ask a physician to disclose to the patient for purely patient safety goals. There is no evidence that shows that a physician who has disclosed to the patient is any less likely to repeat the error, or that patients after disclosure are better able to avoid medical errors in the future.<sup>48</sup> Therefore, patient safety advocates risk sending physicians mixed messages when asking physicians to disclose to patients.

### 3. *Relational Approach*

Finally, the desire for disclosure and apology is important from a third perspective: to protect and improve the physician-patient relationship. Disclosure can both preserve trust and compassion in the doctor-patient relationship as an ethical ideal in itself and help maintain a good relationship in order for the patient and doctor to heal after an adverse event. Bibas and Bierschbach describe the importance of the relational approach in the criminal context:

Remorse and apology are fundamentally about social interactions and relationships. Serious wrongdoers sometimes apologize not only to the direct victim, but also to everyone who suffered indirect harm, such as members of the victim's family and community. Victims, in return, can air their sorrows while expressing forgiveness to the wrongdoer. Ideally, this interactive process teaches moral lessons, brings catharsis, and reconciles and heals offenders, victims, and society.<sup>49</sup>

Despite the ethical appeal of this perspective, advocates of the relational approach and even the physicians who subscribe to this approach will experience resistance from physicians. One of the founders of the apology and full disclosure movement, Steve Kraman and Richard Boothman, have admitted that emphasizing apologies without grounding it in other “hard-edged” justifications makes disclosure seem “too touchy-feely and self righteous.”<sup>50</sup> Calling for

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<sup>48</sup> Patient safety advocates could argue that disclosing errors to patients makes more information available to consumers and allows them to vote with their feet by choosing better hospitals or health care providers. Or they could argue that a physician who must go through the experience of disclosure to a patient is more likely to remember the error and not repeat it. However, this value-based purchasing model and deterrence justification has been neither proved nor offered as justification by patient safety advocates. Harrington, *supra* note 46, at 392.

<sup>49</sup> Bibas & Bierschbach, *supra* note 39, at 88-89.

<sup>50</sup> Steven Kraman & Richard Boothman, *Sorry Doesn't Work Alone*, available at <http://www.sorryworks.net/article31.phtml>.

disclosure without providing incentives other than the satisfaction acting morally will likely fall upon deaf ears. Kraman and Boothman admit that “[a] constant litany of “doing the right thing” won’t persuade the doubters.”<sup>51</sup>

#### **D. The Political Economy**

The problem of disclosure and how to encourage disclosure is at the center of all three approaches. I suggest that one fundamental cause of the difficulty and slowness to encouraging disclosure may be that the process has been “determined by the efforts of individuals and groups to further their own interests.”<sup>52</sup> As a result of many players at the table with different interests, the movement toward reducing error and encouraging disclosure has been both incremental and largely ineffective.<sup>53</sup>

Different parties blame others, declaring that each is disadvantaged by the political process compared to the other groups. Take, for example, the debate over the tort reform approach to medical error. Groups with defense interests, like physicians and hospitals, point out that state legislators and judges are swayed by plaintiffs’ lawyer contributions. They assert that well-organized trial bar associations like the American Trial Lawyers’ Association stymie efforts for reform.<sup>54</sup> One commentator claimed that the “trial bar, a powerful constituency in the Democratic party” and is “focused on scuttling [malpractice] reform and . . . expected to resist vigorously any attempt to introduce radical changes in the system.”<sup>55</sup>

In contrast, plaintiff’s groups suggest that patients are a diffuse group of consumers who

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<sup>51</sup> *Id.*

<sup>52</sup> Gary Becker, *A Theory of Competition Among Pressure Groups for Political Influence*, 98 Q.J. ECON. 371, 371 (1983).

<sup>53</sup> See Maxine M. Harrington, *Revisiting Medical Error: Five years after the IOM Report, Have Reporting Systems Made Measurable Difference?*, 15 Health Matrix 329, 366 (2005) (“[m]ost experts believe that the low incidence of reporting is due not to a tremendous decrease in adverse incidents or medical errors, but to widespread underreporting”); Bovbjerg, *supra* note 38, at 373-74 (noting that progress in medicine has been slow and conflicted).

<sup>54</sup> John Fabian Witt, *Lessons from History: State Constitutions, American Tort Law, and the Medical Malpractice Crisis* (2004), available at <http://www.medliabilitypa.org>.

<sup>55</sup> Studdert, *supra* note 36, at 290.



need strong representation. The trial bar argues that they need to counter the powerful organizations that represent hospitals, manufacturers, physicians, and insurance companies. Indeed, the patient safety movement is backed by “institutions and associations rather than a grass-roots response.”<sup>56</sup>

In fact, no one stakeholder has been able to dominate the discussion of medical errors or issues like tort reform.<sup>57</sup> The political economy helps to explain why progress has been slow and frustrating. But all three approaches have pushed for disclosure. They have relied on their own methods: used the threat of malpractice, coaxed physicians with nonpunitive reporting systems, or even stressed the moral goodness of disclosure. These methods may be in conflict with each other, which have contributed to the overall ineffectiveness. But it is not only this conflict that has stymied the movement to disclosure. All three approaches have encountered a strong, underlying resistance to disclosure by physicians.

### **III. Principles v. Practice: The Rule of Silence**

#### **A. Disclosure to Patients**

In January 2002, Dr. Alan Kliger, the chairman of the Department of Medicine at the Hospital of St. Raphael in New Haven, faced a physician’s worst nightmare. Two patients died—both deaths were determined accidental. Two women had been given nitrous oxide instead of oxygen during a cardiac catheterization. The hospital contacted the families to disclose the error

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<sup>56</sup> Bovjberg et al., *supra* note 38, at 372.

<sup>57</sup> A recent historical analysis of the struggle over tort reform pushes past the rhetoric and calls into question all the finger-pointing. The study suggests that tort reform actually draws robust political competition among the interested parties—competition with enough resources and incentives for every party such that no one stakeholder will be able to dominate the discussion. John Fabian Witt, *Lessons from History: State Constitutions, American Tort Law, and the Medical Malpractice Crisis* (2004), available at <http://www.medliabilitypa.org>.

and apologize.<sup>58</sup> Dr. Kliger recounts that speaking with the family was “one of the hardest things that I have ever done in my life.”<sup>59</sup>

A subsequent analysis revealed that a series of events had gone wrong: a faulty oxygen flowmeter, over a dozen systemic failures, and human error. Although the literature of medical errors and patient safety emphasizes the focus on errors as systemic failures and not individual mistakes,<sup>60</sup> the public (patients, families, or the media) naturally wants to hold individuals accountable.<sup>61</sup> It particularly does not ease the immense emotional burden on patients or the family of patients. Thus, when a physician must face the patient or family, the job remains enormously difficult.

One must not overlook the importance of the interaction between the individual physician and patient. The disclosure of adverse events is distinctly an “individual moment.”<sup>62</sup> This Part focuses on the “individual moment” of disclosure of adverse events in the physician-patient relationship. Several considerations are at play. The physician might feel great duty and responsibility to the patient and the need to explain the situation or to convey his remorse regarding errors. The physician might even want to admit error—to confess—as a way of asking for absolution of her guilt.<sup>63</sup> On the other hand, the physician might be much more cautious and reluctant to speak about error, given greater fears of liability. The physician might also be concerned about long-term repercussions of revealing error. She may be concerned about her reputation, losing the respect of her peers or colleagues, or disciplinary action from her seniors or

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<sup>58</sup> Robert F. Worth, *Hospital Says Two Died in Nitrous Oxide Mistake*, N.Y. TIMES, January 17, 2002, at B.

<sup>59</sup> Alan Kliger, Presentation at Yale School of Medicine, March 13, 2006.

<sup>60</sup> James Reason, *Human Error: Models and Management*, 320 BRITISH MED. J. 768 (2000).

<sup>61</sup> Robert J. Blendon et al., *Views of Practicing Physicians and the Public on Medical Errors*, 347 NEW ENGL. J. MED. 1933, 1938 (2002).

<sup>62</sup> Kliger, *supra* note 59.

<sup>63</sup> The statement “I confess” has a double meaning, two separate purposes. J. L. Austin distinguishes between the *constative* element, the sin or guilt to which one admits, and the *performative* aspect, the action performed by the speech act. The constative meaning in this case would be the physician admission of error, while the performative meaning would be to ask for forgiveness from the patient. PETER BROOKS, TROUBLING CONFESSIONS 21 (2000).

the hospital. It can be also extremely psychologically difficult to face the person whom she has harmed or put at risk, someone who might react to her with anger or loss of trust. There are also pressures exerted on the physician's decision external to the physician-patient relationship—particularly the recommendations of hospital lawyers, risk managers, and administration. It is not clear a priori how this complex set of considerations would affect the disclosure of errors of physicians to patients.

The public, however, is largely unanimous on wanting disclosure. The public expects physicians to be honest, open, and forthcoming. Patients generally desire (in order of diminishing unanimity): 1) a clear statement that an error has occurred; 2) an explanation of the full detail of the error; 3) a sincere apology; 4) reassurances that the something is being done to make sure the error does not happen again; and 5) financial compensation for injury, pain or suffering; and 6) accountability on the part of the responsible physician.<sup>64</sup>

Patients have an overwhelming consensus in their desire to be informed of details of what happened, even for trivial errors: 98-99% of patients favor disclosure.<sup>65</sup> A smaller majority of patients believe that near misses should be disclosed.<sup>66</sup> Patients largely want to know the full details of the error.<sup>67</sup> But disclosure of facts is insufficient. One study found that 88% of patients wanted the doctor to apologize and 99% wanted to know that something was being done to prevent the error from occurring again. Many wanted financial compensation for injury as well.<sup>68</sup>

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<sup>64</sup> See Kathleen M. Mazor et al., *Health Plan Members' Views about Disclosure of Medical Errors*, 140 ANNALS OF INTERNAL MED. 409 (2004); Thomas H. Gallagher et al., *Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors*, 289 J. AM. MED. ASS'N 1001, 1006 (2003).

<sup>65</sup> Mazor et al, *supra* note 64; Amy B. Witman et al., *How Do Patients Want Physicians to Handle Mistakes? A Survey of Internal Medicine Patients in an Academic Setting*, 156 ARCHIVES OF INTERNAL MED. 2565 (1996).

<sup>66</sup> See also Gallagher et al., *supra* note 64, at 1004.

<sup>67</sup> *Id.*

<sup>68</sup> Mazor et al., *supra* note 64 at 415; Christine W. Duclos et al., *Patient Perspectives of Patient-Provider Communication After Adverse Events*, 17 INT'L J. FOR QUALITY IN HEALTH CARE 479, 483 (2005).

In principle, at least, physicians are on the side of the patients in this matter: Between 70-90% of physicians agree that doctors should disclose medical errors to patients.<sup>69</sup> Individual physicians have stated that “[t]he bottom line is that physicians have an obligation to disclose to their patients clear-cut mistakes that cause significant harm.”<sup>70</sup> But far fewer believe trivial harm or near misses should be disclosed.<sup>71</sup>

The ethical standards of physicians reflect this narrow principle of disclosure. The American Medical Association (AMA) Code of Ethics requires disclosure when “a patient suffers *significant* medical complications that may have resulted from the physician’s mistake or judgment.”<sup>72</sup> The Joint Commission on Accreditation of Health Care Organizations (JCAHO) requires that patients must be informed of any “unanticipated” outcomes that significantly differ from their expected outcome.<sup>73</sup> The American College of Physicians (ACP) Ethics Manual states that physicians should tell patients about “procedural or judgment errors” if such information is “material to the patient's well-being.”<sup>74</sup>

These standards lack adequate specificity, are ill-suited to the complex nature of errors, and are narrow in scope. JCAHO standards have left physicians confused as to what counts as “unanticipated.”<sup>75</sup> The ACP Ethics Manual, co-authored by two attorneys, does not define materiality (which is a legal, and not medical term), and the AMA Code of Ethics is silent on

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<sup>69</sup> Kathleen M. Mazor et al., *Communicating With Patients About Medical Errors*, 164 ARCHIVES OF INTERNAL MED. 1690 (2004).

<sup>70</sup> Albert W. Wu, *A Major Medical Error: Case Scenario*, 63 American Family Physician 985, 986 (2001). For more opinions on the need for physicians to offer full disclosure, see Albert W. Wu, *Doctors are Obligated to be Honest With Their Patients*, 322 BRITISH MED. J. 1238 (2001); Albert W. Wu, *Medical Error: The Second Victim*, 320 BRITISH MED. J. 726 (2000).

<sup>71</sup> *Id.* at 1692.

<sup>72</sup> American Medical Association, AMA Code of Medical Ethics, A-02 Edition, E-8.00 Opinions on Practice Matters, at <http://www.insp.mx/Portal/MSP/bases-eticas/pdf/Declaraciones-materia.pdf>.

<sup>73</sup> Joint Commission on Accreditation of Health Care Organizations, *Revisions to Joint Commission Standards in Support of Patient Safety and Medical Health Care Error Reduction* (2001), available at [http://www.premierinc.com/all/safety/resources/patient\\_safety/downloads/12\\_JCAHO\\_strds\\_05-01-01.doc](http://www.premierinc.com/all/safety/resources/patient_safety/downloads/12_JCAHO_strds_05-01-01.doc).

<sup>74</sup> Lois Snyder & Cathy Leffler, American College of Physicians, *Ethics Manual*, Fifth Edition, 142 Annals of Internal Med. 560 (2005).

<sup>75</sup> Janet Barnes et al., *supra* note 28.

how to determine whether a complication is “significant.” Also, the standards do not tackle common, but complex, questions: How much physician contribution to an error creates the duty to disclose? Is a physician obligated to disclose a systems error? What are the obligations of a physician who witnesses a colleague’s harmful error?

Furthermore, these codes do not state who should report the error to the patient or family. On the one hand, the openness of the codes lends flexibility. On the other hand, the lack of assignment of the difficult task of disclosure can lead to passing of responsibility from person to person. Both physicians and the public significantly agree that a physician should disclose the error to the patient, more so than the hospital or nurse involved.<sup>76</sup> However, interestingly, another study suggests that as the severity of the mistake increases, the desire of the patient to speak to the erring physician drops: Only half of patients would like to speak about the physician who made a severe mistake, whereas their desire to speak to *another* physician about the mistake increases.<sup>77</sup> This study suggests that the appropriateness of the responsible physician to speak directly with the patient may depend on the severity of the error. Should the physician who has committed a severe mistake speak to the patient directly? Should the erring physician provide other physicians or administrators to whom the patient may feel more comfortable speaking about the error? The ethical codes do not help to answer these questions.

Moreover, these standards require only disclosure of facts. The Code of Ethics requires the physician “to inform the patient of all the *facts* necessary.”<sup>78</sup> The Veterans Health Administration Directive defines disclosure as a “discussion of *clinically significant facts*.”<sup>79</sup> All

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<sup>76</sup> Blendon et al., *supra* note 76, at 1939 (finding that both physicians and the public believed that the doctor should report the error to the patient or family rather than the nurse or hospital).

<sup>77</sup> Witman, *supra* note 65, at 2567.

<sup>78</sup> Am. Med. Ass’n, AMA Code of Medical Ethics, A-02 Edition, E-8.00 Opinions on Practice Matters, at <http://www.insp.mx/Portal/MSP/bases-eticas/pdf/Declaraciones-materia.pdf>.

<sup>79</sup> Department of Veterans Affairs, *Disclosure of Adverse Events to Patients*, VHA Directive 2005-049, October 27, 2005, available at <http://www1.va.gov/vhaethics/download/AEPolicy.pdf>.

standards are silent on the whether the physician should issue an apology, expression of regret or remorse, assumption of responsibility, or even reassurance that there are changes in place to prevent future errors. One suspects, particularly given patient expectations, that the duty to disclose and responsibility to one's patient include much more than a factual release—that physicians have an obligation to repair the broken trust in some deeper way. One wonders whether these guidelines recommend an “ethical” disclosure after all.

Physicians fail to meet even their own ethical standards and disappoint patient expectations on all fronts. Only about a quarter of physicians actually disclose medical errors. In a study of physicians-in-training, only 24% discussed the mistake with the patient or the patient's family.<sup>80</sup> Of note, these rates of disclosure may not be entirely accurate since it has been shown that attitudes toward disclosure significantly differ based on level of experience: Those who are more experienced have less trouble and are and less reluctant to disclosing errors.<sup>81</sup> Some subsequent studies of experienced physicians have corroborated the low rates of disclosure to patients.<sup>82</sup> Nationwide studies suggest that physicians in only about 30% of cases disclose errors.<sup>83</sup>

The disconnect between physicians and patients reaches deeper, disturbing levels. Disclosure is not only uncommon, but also the content and form of disclosure can vary widely—often both failing the expectations of patients and falling short of clear disclosure. The language of disclosure to patients avoids blame or responsibility, and sometimes does not suggest a

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<sup>80</sup> Albert W. Wu et al., *Do House Officers Learn From Their Mistakes?*, 12 QUALITY & SAFETY IN HEALTH CARE 221 (2003).

<sup>81</sup> Lauris Kaldjian, Pending data—study to be published.

<sup>82</sup> Joyce Allman, *Bearing the Burden or Baring the Soul: Physicians' Self-disclosure and Boundary Management regarding Medical Mistakes*, 10 HEALTH COMMUNICATION 175 (1998) (finding that physicians disclosed their error to the patient or patient's family only 21% of the time, but her study sample was only 39 physicians).

<sup>83</sup> Robert J. Blendon et al., *Views of Practicing Physicians and the Public on Medical Errors*, 347 NEW ENGL. J. MED. 1933, 1935 (2002).

problem at all.<sup>84</sup> In a study of physicians disclosing clear-cut, harmful errors to standardized patients, surgeons described clear, harmful errors to patients using “error” or “mistake” in 57% of cases, “complication” or “problem” in 27% of cases, and did not suggest the error at all in 16% of cases.<sup>85</sup> Physicians admit that they choose their words carefully, some consciously protect themselves and other rationalize that it is to “protect” the patient. One physician explained:

I think you have to be a spin doctor all the time and put the right spin on it. . . . I don’t think you have to soft pedal the issue, but I think you try to put it in the best light. I think you have to be forthright with the patient *to help them*. And how you word it makes a big difference.<sup>86</sup>

Physicians do not often take responsibility or apologize with empathy. Only 21% of physicians apologized after they made a harmful mistake.<sup>87</sup> In fact, some doctors believe that to admit a mistake or say that they were affected emotionally is unprofessional.<sup>88</sup>

Even when physicians eventually disclosed the error, they did so only *after* patients press them for further details about the incident.<sup>89</sup> This response directly conflicts with what patients want: a forthcoming and honest physician, rather than having to be the one to ask the doctor and search for answers. Patients and family members sense that their physicians are being unforthcoming and protective,<sup>90</sup> and feel alone and frustrated—both emotions that are commonly

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<sup>84</sup> Gallagher et al., *supra* note 66, at 1004 (reporting that physicians choose their words carefully when talking to patients about errors that have occurred).

<sup>85</sup> David K. Chan et al., *How Surgeons Disclose Medical Errors to Patients: A Study Using Standardized Patients*, 138 *Surgery* 851, 854-55 (2005).

<sup>86</sup> Gallagher et al., *supra* note 66, at 1004 (emphasis added).

<sup>87</sup> Albert W. Wu et al., *Do House Officers Learn From Their Mistakes?*, 12 *QUALITY & SAFETY IN HEALTH CARE* 221 (2003).

<sup>88</sup> Gallagher et al., *supra* note 66, at 1005.

<sup>89</sup> Chan, *supra* note 85, at 855.

<sup>90</sup> Patients have reported that communication with the physician often breaks down after they perceive that the physician is afraid of liability or “covering his butt.” Duclos et al., *supra* note 68, at 482.

experienced by patients after injurious errors.<sup>91</sup> The breakdown of the physician-patient relationship quickly ensues.

## **B. Disclosure Among Physicians**

One might expect that physicians have a much harder time telling a patient that they have made a mistake compared to explaining it to another physician. Other physicians might be more understanding and would be less likely to react with anger or retaliation. The morbidity and mortality (M & M) conferences are places where physicians can conduct such peer review and self-regulation. But these conferences illustrate that even a legally protected forum cannot successfully encourage physicians to speak about errors openly and transparently.

There are substantial safeguards in place to protect proceedings and statements in M & M conferences from discovery and admission in malpractice cases. This has not encouraged admission of error or disclosure in these forums as successfully as one might expect. Despite protections of the confidentiality of such forums in both federal and state courts, physicians remain reluctant to discuss their mistakes or errors. This example suggests that legal liability does not constrain the discussion of error as much as perhaps other factors, such as the social norms of medicine. It also shows that evidentiary protections meant to promote candor and self-improvement do not necessarily make it much easier to physicians to talk about their own errors. This provides grounds to question the potential effectiveness of apology laws.

Physicians have historically resisted public acknowledgement of medical errors to the public, even to other physicians. The tradition of M & M conferences has been commonly traced to Ernest Codman, a surgeon at Massachusetts General Hospital between 1911 and 1917.<sup>92</sup>

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<sup>91</sup> Duclos et al., *supra* note 68, at 482 (finding that patients drawn from a post-injury program complained of feeling alone and forced to bear the burden of searching for information of what happened).

<sup>92</sup> Jay D. Orlander, et al., *The Morbidity and Mortality Conference: The Delicate Nature of Learning from Error*, 77 ACAD. MED. 1001, 1002 (2002).



Codman wanted to standardize care and devised an “End Result System” that documented each patient’s diagnosis, outcome, treatment plan, and any complications from treatment.<sup>93</sup> He pressed for the publication of these results and for transparency among colleagues and even to the public. Codman urged hospitals to review cases in which errors may have occurred. Codman’s effort toward reform was met with resistance by his colleagues. He later established his own private hospital and published the results of his End Result System.<sup>94</sup> He called for public hospitals to do the same, to no avail.<sup>95</sup>

It was not until 1935 that a formal group was created to review and share information about adverse outcomes: the Anesthesia Mortality Committee in Philadelphia. The meetings served to educate physicians and to improve the quality of care by reviewing cases in which morbidity or mortality occurred.<sup>96</sup> The committee was an early prototype of M & M conferences. They reviewed fatalities related to anesthesia and also aimed to enhance the education of physicians-in-training. Transparency also increased, with the commission releasing public reports and data. But the system was still relatively conservative in its review of errors. Reporting error remained voluntary, and often the physician responsible for the case was not present. Obvious and more egregious errors were not discussed.<sup>97</sup>

Since then, the M & M conference has spread throughout different areas of medicine, including emergency medicine, surgery, and internal medicine. But the primary goal of these meetings has given way to almost an exclusive emphasis on education and teaching “interesting” cases.<sup>98</sup> Staff surgeons and residents believe the primary goal of the conference is education, and

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<sup>93</sup> E. A. Codman, *A STUDY IN HOSPITAL EFFICIENCY* (1992) (1918).

<sup>94</sup> *Id.* at 98-107. He divided errors into categories like errors due to lack of care, lack of judgment, and incorrect diagnoses. *Id.*

<sup>95</sup> *Id.* at 107.

<sup>96</sup> *Id.*

<sup>97</sup> Orlander, *supra* note 92, at 1002.

<sup>98</sup> Charles Biddle, *Investigating the Nature of the Morbidity and Mortality Conference*. 65 *ACAD MED.* 420 (1990).

residents have asserted that the environment should be improved to decrease blame.<sup>99</sup> In one study, only 72% of cases reviewed at weekly anesthesia M & M conferences included morbidity or mortality at all.<sup>100</sup> Most cases were selected mainly for their teaching value.

One might argue just because the focus has shifted to education, that does not necessarily mean that physicians do not analyze their errors. Components like admission of error, acknowledgement of responsibility, and commitment not to repeat similar errors could still exist in an educational environment. But, in reality, errors are infrequently discussed. As low as 10% of cases presented in internal medicine conferences<sup>101</sup> and 34% of cases in surgery conferences discussed error.<sup>102</sup> Even more sobering, a study of surgical M & M conferences which were part of a formal quality assurance program revealed that physicians were often absent when their complications were discussed, with only 33% of the staff surgeons attending when their complications were discussed.<sup>103</sup> Even when errors are discussed at the conferences, it is rare for participants to use language that indicated that an error had occurred. Few acknowledged making the error at hand.<sup>104</sup> Physicians reported that in about half of cases in which error was discussed, “the tough issues were not addressed.”<sup>105</sup> In fact, most internal medicine conferences lack clear error-related objectives or established procedures for handling the discussion of errors.<sup>106</sup>

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<sup>99</sup> Sean P. Harbison et al., *Faculty and Resident Opinions Regarding the Role of Morbidity and Mortality Conference*. 177 AMER. J. SURGERY 136 (1999).

<sup>100</sup> Charles Biddle, *Investigating the Nature of the Morbidity and Mortality Conference*. 65 ACAD MED. 420 (1990).

<sup>101</sup> Charles Biddle, *Investigating the Nature of the Morbidity and Mortality Conference*. 65 ACAD MED. 420 (1990).

<sup>102</sup> Jon S. Thompson & Mary A. Prior, *Quality Assurance and Morbidity and Mortality Conference*, 52 J. SURGICAL RES. 97 (1992).

<sup>103</sup> *Id.*

<sup>104</sup> Edgar Pierluissi, et al. *Discussion of Medical Errors in Morbidity and Mortality Conferences*, 290 J. AM. MED. ASS'N 2838 (2003).

<sup>105</sup> Wu, *supra* note 87.

<sup>106</sup> Jay D. Orlander, et al., *The Morbidity and Mortality Conference: The Delicate Nature of Learning from Error*, 77 ACAD. MED. 1001, 1003 (2002).

The reluctance to discuss errors publicly comes from many different sources. Physicians have cited the anxiety of exposing individual fault, reputational costs, fear of loss of referrals, and fears of liability and exposure to malpractice litigation.<sup>107</sup> But one must question whether the legal liability of statements made during these conferences is a reasonable concern. Despite the perceived specter of liability in these forums, there are several evidentiary protections that are in place precisely to encourage physicians to speak out honestly and review their errors. The law affords multiple ways of preventing the information discussed in these conferences from getting to a jury. The two main sources are from the general federal rules of evidence, including the federal self-critical analysis, and the medical peer review privilege.

First, in terms of the general federal rules of evidence, the categorical exclusion rule, Rule 407 of the Federal Rules of Evidence, states that remedial action taken after an injury cannot be admitted as proof that the injury was a consequence of negligence.<sup>108</sup> The underlying policy for the rule is to encourage defendants to improve the safety of their practices or product. Some states have extended the rule to cover self-evaluative reports and postinjury analyses, and the reports in M & M conferences can fall under this protection. However, the rule does not prevent the plaintiff from admitting the evidence for other purposes, such as proving causation or impeaching a witness. This may help explain physicians' reluctance to speak, but at the same time, Rule 403 still gives the judge discretion to exclude evidence based on its prejudicial value. Given the strong underlying public policy of encouraging candor in the medical review process, the proceedings of M & M conferences have a high likelihood of being excluded from malpractice litigation either under Rule 407 or Rule 403 of the Federal Rules of Evidence.

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<sup>107</sup> Dr. Francis D. Moore described M & M conferences as integral to continuing medical education and error correction, but notes that colleagues cannot errors openly because of risks of liability. *See* FRANCIS D. MOORE, *A MIRACLE AND A PRIVILEGE: RECOUNTING A HALF CENTURY OF SURGICAL ADVANCE* 91 (1995).

<sup>108</sup> FED. R. EVID. 407.

Moreover, courts have recognized immunity to discovery based on a federal self-critical analysis privilege. Under Rule 501 of the Federal Rules of Evidence, a court can recognize privileges under “the principles of the common law as they may be interpreted by the courts of the United States in the light of reason and experience.”<sup>109</sup> In *Jaffee v. Redmond*, the Supreme Court held that Rule 501 authorized federal courts to define new privileges, but stressed that the evidentiary privileges should be construed narrowly and applied only where it “promotes sufficiently important interests to outweigh the need for probative evidence.”<sup>110</sup> The court in *Bredice v. Doctors Hospital, Inc.*, recognized a self-critical analysis privilege under Rule 501 for a hospital peer review conference on the treatment of patients, holding that the public’s interest is best served by encouraging candid discussions.<sup>111</sup> This decision was affirmed in *Weekoty*, which held that the self-critical analysis privilege would be recognized in the context of proceedings and reports at morbidity and mortality conferences.<sup>112</sup> The court stated that “[t]o open these meetings to public scrutiny would completely undermine the public good produced by ensuring confidentiality. ‘Constructive professional criticism cannot occur in an atmosphere of apprehension that one doctor’s suggestion will be used as a denunciation of a colleague’s conduct in a malpractice suit.’”<sup>113</sup> The production of materials from M & M conferences and similar peer review mechanisms have been protected from discovery in other cases as well.<sup>114</sup>

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<sup>109</sup> FED. R. EVID. 510.

<sup>110</sup> 518 U.S. 1 (1996) (citing *Trammel v. United States*, 445 U.S. 40, 51 (1980)).

<sup>111</sup> *Bredice v. Doctors Hospital, Inc.*, 50 F.R.D. 249 (D.D.C. 1970).

<sup>112</sup> *Weekoty v. U.S.* 30 F. Supp. 3d 1343 (D.N.M. 1998).

<sup>113</sup> *Id.* at 1346.

<sup>114</sup> *Spinks v. Children’s Hospital National Medical Center*, 124 F.R.D. 9, 12 (D.D.C. 1989) (recognizing the protection of morbidity and mortality conference materials under statutory privilege); *Utterback v. Yoon*, 121 F.R.D. 297 (W.D.Ky. 1987) (holding that quality assurance records are confidential and protected from discovery in Federal Tort Claims Act medical malpractice claim against the United States).

Within the medical context, the self-critical analysis privilege has been rejected only in the context of claims by doctors against hospitals alleging racial or sexual discrimination,<sup>115</sup> defamation of character,<sup>116</sup> or revocation of hospital privileges.<sup>117</sup> While these opinions recognize that not all opinions held by physicians are protected by discovery, the underlying policy to safeguard proceedings and materials related to medical error in malpractice cases remains intact.<sup>118</sup>

Finally, all states (except New Jersey) have statutes that protect the work of medical review committees or peer review committees.<sup>119</sup> The stated policy goal of these laws is to encourage honesty and effective risk-management by physicians. These state laws differs both in terms of scope and strength by jurisdiction, but share two common purposes: 1) to provide immunity from liability for committee members participating in good faith in the peer review process; and 2) to protect the medical review committee, and its records and materials from discovery in civil actions.<sup>120</sup> These laws were enacted to encourage effective medical peer review.

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<sup>115</sup> Johnson v. Nyack Hospital, 169 F.R.D. 550 (1996); Brem v. Decarlo, Lyon, Hearn & Pazourek, 162 F.R.D. 94 (1995).

<sup>116</sup> Brem v. Decarlo, Lyon, Hearn & Pazourek, 162 F.R.D. 94 (1995).

<sup>117</sup> Franzon v. Massena Memorial Hospital, 189 F.R.D. 220 (1999) (denying privilege to physician peer review and quality assurance process in a claim that hospital refused to renew plaintiff's hospital privileges after advocating for a nurse-midwifery program).

<sup>118</sup> Physicians might still be concerned that there are limitations to the privilege of self-critical analysis. Courts have refused to extend the privilege to the facts upon which the evaluation is based, but these cases are not in the medical context. Such examples include *In re Crazy Eddie*, 792 F.Supp. 197 (E.D.N.Y. 1992), in which the court held that the privilege of self-critical analysis is not absolute and applies only to the analysis and evaluation itself and not to the facts on which the evaluation is based. The court admitted that not extending the privilege would risk a chilling effect on a company's attempt to monitor its work. The court nevertheless decided the effect did not outweigh the need for discovery and to determine the issues fairly in this particular case, involving audit documents in a securities case. *In re Crazy Eddie*, at 205-06. Courts have rejected the privilege in other nonmedical contexts, including academic tenure and mortgage loans. *University of Pennsylvania v. EEOC*, 493 U.S. 182 (1990) (rejecting peer review privilege in the academic tenure context); *Spencer Savings Bank v. Excell Mortgage Corp.*, 960 F.Supp. 835, 843-44 (D.N.J.1997). While the courts are willing to reject the privilege in nonmedical contexts, these cases can be successfully distinguished from medical malpractice cases.

<sup>119</sup> IOM REPORT, *supra* note 2, at 119.

<sup>120</sup> Charles David Creech, *The Medical Review Committee Privilege: A Jurisdictional Survey*, 67 N.C. L. REV. 179 (1988).

The Washington Supreme Court articulated a test for determining whether the privilege was recognized and applied the privilege only where the committee in question was a “regularly constituted committee or board of the hospital whose duty it is to review and evaluate the quality of patient care.”<sup>121</sup> Since courts generally realize that the privilege exists to encourage effective medical peer review, morbidity and mortality conferences usually qualify as “medical review committees” as defined with the statutes.<sup>122</sup> A minority of courts, like the Georgia Supreme Court, have read the statutory privilege more narrowly, strictly limiting the privilege to only committees specified by the statute.<sup>123</sup> The court held that the statute did not protect information generated by or kept by groups other than the specified “medical review committee” under the statute. However, in *Poulcott*, the Georgia appellate court held that a surgical conference fell within the definition of a medical review committee, despite the fact that there was no set membership, since it was considered an initial step in the peer-review process.<sup>124</sup> Therefore, even in jurisdictions that strictly construe the scope of the statute, the conferences can be structured to conform to the formal requirements of a medical review committee in order to show that these conferences are steps toward a peer-review process.

This brings us back to the earlier point that modern M & M conferences have strayed from their original purpose of overseeing error and quality control. The paradox is that the less likely physicians are willing to format such conferences as places for discussion of error and quality of patient care, the less likely courts will be willing to extend medical peer review privilege to them. In other words, if physicians are worried that what they say at M & M

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<sup>121</sup> *Coburn v. Seda*, 101 Wash. 2d 270, 276, 677 P.2d 173, 177 (1984).

<sup>122</sup> In Texas, the medical review statute was interpreted broadly to cover proceedings and materials of any group of persons constituted by the rules and bylaws of the hospital. *Texarkana Memorial Hosp v. Jones*, 551 S.W.2d 33 (Tex. 1977).

<sup>123</sup> *Hollowell v. Jove*, 247 Ga. 678, 279 S.E.2d 430 (1981).

<sup>124</sup> *Poulcott v. Surgical Ass'ns of Warner Robins*, 179 Ga. App. 138, 140, 345 S.E.2d 639, 641 (1986).

conferences might not be protected, their behavior to steer these conferences clear of error discussion will ultimately lead to *less* protection for these conferences, creating a self-fulfilling prophecy. Instead, these conferences are in fact strongly protected by the law as long as address and discuss error and seek to improve the quality of care.

But the strong legal protection of proceedings at M & M conferences does not necessarily mean that they provide the best setting for error discussion. The resistance to disclosure among physicians suggests that there other sources for physicians' silence. As mentioned before, the social, nonlegal pressures of the M & M conference are considerable. Physicians-in-training have reported that mistakes were discussed at attending rounds in 57% of cases and at morning report or morbidity and mortality conferences in only 31% of cases.<sup>125</sup> The latter category has a much broader, larger audience compared to attending rounds. Attending rounds are generally comprised of the immediate medical team that is intimately involved in the patient care and usually includes only one treating attending physician. In contrast, morning reports include most physicians-in-training (i.e., chief residents, senior residents, and interns). M & M conferences include even more people: dozens of attending physicians, nearly all residents, and also medical students.

Most of these physicians at either morning report or M & M conferences are not familiar to the patient case that is being presented and are not directly responsible for the patient's care. When the physician-in-training on the team (usually mid-level or senior resident) presents the cases at the M & M conferences, she faces both a potential loss of respect not only from those higher up but also faces potentially undermining her authority over interns and medical students. The loss of respect not only translates into weakening her professional relationships, but also puts at risk her future performance assessment and recommendations from her seniors.

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<sup>125</sup> Albert Wu et al., *supra* note 105, at 225.

Furthermore, she may be unable to explain fully her error within the context of a complicated patient case in such a broad, public forum, most of whom are not familiar with the case history.

One might expect that the doctors who are more senior are more secure and thus more willing to discuss error. While this might be the case, even those at the top of the hierarchy risk the economic loss of future referrals by their fellow colleagues and loss of respect. Worse still, even when high-ranking physicians do admit error, the M & M conference may not provide an effective self-checking mechanism. Dr. Atul Gawande points this out, in his account of an orthopedic surgeon who repeatedly demonstrated poor decision-making and patient care. Physician colleagues did not prevent him from continuing to operate.<sup>126</sup> Dr. Sherwin Nuland, also a surgeon, goes even further and writes that that M & M conferences “support our tendency to excuse ourselves for looking the other way. At such meetings various commentators are certain to bring up what in the confines of a conference room would appear to be the perfect apology, namely, that ‘the patient’s disease was the culprit.’”<sup>127</sup>

Charles Bosk notes that one strong prohibition against criticism among physicians at the M & M conference is the professional norm that the patient is the individual responsibility of the supervising attending physician.<sup>128</sup> In other words, it would be disrespectful for an attending physician to criticize another attending physician or members of her team regarding how they handled their patient.<sup>129</sup> This unspoken professional rule makes self-regulation even less

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<sup>126</sup> ATUL GAWANDE, *COMPLICATIONS: A SURGEON’S NOTES ON AN IMPERFECT SCIENCE* 90-91 (2002).

<sup>127</sup> Sherwin B. Nuland, Letter to Mary Dilligan, July 18, 2002, 49 N.Y. REV. OF BOOKS (2002).

<sup>128</sup> BOSK, *supra* note 33, at 135.

<sup>129</sup> Of note, the lack of criticism among colleagues does not conflict with a long-standing, underlying principle of the American Medical Association Code of Ethics to protect the quality of the professional care for patients from other non-physicians, rather than a self-checking mechanism. In 1903, the Code of Ethics imposed a duty on physicians to “enlighten the public” and “make known the injuries sustained by the unwary from the devices and pretensions of artful impostors” especially when it came to injuries or death that might be the result of “great wrongs committed by charlatans.” The same Code makes no mention of what physicians are to do with their own errors or the errors of other physicians. Am. Med. Ass’n, *Principles of Medical Ethics*, May 16, 1903, Chapter III, Section 4, available at <http://www.ama-assn.org/ama1/pub/upload/mm/43/1903principalsofethi.pdf>. A similar principle underlies the 2001



effective. Physicians who make obvious errors may go unchecked by other physicians. It is considered unprofessional and unfathomable if a physician discloses to the patient that another physician may have committed an error, no matter how obvious the error might be. This tradition is deeply entrenched in the history of the medical profession and its tendency to protect its own. In the early twentieth century, when professional medical societies were at their height of control, it was nearly impossible to find a physician willing to be an expert witness for the plaintiff.<sup>130</sup> This is no longer the case today as the power of the professional societies has faded, but the underlying sentiment of self-protective behavior of physicians is still strong.

The social norms of medicine and physicians may prevent physicians from criticizing each other either publicly or from attending to attending. But physicians also do not always report and discuss errors even on their own team. In a recent study, only 54% of physicians-in-training reported that they discussed the mistake with the supervising attending physician of the patient.<sup>131</sup> Although this is higher than reporting in M & M conferences (31%), it is still little over half of the time. A substantial percentage of mistakes go thus unreported to the supervising physician. One might try to give physicians the benefit of the doubt—perhaps physicians did not find it necessary to report the mistakes because the mistakes did not actually harm the patient. But 90% of the physicians in the same study reported that the mistakes actually had “significant adverse outcomes” for the patient.<sup>132</sup> What could then explain the decision to keep such harmful mistakes concealed from the supervising physician?

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Code of Ethics, which states that physicians have the duty to “strive to report physicians deficient in character or competence.” Chapter II, <http://www.ama-assn.org/ama/pub/category/2512.html>.

<sup>130</sup> Catherine T. Struve, *Expertise in Medical Malpractice Litigation: Special Courts, Screening Panels, and Other Options*, 11-12 (2003), available at <http://medliabilitypa.org/research/struve1003/StruveReport.pdf>.

<sup>131</sup> Albert W. Wu et al. *supra* note 105, at 225.

<sup>132</sup> *Id.* at 224.

One explanation is the natural discomfort of drawing attention to your own weaknesses and mistakes, particularly to an authority figure who is evaluating your performance. In the same study, 88% of physicians-in-training discussed the mistake with another physician who was *not* in a supervisory capacity and 58% spoke with a non-medical person about the mistake.<sup>133</sup> This dispels the notion that physicians are simply silent about their own mistakes to everyone. On the contrary, physicians feel a strong need to communicate and confess the mistake to someone. A strikingly low 5% of physicians did not tell anyone about the mistake.<sup>134</sup>

But while the fear of a poor evaluation and the hierarchical nature of medicine contribute to the unwillingness to admit error openly among colleagues, this alone does not explain fully why physicians are unable to discuss such errors. Physicians-in-training actually do not demonstrate a strong fear of negative consequences: Only 28% of physicians reported a fear of negative repercussions to themselves from these mistakes. So if they are not worried about negative consequences for themselves, what else is stopping them from telling their supervising physicians?

The examples of the M & M conference and discussion with supervising physicians demonstrate that the fear of liability or damage to reputation is not an adequate or satisfying explanation for why physicians are reluctant to discuss and admit to errors in patient care even among themselves. The discomfort of public accountability may not be the only reason doctors remain silent about errors. But if physicians are unable to admit error among their own

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<sup>133</sup> *Id.*

<sup>134</sup> *Id.* It is possible that the percentage of physicians who do not tell anyone about their mistake is greater, since there are limitations to the research survey that could weaken this conclusion. In particular, it is possible that the nonresponse to the survey was nonrandom. In other words, those who responded to the survey on medical mistakes may also be the type of physicians who are able to share their mistakes in the first place. Those who remain in denial or refuse to share the information could be more likely to decline to return the survey (45% of the 254 physicians surveyed responded).

colleagues and under legal protection, it comes as little surprise that physicians rarely admit or disclose errors to the public or to their patients, to whom they are perhaps the most accountable.

## **B. Disclosure to Reporting Systems**

What is most striking is that even nonpunitive measures suffer from underreporting. Reporting systems at the federal and state level attempt to build a database upon which providers can patient safety.<sup>135</sup> The detection and prevention of medical error continues to be plagued by underreporting of adverse events, even when they are anonymous, voluntary and confidential.<sup>136</sup> This is in marked contrast with the reporting systems that have successfully monitored other kinds of events, like adverse drug reactions, vaccine reactions, or nosocomial infections.<sup>137</sup> This suggests that there is something particular about the nature of medical errors that physicians are uncomfortable with reporting, even when they will not be held accountable.

The most recent effort to encourage reporting is the Patient Safety and Improvement Act of 2005.<sup>138</sup> Providers can contract with Patient Safety Organizations (PSOs), new public or private entities created by this Act that would identify and analyze patient safety issues. The work product between the provider and PSO is both confidential and privileged.<sup>139</sup> PSOs will not be federally funded, however: providers are expected to fund PSOs. It is too soon to know whether these PSO systems will also suffer from underreporting as the other reporting systems before it. But there is little to suggest that these systems will be any more successful in inducing physicians to report errors.

## **IV. Why physicians resist disclosure**

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<sup>135</sup> For an overview of the development of reporting systems, see Harrington, *supra* note 136, at 355-65.

<sup>136</sup> *Id.* At 362-67 (2005) (discussing the problem of underreporting).

<sup>137</sup> Harrington, *supra* note 136, at 357-58 (discussing the Food and Drug Administration's MedWatch program, the Centers for Disease Control's (CDC's) system for reporting vaccines reactions, and the CDC's National Nosocomial Infections Surveillance database for hospital-based infections and antimicrobial resistance, which has about 315 general hospitals participating).

<sup>138</sup> Patient Safety and Improvement Act of 2005, S. 544, 109th Cong., § 923 (2005).

<sup>139</sup> *Id.*, § 922.

Part IV explores what creates this strong, pervasive resistance by physicians to speak about medical errors. The previous sections have illustrated that physicians are reluctant to report and speak about errors, even when they are provided with legal protections. This suggests that accountability and legal liability are incomplete answers. But these concerns about legal liability are frequently cited as major contributors to why physicians do not disclose their medical errors, particularly to patients. Other common reasons are disciplinary action, damage to one's reputation within the public or medical community all weigh against the decision to disclose.<sup>140</sup> This Part examines these concerns one by one.

### **A. The Risk of Malpractice Litigation**

In the aftermath of adverse events, many physicians claim that they are concerned about the risk of malpractice litigation. It is an answer commonly used by those with defense interests. The Institute of Medicine claims that “[p]atient safety is . . . hindered through the liability system and the threat of malpractice, which discourages the disclosure of errors.”<sup>141</sup> Troyen Brennan and Philip Howard also assert that health care errors go unreported because “people fearful of legal consequences are reluctant to speak up.”<sup>142</sup>

The AMA Code of Ethics clearly forbids physicians from considering legal liability when during disclosure.<sup>143</sup> But the fear of malpractice litigation is pervasive and potent.<sup>144</sup> Physicians see the tort system as an irrational “lawsuit lottery” and “revile malpractice claims as random

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<sup>140</sup> Lauris C. Kaldjian et al., *Facilitating and Impeding Factors for Physicians' Error Disclosure: A Structured Literature Review*, 32 J. QUALITY AND PATIENT SAFETY 188 (2006).

<sup>141</sup> IOM REPORT, *supra* note 2, at 37.

<sup>142</sup> Troyen A. Brennan & Philip K. Howard, *Help the Law, Then Health Care*, WASH. POST, Jan 25, 2004, at B7.

<sup>143</sup> The AMA Code states: “[c]oncern regarding legal liability which might result following truthful disclosure should not affect the physician's honesty with a patient.” American Medical Association, AMA Code of Medical Ethics, A-02 Edition, E-8.00 Opinions on Practice Matters, at <http://www.insp.mx/Portal/MSP/bases-eticas/pdf/Declaraciones-materia.pdf>.

<sup>144</sup> Wu et al. *supra* note 105. See Ann G. Lawthers et al., *Physicians' Perceptions of the Risk of Being Sued*, 17 J. HEALTH POL. POL'Y & L. 463, 469 (1992); Joseph E. Schumacher & Ferris J. Ritchey, *Malpractice Litigation Fear and Risk Management Beliefs*, 88 S. Med. J. 1204 (1995).

events that visit unwarranted expense and emotional pain on competent, hardworking practitioners.”<sup>145</sup> But physicians overestimate the certainty and severity of legal sanctions, and the actual risk of getting sued by threefold.<sup>146</sup> Studies suggest that physicians believe erroneously that most negligent adverse events lead to lawsuits, estimating that 60% of cases involving negligence result in litigation, which is thirty times higher than most estimates.<sup>147</sup>

The reasons behind this overestimation may be linked to a misunderstanding of the legal system, including a failure to consider practical barriers to filing lawsuits (e.g. accessibility to lawyers, willingness for plaintiff lawyers to take on malpractice suits) or an overestimation of patients’ litigiousness. Faced with a rising frequency of claims, seemingly more aggressive clients, and spikes in insurance premiums, doctors and hospitals blame the trial bar.<sup>148</sup> Others have blamed these inflated fears as a result of predictable guild behavior stemming from “self-interest” or “the influence of organized medicine.”<sup>149</sup> Such interpretations are at risk for oversimplification and do not analyze the many distortions inherent to risk perception in general. Also, to reduce the problem to merely misinformation or miscalculation in statistical probabilities ignores the effect of psychological aspects on risk perception.

Risk perceptions are generated by both feelings and cognitive variables, like probabilities and outcomes.<sup>150</sup> Risk perception literature illuminates how the fear of legal liability is linked to multiples sources. Hazards that are more dramatic are more easily remembered and have high

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<sup>145</sup> Studdert et al., *supra* note 36, at 283.

<sup>146</sup> Lawthers et al., *supra* note 163, 469.

<sup>147</sup> *Id.* at 477 (only 2% of all patients in New York State injured due to negligence actually filed malpractice claims).

<sup>148</sup> Michelle M. Mello et al., *The New Medical Malpractice Crisis*, 348 NEW ENG. J. MED 2281, 2283 (2003).

<sup>149</sup> TOM BAKER, THE MEDICAL MALPRACTICE MYTH 40 (2005).

<sup>150</sup> Paul Slovic & Elke U. Weber, *Perception of Risk Posed by Extreme Events*, 9-15 (2002), available at [http://www.sfu.ca/media-lab/archive/2004/226jan2004/notes/slovic\\_wp.pdf](http://www.sfu.ca/media-lab/archive/2004/226jan2004/notes/slovic_wp.pdf).

cognitive “availability,” leading to overestimation of risk.<sup>151</sup> Well-publicized effects on malpractice premiums and large malpractice jury awards impress upon physicians the drama and horror of malpractice lawsuits.<sup>152</sup>

Risk perceptions are highest if an adverse event causes “dread risk”—events associated with a lack of control, dread, catastrophic potential, fatal consequences, or an unjust distribution of risks and benefits.<sup>153</sup> Malpractice suits contain all of these elements, except for fatal consequences. Physicians are distressed by the lack of control during a lawsuit.<sup>154</sup> The lawsuit makes physicians feel “uneasy, vulnerable, dependent, frustrated.”<sup>155</sup> Malpractice cases strike a heavy blow and threaten their careers and reputation, both of which most physicians have invested in and prepared for meticulously for years. Physicians feel angry and insulted by lawsuits—perceiving them as a challenge to their authority and their integrity.

Physicians dread the monetary costs, damage to professional reputation, risk to licensure and the emotional burdens that come with lawsuits. Individuals base risk assessment on subjective factors, like the similarity of their own situation to those whom they have personal knowledge.<sup>156</sup> Physicians therefore identify with the experience of their colleagues. A majority of physicians know at least one colleague who has gone through an emotionally and

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<sup>151</sup> Asabo Holm, *Comparative Studies of Risk Perception: A Review of Twenty Years of Research*, 1 J. RISK RES. 135, 138 (1998) (citing work of Lichtenstein et al.).

<sup>152</sup> *Id.* at 475.

<sup>153</sup> *Id.*

<sup>154</sup> The difficult experience of malpractice litigation on physician has prompted works to coach physicians. *See e.g.*, SARA C. CHARLES & PAUL R. FRISCH, ADVERSE EVENTS, STRESS AND LITIGATION. A PHYSICIAN’S GUIDE (2005). Charles & Frisch focus on how physicians can help themselves by “regaining control.” *Id.* at 126-27.

<sup>155</sup> *Id.* at 126.

<sup>156</sup> *Id.* at 473 (citing risk assessment literature).

professionally trying malpractice lawsuit.<sup>157</sup> A substantial number of physicians who are sued speak about the negative experience with their peers.<sup>158</sup>

Physicians have reason to dread lawsuits. Lawsuits provoke marked distress in most physicians. Over 95% of physicians report strong emotional responses, physical reactions, or both.<sup>159</sup> A majority of physicians who have been sued report depressed mood (72-80%), inner conflict (74-86%), frustration (70-78%), and anger (70-88%).<sup>160</sup> Half of physicians report insomnia and a minority describe an onset or exacerbation of physical problems that they attribute to the lawsuit. These emotions were not relieved, even if the physician won the case. The psychological and physical reactions to malpractice lawsuits are tied to the *allegations*, not necessarily the outcome of the case.<sup>161</sup> The allegation, legal process, and outcome are all stressful to physicians. Physicians must face burdens of questioning themselves and being questioned by others, and grapple with the stigma of implied failure of due care. Being cleared of the charge does little to lift those burdens. In fact, physicians who have successfully defended their case may still go on to change their clinical decisions, including ordering unnecessary tests, changing record keeping, avoiding high-risk procedures or certain patients, and even choosing early retirement.<sup>162</sup>

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<sup>157</sup> *Id.* at 475. In fact, physicians also report that some of their colleagues decided not to return to medicine after a lawsuit, even after they won their malpractice case, because they did not want to ever subject themselves to the emotional costs of enduring a lawsuit. Interview with Dr. David Coleman, March 14, 2006.

<sup>158</sup> Sara C. Charles et al., *Physicians on Trial—Self-Reported Reactions to Malpractice Trials*, 148 W. J. MED. 358, 359 (1988).

<sup>159</sup> Sara C. Charles, *Coping with a Medical Malpractice Suit*, 174 W. J. MED. 55 (2001).

<sup>160</sup> *Id.*

<sup>161</sup> Charles et al., *supra* note 158, at 360.

<sup>162</sup> *Id.* At 360; Charles, *supra* note 159. Physicians also cite anecdotal evidence about physicians who have been sued, cleared of charges, but then decide to retire early since they never want to go through another lawsuit again. Interview with Dr. David Coleman, March 14, 2006.

Many physicians also believe that the tort system is not a just distribution of benefits and costs. They believe that they will be sued for non-negligent adverse events.<sup>163</sup> In fact, research published in the *New England Journal of Medicine* feeds this idea; researchers found that the severity of the patient's disability, not the presence of negligence, was more predictive of payment to plaintiff. This result was interpreted to suggest an unjust torts system, even though there are alternative explanations.<sup>164</sup> Finally, events that occur in a poorly understood system further amplify risk perception. In most cases, physicians are unfamiliar with the legal system—and particularly an adversarial system. Given this backdrop, the decision to disclose and therefore possibly expose oneself to a lawsuit runs against basic fears of exposing oneself to harm—whether professional, emotional or physical.

But the problem is deeper than the fact that physicians dislike the unpredictability of the malpractice system. Doctors are not just afraid of being sued for errors that they may not have committed. But physicians *also* resent being sued for errors that they did in fact make.<sup>165</sup> The fear litigation includes a fear of retribution. Physicians recognize that patients and families demand accountability. One *New England Journal of Medicine* study concluded that “[t]he public believes that persons responsible for errors with serious consequences should be sued, fined, and subject to suspension of their professional license.”<sup>166</sup>

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<sup>163</sup> Ann G. Lawthers et al., *Physicians' Perceptions of the Risk of Being Sued*, 17 J. HEALTH POLITICS POL. & L. 463, 469 (1992) (finding that 45% of physician believe they will be sued for non-negligent events).

<sup>164</sup> Troyen A. Brennan et al., *Relationship between Negligent Adverse Events and the Outcomes of Medical-Malpractice Litigation*, 335 NEW ENG. J. MED. 1963 (1996). The finding that the severity of the case and not the negligence in this study increases plaintiff's chance of winning does not necessarily mean that the tort system is arbitrary. There are at least two alternative interpretations. The more severe the injury, the easier it is for the plaintiff to show injury, one of the necessary claims to a prima facie case of negligence. Also, the more severe the injury, one may reason that the likelihood that negligence occurred is higher. See PATRICIA MUNCH DANZON & LEE A. LILLARD, *THE RESOLUTION OF MEDICAL MALPRACTICE CLAIMS*, 39 (1982).

<sup>165</sup> Catherine T. Struve, *Expertise in Medical Malpractice Litigation: Special Courts, Screening Panels, and Other Options*, 15 (2003), available at <http://medliabilitypa.org/research/struve1003/StruveReport.pdf>.

<sup>166</sup> Robert J. Blendon et al., *Views of Practicing Physicians and the Public on Medical Errors*, 347 NEW ENGL. J. MED. 1933, 1938 (2002).



Most patients and families who file a legal action report feeling angry, bitter, betrayed, or humiliated.<sup>167</sup> In cases where explanations were given, patients and family report feeling dissatisfied—that the explanation was unclear, inaccurate, or sparse—even though 40% felt like the explanations were given sympathetically. Most were informed of the error by hospital administration in 70% of cases, and by the doctor in less than 10% of cases.<sup>168</sup> This leaves one to wonder whether a doctor’s direct acknowledgment and explanation of the error would have changed the patient’s willingness to sue. But even more importantly, this data suggests that an empathetic discussion is insufficient to deter a lawsuit, undermining a major presumption of apology laws that apologies can lead to lower lawsuits.

The most prominent reasons that patients and families filed a lawsuit was because they did not want the mistake to happen to anyone else, wanted an explanation, or wanted the doctor to realize what they had done or to admit negligence.<sup>169</sup> Many wanted the doctor to know how they felt, felt ignored, and wanted financial compensation. Patients also report feelings of revenge and desire for punitive measures. One study found that two-thirds of patients in general want the responsible physician to be reprimanded by an authority and almost half wanted the doctor to be punished, including that the physician be put on probation or to have their license suspended or revoked.<sup>170</sup> Indeed, a substantial number of patients who filed lawsuits reported that they wanted of revenge and disciplinary action against their physician.<sup>171</sup> In general, a poor

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<sup>167</sup> Charles Vincent et al., *Why do people sue doctors? A study of patients and relatives taking legal action*, 343 *The Lancet* 1609, 1611 (1994) (finding 90% of those seeking legal action were angry, 80% bitter, 55% betrayed, and 40% feeling humiliated). Families who filed medical malpractice claims after perinatal injuries reported a range of reasons: 33% of cases were advised by acquaintances, 24% felt like there was a cover-up; 24% needed financial help, 23% felt their child had no future, 20% wanted information, and 19% felt they wanted to seek revenge or protect others from harm. Gerald B. Hickson et al., *Factors that Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries*, 267 *J. Am. Med. Assoc* 1359 (1992).

<sup>168</sup> *Id.* at 1611.

<sup>169</sup> *Id.* at 1611.

<sup>170</sup> Mazor et al., *supra* note 64.

<sup>171</sup> Vincent et al., *supra* note 167, at 1611.

physician-patient relationship can be a major contributor to why patients seek suit.<sup>172</sup> Plaintiffs report that their physicians did not listen, would not speak openly, or was misleading or did not adequately warn the patient of the risks.<sup>173</sup> People also report that they sued because they felt that the physician was not honest, were unable to find out information about the incident, or that a non-lawyer third party recommended a lawsuit.<sup>174</sup> Although these studies suggest that disclosure might actually lower the number of claims, all studies in this area are conducted retrospectively and are thus subject to hindsight bias. There is no reassurance that even if things had been done differently, that patients would have actually forgone a lawsuit.

To make matters worse, the impact of full disclosure may only buffer a difficult situation after a severe mistake. There has been no clear empirical study in this area. The relationship between full disclosure and a patient's desire to sue remains unclear: disclosure has been shown to increase, decrease, or not change at all the patient's desire to sue.<sup>175</sup> Given the lack of a consensus, many physicians remain skeptical of the ability for disclosure to stop a patient from legal action: "Despite anecdotal reports of such positive experiences, the notion that disclosure reduces litigation is largely unproven and somewhat implausible."<sup>176</sup>

Advocates of full disclosure and apology laws frequently tout the Veterans Affairs medical center experience in Lexington, Kentucky as an example where full disclosure led to

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<sup>172</sup> LaRae I. Huycke & Mark M. Huycke, *Characteristics of Potential Plaintiffs in Malpractice Litigation*, 120 *Annals of Internal Med.* 792 (1994) (finding that over half of potential plaintiffs complained of a poor relationship with the health care provider).

<sup>173</sup> Hickson et al., *supra* note .

<sup>174</sup> W. Levinson et al., "Physician-Patient Communication: The Relationship with Malpractice Claims among Primary Care Physicians and Surgeons," 277 *J. Amer. Med. Ass'n* 553 (1997).

<sup>175</sup> Mazor et al., *supra* note 69 (demonstrating no affect of disclosure on patient's desire to seek legal advice); Witman, *supra* note 65, at 2565 (finding that patients who wanted to sue slightly decreased in cases where the adverse event was fully disclosed, but did not impact cases of severe mistakes as much).

<sup>176</sup> Studdert et al., *supra* note 36, at 287.

overall lower legal costs.<sup>177</sup> In 1987, the Lexington center instituted a new policy of mandatory disclosure. They notified patients of negligence, scheduled a face-to-face meeting of a group of administrators with the patient and family, and assisted patients in filing claims. The medical center settled most of their claims and was in the top quarter of VA medical centers for number of tort claims filed but was in the lowest quarter for malpractice payouts. But the administrators of Lexington center were hesitant to compare this number with other health care facilities, given their limited access to factors like workload, inpatient days, size and complexity of facility, types of procedures and regional differences—all of which can affect the patient’s willingness to sue.<sup>178</sup> Nevertheless, in 2005, the disclosure policy was extended to all Veterans Affairs medical centers.<sup>179</sup>

What is strikingly absent or glossed over when advocates of disclosure use the Lexington VA as an example of a full disclosure policy are the major differences in the way the law treats Veterans Affairs (VA) hospitals compared to nongovernmental hospitals. First, the VA system is a government-based system that offers comprehensive, nearly free universal coverage. The system has the ability to compensate those who have suffered an adverse event through remedial treatment or even disability payments without going through a lawsuit.<sup>180</sup> In contrast, compensation for patients in nongovernmental hospitals is sought through more limited means: Some patients can seek compensation through direct negotiations between a patient’s representative and hospital lawyers but usually only if there is obvious error. If there is no

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<sup>177</sup> Albert W. Wu, *Handling Hospital Errors: Is Disclosure the Best Defense?*, 131 ANN. INTERNAL MED. 970 (1999).

<sup>178</sup> Steve S. Kraman & Ginny Hamm, *Risk management: Extreme honesty may be the best policy*, 131 ANN. INTERNAL MED. 963, 965-66 (1999).

<sup>179</sup> Department of Veterans Affairs, *Disclosure of Adverse Events to Patients*, VHA Directive 2005-049, October 27, 2005, available at <http://www1.va.gov/vhaethics/download/AEPolicy.pdf>.

<sup>180</sup> Kraman & Hamm, *supra* note 178, at 966.

obvious case of error, the plaintiff must file a lawsuit in order to seek compensation.<sup>181</sup> Second, government health care practitioners are immune from personal liability as government employees under the Federal Tort Claims Act (FTCA).<sup>182</sup> Under the FTCA, the court applies the tort standards of the state where the incident occurred for its substantive law.<sup>183</sup> But before a claim can be filed in federal court, the claimant must file an administrative demand against the government and must exhaust administrative remedies. The administrative claim requirement gives the government the opportunity to settle the claim outside of court and to provide the claimants with a way to resolve small claims that would not be cost-effective to litigate.<sup>184</sup> Thus, physicians at VA hospitals benefit from much stronger barriers to lawsuits and more options outside of litigation. At a more basic level, the patient population at VA hospitals is also skewed compared to nongovernmental hospitals. A predominantly male patient population means that most facilities do not usually include obstetrics—one of the most frequently named specialties in malpractice cases.<sup>185</sup> The VA system and doctors are better situated to deal with the potentially costly consequences of a full disclosure policy. Such differences make the Lexington center disanalogous to nongovernmental hospitals and physicians.

Few nongovernmental hospitals, in fact, have a disclosure policy in place.<sup>186</sup> But some have implemented a disclosure policy. Studies of these hospitals should be conducted in order to determine the costs and benefits to hospitals. Dana Farber Cancer Institute in Boston reports that

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<sup>181</sup> Interview with Lisa Fay, hospital lawyer, Yale-New Haven Hospital, March 31, 2006.

<sup>182</sup> 28 U.S.C. § 2671-2680.

<sup>183</sup> For an example of medical malpractice cases under the FTCA, see *Oslund v. United States*, 701 F. Supp. 710, 713-14 (D. Minn. 1988) (interpreting Minnesota's malpractice statute as applied to Vietnam veteran), and *Hill v. United States*, 751 F. Supp. 909, 910 (D. Colo. 1990) (applying Colorado malpractice statute to child injured in Army care)

<sup>184</sup> Brief, *Medical Malpractice Claims Against Public Health Service and Federally Funded Community Health Center Physicians*, available at [http://biotech.law.lsu.edu/cases/immunity/malpractice\\_ftca.htm](http://biotech.law.lsu.edu/cases/immunity/malpractice_ftca.htm).

<sup>185</sup> Sloan et al., *Medical Malpractice Experience of Physicians: Predictable or Haphazard?* 262 J. AMER. MED. ASS'N 3291 (1989).

<sup>186</sup> Rae M. Lamb et al., *Hospital Disclosure Practices: Results of a National Survey*, 22 HEALTH AFFAIRS 73 (2003).

their policy to disclose has not resulted in a dramatic increase in lawsuits, and another hospital in Massachusetts, Sturdy Memorial, reports that disclosure has been positive for the hospital overall. But hospitals are split on whether patients are less likely to sue after disclosure, reflecting the similar ambivalence of physicians toward disclosure's impact on litigation.<sup>187</sup>

The fear of liability is an unsatisfying answer to why physicians choose not to disclose. Some physicians have admitted that there is no empirical basis for this assertion: “[n]o link between [error] reporting and litigation has ever been demonstrated.”<sup>188</sup> Critics like David Hyman and Charles Silver dispute the fact that the fear of liability is a major contributor to nondisclosure. They contend that “there is massive underreporting of errors throughout the health care system, regardless of the level of liability risk that providers face.”<sup>189</sup> Hyman and Silver point out those physicians at VA hospitals, who are not individually liable, have not historically disclosed more often than physicians at nongovernmental hospitals.<sup>190</sup> Specialties with varying levels of liability are also no different at reporting errors.<sup>191</sup> This paper has also suggested that the real reason behind physician nondisclosure is not fully answered by legal liability, since forums that are more legally protected fare no better in encouraging doctors to disclose and even when reporting systems are nonpunitive.

Will physicians be persuaded by this evidence or Hyman and Silver's criticism? I believe not. Such criticisms will do little to persuade physicians to reflect on why they really choose not to disclose errors. As outsiders of a highly insulated profession, authors like Hyman and Silver and Tom Baker, author of *The Myth of Medical Malpractice*,<sup>192</sup> will be accused of not really

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<sup>187</sup> *Id.* at 76-78.

<sup>188</sup> Lucian L. Leape, *Reporting of Adverse Events*, 347 *New Engl. J. Med.* 1633, 1635 (2002).

<sup>189</sup> David A. Hyman & Charles Silver, *Believing Six Improbably Things: Medical Malpractice and “Legal Fear”*, 28 *HARV. J. L. & PUB. POL’Y* 107, 110 (2004).

<sup>190</sup> *Id.* at 110-11.

<sup>191</sup> *Id.*

<sup>192</sup> TOM BAKER, *THE MEDICAL MALPRACTICE MYTH* 40 (2005).

understanding medicine. As one physician noted, Baker's book was "clearly written by a law professor."<sup>193</sup> The same physician quickly followed with a story of how his friend, also a physician, suffered a traumatic experience in a malpractice suit.

## **B. The Tradition of Self-Regulation**

The desire for self-regulation in medicine is a major reason why physicians continue to resist disclosure. The fear of legal liability is but one part of the broader tradition that physicians like to be in control when it comes to their profession. Physicians resent being told what to do or how to treat their patients, especially by nonphysicians.

Medicine has a history of self-regulation. Physicians worked hard to create an impermeability of the medical community to critics from the outside. Through control of licensing and professional societies, the medical profession had successfully gained control of both credentialing and disciplining physicians during the nineteenth and early twentieth centuries. The medical community had successfully insulated itself from outside judgment and criticism.<sup>194</sup> Local medical societies protected their members, and disciplinary actions were very rarely filed against physicians. This period has been regarded by physicians as the "golden age."<sup>195</sup>

But the push for public accountability in the 1970s and 1980s challenged this model of local, informal professional self-regulation and opened up the medical community to unprecedented scrutiny.<sup>196</sup> Physicians no longer dominated disciplinary boards. States expanded

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<sup>193</sup> Alan Kliger, interview, March 24, 2006.

<sup>194</sup> PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* (1982); Ken Marcus Gatter, *The Continued Existence and Benefit of Medicine's Autonomous Law in Today's Health Care System*, 24 U. DAYTON L. REV. 215 (describing medicine as tries to protect itself from external threats of regulation).

<sup>195</sup> John B. McKinlay & Lisa D. Marceau, *The End of the Golden Age of Doctoring*, INT'L J. HEALTH SERVICES 379 (2002).

<sup>196</sup> Struve, *supra* note 165, at 14.

the role of the layperson and scaled back the role of medical societies.<sup>197</sup> The quality control and patient safety movement, spurred by the IOM report in 2000, was part of this larger trend which threatened medicine's autonomy. The movement to bring medical errors into the public eye and the push for physicians to disclose medical mistakes heightened physicians' fears not just of liability, but, more fundamentally, their fear of having their control taken away from them. Six years after the IOM report, physicians continue to acknowledge that the discussion of medical errors remains hidden from the public eye: "As most of you are well aware, discussion of medical errors is still largely behind closed doors."<sup>198</sup> Few physicians have advocated for this to change.

### **C. The Mask of Infallibility**

The issue of error hits a raw nerve in medicine. It is a difficult reminder of the profession's vulnerability, a reality that threatens both the public and medical community's idealization of the physician as infallible. Dr. David Hilfiker explains that both patients and physicians perpetuate the expectation of physician perfection:

We are not prepared for our mistakes, and we don't know how to cope with them when they occur. Doctors are not alone in harboring expectations of perfection. Patients, too, expect doctors to be perfect. Perhaps patients have to consider their doctors less prone to error than other people: how else can a sick or injured person, already afraid, come to trust the doctor?<sup>199</sup>

Physicians are expected to be perfectly competent, conscientious, and compassionate in all domains.<sup>200</sup> The image of perfection, as Dr. Jay Katz emphasizes, facilitates the fantasy of

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<sup>197</sup> *Id.* at 15.

<sup>198</sup> Herbert Chase, Deputy Dean of Education at Yale School of Medicine, email to author and students at Yale School of Medicine, Jan 17, 2006 (on file with author).

<sup>199</sup> DAVID HILFIKER, HEALING THE WOUNDS: A PHYSICIAN LOOKS AT HIS WORKS 76-77 (1985).

<sup>200</sup> Neeli M. Bendapudi et al., *Patients' Perspectives on Ideal Physician Behaviors*, 81 MAYO CLIN. PROCEEDINGS 338, 340 (2006).

both the patient as healed and physician as healer.<sup>201</sup> The yoke of perfection is both attributed and self-imposed. As a result, Dr. Hilfiker describes how mistakes end up underground:

[P]erfection is a grand illusion, of course, a game of mirrors that everyone plays. Doctors hide their mistakes from patients, from other doctors, even from themselves. Open discussion of mistakes is banished from the consultation room, from the operating room, from physicians' meetings . . .<sup>202</sup>

This image of perfection reinforces and feeds two fundamental aspects of the physician-patient relationship: the physician's position of authority and the physician as a source of certainty—both of which are foundations for trust.<sup>203</sup> The authority of the physician figure is deeply connected with the idea of both moral and clinical perfection, and rests in:

a belief in the physician's superior expertise and . . . some sort of trust that a physician will make use of such expertise beneficently, in consideration only or mostly of the patient's welfare and/or autonomy and not for mere profit, or in consideration only or mostly, of the outcome of some peer panel's evaluation in an HMO review procedure.<sup>204</sup>

Physicians and patients rely on the reassurance of certainty in medicine—in their diagnostic tests and imaging, clinical skills, and treatment plans. Though unrealistic, such certainty provides stability and comfort to both sides. Physicians are not trained to develop a keen awareness of uncertainty, much less acknowledge it to patients, though much of training is learning to cope with uncertainty. Dr. Sherwin Nuland notes, “If it is true, as some say, that physicians are the least introspective or self-doubting of the learned professionals, the reason may be that they are convinced of their own good intentions and of their ability to make correct therapeutic choices.”<sup>205</sup>

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<sup>201</sup> JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 142-43 (1984).

<sup>202</sup> HILFIKER, *supra* note 199, at 77.

<sup>203</sup> KATZ, *supra* note 201, 165-206.

<sup>204</sup> ROBERT B. PIPPIN, *THE PERSISTENCE OF SUBJECTIVITY: ON THE KANTIAN AFTERMATH* 242 (2005).

<sup>205</sup> *Books: Five Best*, WALL ST. J., April 1, 2006.



An increased awareness of uncertainty may or may not be helpful to patients, physicians, or the physician-patient relationship.<sup>206</sup> One could also imagine that a worrywart physician who is aware of risks and limitations of science could be more conscientious and realistic: “diligence and attention to the minutest details can save you.”<sup>207</sup> A mutual acknowledgement of uncertainty could make for better communication, where both parties set reasonable expectations. It may also produce a more humble and humane physician. Gawande emphasizing that although true perfection may be unrealistic, it should remain the ideal: “[D]octors will sometimes falter, and it isn’t reasonable to ask that we achieve perfection. What is reasonable is to ask that we never cease to aim for it.” However, a constant awareness of uncertainty (and reminder of one’s fallibility) might paralyze the physician, for, such doubts are “anxiety-producing for all concerned.”<sup>208</sup> Dr. Atul Gawande describes a surgeon who made a mistake that killed a patient: “[a]fterwards, he [the surgeon] could barely bring himself to operate. When he did operate, he became tentative and indecisive. The case affected his performance for months.”<sup>209</sup> The physician must struggle with a delicate balance of authority and semblance of certainty in gaining a patient’s trust and trust in oneself, carefully avoiding either extreme of being either too prideful or lacking confidence altogether.

#### **D. Potential Loss of Trust**

Physicians worry that to admit error tips this balance, pierces the “mask of infallibility”<sup>210</sup> and undermines trust. Physicians are concerned about an increasingly fragmented delivery of medical service and shorter available visits with their patients. All this combined, they claim, makes it difficult to form strong relationships with their patients—relationships that may not be

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<sup>206</sup> KATZ, *supra* note 201, 165-73, 169.

<sup>207</sup> *Id.* at 73.

<sup>208</sup> HILFIKER, *supra* note 199, at 61.

<sup>209</sup> ATUL GAWANDE, *COMPLICATIONS* 61 (2002).

<sup>210</sup> KATZ, *supra* note 201, at 198.

resilient to disclosure of mistakes. While the constraints on the physician-patient relationship (or at least the physician perception of them) may be true,<sup>211</sup> it is not clear that patients are as unforgiving as physicians fear. Physicians may be much harsher on themselves and project this expectation onto the patients. Would the disclosure of a mistake destroy the trust that is so necessary to a meaningful therapeutic connection between the doctor and patient?

Some studies show that patients are indeed less willing to see the physician again after mistakes, regardless of disclosure.<sup>212</sup> One survey demonstrated that patients' desire for referrals to another physician grew as the severity of the mistakes increased.<sup>213</sup> The physician-patient relationship most likely takes a toll from the very event of the mistake—and disclosure can only buffer that breakdown in trust. If willingness of seeing the physician again is a proxy for trust, the breakdown of trust after mistakes—regardless of disclosure or not—clearly drops as the severity of mistakes increases. If the physician disclosed the mistake, 69% of patient reported they would retain their physician after a minor mistake, 41% after a moderate mistake, and 7% after a severe mistake. Compare this with the scenario where the physician does not disclose the mistake: 13% of patients would return after a minor mistake, 8% after a moderate mistake, and 3% after a severe mistake.<sup>214</sup> This data suggests that a significant percentage of patients lose trust in their doctor after a mistake, but that doctors can at least repair some of the damage by disclosing minor or moderate mistakes. Severe mistakes are only slightly affected by disclosure—and trust may be irreparable at that point.

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<sup>211</sup> The claims of shorter visits, loss of physician autonomy, and an increasingly difficult environment for strong physician-patient relationships are controversial. For a study of patient office visits that suggests that shorter clinical visits may actually be a myth, see David Mechanic et al., *Are Patients' Office Visits Getting Shorter?*, 344 NEW ENG. J. MED. 198 (2001).

<sup>212</sup> Witman et al., *supra* note 65.

<sup>213</sup> *Id.*

<sup>214</sup> *Id.*

Other studies suggest that disclosure can actually increase patient satisfaction and trust.<sup>215</sup> One study has shown that full disclosure actually *reduced* the reported likelihood of changing physicians and *increased* patient satisfaction, trust, and positive emotional response.<sup>216</sup> But one major limitation of these studies is that they are hypothetical; participants are often drawn from outpatient clinical settings with no criteria or indication that they have had any significant experience with the medical system.<sup>217</sup> Physicians may reasonably fear that patients are even less forgiving in reality—particularly when patients are ill—compared to what they might report on a survey study. Thus whether disclosure successfully buffers the erosion of trust is uncertain. As a result, physicians are faced with a paradox of self-defeat: In order to restore trust, physicians must reveal mistakes, events that may be viewed as a betrayal of trust. The physician-patient relationship must first be put into jeopardy before it can be redeemed. And to remain silent betrays a patient’s trust even more. The process of disclosure to physicians is anxiety-producing not only because it leaves them exposed to the patient’s distrust, but also because it exposes them to their own distrust of themselves.

### **E. Guilt and Shame**

One major piece of this puzzle may be found in the immense amount of guilt in physicians who have committed mistakes. Assuming good faith, physicians, like other health care professionals, choose their profession because they want to help people, not harm them. Moral guilt occurs when one has contravened one’s conscience.<sup>218</sup> Physicians experience strong feelings of guilt and similar oppressive emotions after mistakes. Dr. Gawande describes his

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<sup>215</sup> Mazor et al., *supra* note 64, 414-16.

<sup>216</sup> *Id.*

<sup>217</sup> See e.g., Mazor et al., *supra* note 64 (surveying members of a New-England based health maintenance organization without further criteria); Witman et al., *supra* note 65, (surveying patients from a general internal medicine outpatient clinic who had been seen by a physician during the year).

<sup>218</sup> JOHN CARROLL, *GUILT: THE GREY EMINENCE BEHIND CHARACTER, HISTORY AND CULTURE* 9 (1985).

reaction after his own mistake: “I felt a sense of shame like a burning ulcer. . . . What I felt was shame: I was what was wrong.”<sup>219</sup> Physicians-in-training report strong emotional reactions to their mistakes: 81% reported feelings of remorse after their mistakes, 79% felt angry at themselves, 72% experienced guilt, and 60% felt inadequate.<sup>220</sup> Only about 10% of physicians reported that they didn’t let the mistake get to them, even fewer tried to move on as if nothing had happened, and only 5% tried to forget the mistake.<sup>221</sup>

Guilt can show itself as remorse, obsession, rationalization, resentment, depression or anxiety.<sup>222</sup> Shame is an emotion, a “powerful henchman”<sup>223</sup> of guilt, which occurs when the individual fails her own self-ideal. Physicians who have committed mistakes face at least three potential sources of guilt or shame: 1) the mistake itself; 2) the breach of trust and expectations of the patient; and 3) keeping the mistake secret from the patient. The anxiety of guilt is heightened around people connected to the event, and thus people avoid people who may judge or remind them of their past wrong, which helps explain why physicians avoid patients after mistakes.<sup>224</sup> In fact, even when disclosure occurs, most patients are informed by hospital administration or institutional actors like the chief-of-staff in as much as 70% of cases, with the doctor explaining the error in less than 10% of cases.<sup>225</sup>

It is perhaps these uncomfortable emotions that compel physicians to share their mistakes with other physicians and non-medical people to whom they are not responsible. Few are able to keep the mistake wholly repressed and secret.<sup>226</sup> It is not clear in which direction the cause and

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<sup>219</sup> ATUL GAWANDE, *COMPLICATIONS* 61 (2002).

<sup>220</sup> Wu et al., *supra* note 87, at 225.

<sup>221</sup> Albert W. Wu et al., *How House Officers Cope with Their Mistakes*, 159 *WESTERN J. MED.* 565, 566 (1993).

<sup>222</sup> *Id.* at 15-29.

<sup>223</sup> *Id.* at 29 (on the distinction between guilt and shame).

<sup>224</sup> *Id.* at 15-29 (describing various symptoms of guilt).

<sup>225</sup> *Id.* at 1611.

<sup>226</sup> As mentioned before, in a study of physicians-in-training, only 5% of physicians do not tell anyone about the mistake. See *supra* note 134 and accompanying text.

effect of the guilt and lack of disclosure runs,<sup>227</sup> but one can imagine that it is a vicious cycle; the guilt of hidden knowledge compounds the guilt of the mistake, making it all the more difficult to disclose.

## **F. Physician as Only Healer**

In addition to guilt and the fear of imperfection, disclosure runs against the grain of a tradition of the physician as a healer *exclusively*. The vision of the physician as healer is grounded in a long-standing tradition in medicine of withholding bad news—whether it was negative prognoses, diagnoses, or risks of the procedure and treatment—and refusing to deliver such information to patients and families.<sup>228</sup> In fact, the American Medical Association (AMA) Code of Medical Ethics in 1903 emphasized that the physicians must always be the purveyor of hope and wellness, stating that

[t]he physician should be a minister of hope and comfort to the sick, since life may be lengthened or shortened not only by the acts but by the words and manner of the physician, whose solemn duty is to avoid all utterances and actions having a tendency to discourage and depress the patient.<sup>229</sup>

The Code goes so far to advise physicians to delegate the duty of delivering bad news to persons *other* than the physician.<sup>230</sup>

But delivering bad news in general and delivering news of an adverse event should be distinguished in kind and present different and separate obstacles. The problem of the adverse event can even more difficult than delivering bad news. Delivering bad news about a test result

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<sup>227</sup> It is possible that there is response bias in the study that would affect the numbers of those who feel guilt or similar emotions. In other words, those who felt guilty could be more likely to respond to the survey, and thereby skew the results.

<sup>228</sup> KATZ, *supra* note 201, 1-29 (discussing the history of silence in the physician-patient relationship and exploring the resistance of the profession to informed consent).

<sup>229</sup> AMA Principles of Medical Ethics, ch.1, § 6 (1903) *available at* <http://www.ama-assn.org/ama1/pub/upload/mm/43/1903principalsofethi.pdf>.

<sup>230</sup> AMA Principles of Medical Ethics, Ch. 1, § 5 (1903) (“Ordinarily, the physician should not be forward to make gloomy prognostications . . . This notice, however, is at times so peculiarly alarming when given by the physician, that its deliverance may often be preferably assigned to another person of good judgment.”)

or a diagnosis can upset the patient and family, but the physician is able to be a source of strength and support. In disclosing an adverse event, the physician presents herself instead in opposition to the patient or family's interests. She can still be a source of support, but she delivers news of a breach of trust, and must admit that the medical system, or physicians as part of that system, has failed them. This is a much more difficult and negative role to play. Most physicians are not prepared for this role.<sup>231</sup>

### **G. Asymmetry in the Physician-Patient Relationship**

Another underlying problem of the physician-patient relationship is its inherent imbalance of knowledge. Doctors are able to hide their mistakes because of the major gap in knowledge and expertise between physicians and patients. Patients are in most cases not medically knowledgeable and sometimes are even physically incapable of being aware of their circumstances. The very relationship between physician-patients of such asymmetry at some level enables the physician to keep silent, particularly when there is no obvious harm done.

But the asymmetry goes beyond pure medical expertise and knowledge. The relationship is a one-way enterprise. The physician is the silent observer, the listener. The patients divulge problems, confess symptoms, and, in surgery, have their bodies opened and exposed. In many ways, the physician-patient relationship is like a one-way window: the most intimate details of the patient's life and body are shared with the physician, but there is no expectation that the physician must share information about herself. In fact, physician self-disclosure, when a physician describes a personal experience, is both rare and controversial.<sup>232</sup> Physician self-

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<sup>231</sup> For an example of a recently developed curriculum for medical students in dealing with error, see Deborah C. Meiris et al., *Culture Change at the Source: A Medical School Tackles Patient Safety*, 21 AM. J. OF MED. QUALITY 9 (2006).

<sup>232</sup> Mary Catherine Beach, *What Do Physicians Tell Patients About Themselves?*, 19 J. OF GENERAL INTERNAL MED. 911, 911 (2004).

disclosure is considered an unprofessional boundary violation,<sup>233</sup> criticized as “a misuse of the patient to satisfy ones’ own needs for comfort or sympathy.”<sup>234</sup>

In disclosure, the physicians find that the tables are turned. The physician is now vulnerable and exposed. But, unlike the patient, the physician cannot confess<sup>235</sup>—or ask for absolution of her guilt from the only person who can grant it:

[u]nable to admit our mistakes, we physicians are cut off from healing. We cannot ask for forgiveness, and we get none. We are thwarted, stunted, we do not grow.<sup>236</sup>

In silence, physicians leave the strength of the physician-patient relationship untested — as well as their own ethic unfulfilled.

## **V. Strategies to Encourage Disclosure**

Apology laws will not overcome these barriers to disclosure. From the legal liability angle, apologies may not actually lower litigation costs or number of lawsuits, and in some cases, may actually alert more patients to file a claim. Therefore, physicians will not be reassured that an apology or full disclosure will avert a lawsuit. This uncertainty can only exacerbate the frustrations and fears of physicians have toward liability.

Second, the true location of the physician’s fear of legal liability is not simply losing a lawsuit. Many physicians are upset by simply the *allegation*, even in cases where they recognize negligence did occur. Evidentiary protections like apology laws only tip the lawsuit slightly in the physician’s favor but do nothing to get rid of the underlying fear or discomfort that a patient will file a claim.

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<sup>233</sup> Mary Catherine Beach, What Do Physicians Tell Patients About Themselves?, 19 J. OF GENERAL INTERNAL MED. 911, 911 (2004).

<sup>234</sup> *Id.*

<sup>235</sup> PETER BROOKS, TROUBLING CONFESSIONS 21 (2000).

<sup>236</sup> HILFIKER, *supra* note 199, at 77.

Third, the traditions of self-regulation and physicians' distrust toward the law<sup>237</sup> suggest that apology laws, as part of the legal system, will have little credibility with physicians. They will be approached with suspicion, indifference, or skepticism. It is unclear whether physicians will even be aware of apology laws at all. As a practical matter, most physicians spend significantly much more time worrying about their clinical decision-making and studies in medicine than updating themselves about recent developments in the law.

Finally, many other deeply ingrained traditions in medicine have made the discussion of medical errors uncomfortable or foreign to physicians. Apology laws do nothing to change these norms and habits. As long as they are present, physicians will continue to remain as silent as before.

#### **A. Increasing Physician Confidence in the Law**

One strategy to combat the fear of liability is to increase physicians' confidence in the civil justice system. Physicians may feel less threatened if malpractice cases are screened by medical experts rather than lay people. Three different reforms have been proposed to increase expert involvement: 1) certificate of merit requirements; 2) medical screening panels; and 3) specialized medical malpractice courts.

Among these, commentators suggest that the most promising reform is the certificate of merit requirements.<sup>238</sup> Plaintiffs are required to get an expert assessment of their claim early in the case, which must confirm that the case has a reasonable chance of showing negligence. So far 17 states have passed certificate of merit requirements.<sup>239</sup> The idea behind the system is to lower the number of weak claims by stopping lawyers from filing claims that do not have a reasonable

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<sup>237</sup> For a discussion of the distrust between attorneys and physicians, see PETER D. JACOBSON, STRANGERS IN THE NIGHT: LAW AND MEDICINE IN THE MANAGED CARE ERA 201-21 (2002).

<sup>238</sup> Struve, *supra* note 165, at 47.

<sup>239</sup> *Id.* at 48.



chance of winning. The certification requirement gives plaintiffs a chance to find out from an expert what went wrong in the case. Therefore, patients who are filing to find out information may drop the suit.

The problem with these requirements is that they only affect lawyers who do not already use experts in cases. Most lawyers who specialize in medical malpractice already use experts to screen for cases. The requirement will only deter non-specialist lawyers and increase the initial cost of bringing suit. This means that the plaintiffs that may be most affected will not just be those attempting to bring claims without merit, but patients who cannot afford the now higher cost of bringing suit. In terms of whether these requirements will actually assuage physicians' fears of legal liability is unproven. I believe that physicians will not be sufficiently comforted by these technical legal requirements for the same reasons that have not responded to legal protections in other forums. The ability for these requirements to encourage disclosure of medical mistakes is highly doubtful.

The screening panels perform no better than certificate of merit requirements and may actually be more inefficient and costly for the system overall. Screening panels adds peer review to the medical malpractice system. Physicians participate on a panel that reviews medical malpractice claims and decide the merit of the claim.<sup>240</sup> These panels may give physicians a sense of control over the situation, knowing that their peers are overseeing which claims survive. Screening panels can also enable patients who are looking for information to drop or settle their case without going through costly litigation.

But in practice, these screening panels have only added another layer of bureaucracy, exacerbated the cost of litigation, and contributed to more delay. Of the 31 states that originally

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<sup>240</sup> *Id.* at 58-59.

implemented some form of a screening panel, only 19 have continued to use them.<sup>241</sup> Other states found that the number of claims actually rose.<sup>242</sup> Physicians will be marginally comforted by these results. In states where panels reviews only after claims are filed, the allegation of negligence will still frustrate physicians. It is unlikely these screening panels offer enough confidence in the legal system so that physicians will change their behaviors or attitudes toward disclosure.

Finally, some have proposed specialized medical courts.<sup>243</sup> Judges who sit on these courts would be selected for their expertise in medical malpractice cases and would also develop their knowledge over time. Proponents claim that specialized courts would make the process faster and outcomes more uniform. Physicians may feel better that they will be tried by a judge that is more familiar with medical malpractice cases, though the reassurance is likely again marginal. By the time that defendant doctors appear in court, they will have already endured frustrations and the emotional harms of allegation, discovery, or other parts of the suit.<sup>244</sup> Also, these courts would come with significant costs. The cost to litigants would be higher. The smaller number of judges would be more vulnerable to rent-seeking by interest groups. Judges themselves might develop a more narrow philosophy of judging, since they are seeing only medical malpractice cases.<sup>245</sup> These costs will likely outweigh the small comfort that these courts provide to physicians.

These legal reforms share one fundamental assumption. They assume that increasing physicians' confidence in the legal system will change the way that physicians behave. But this paper has tried to demonstrate that legal liability may contribute to the resistance to disclose, but

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<sup>241</sup> *Id.* at 60.

<sup>242</sup> *Id.* at 60.

<sup>243</sup> *Id.* at 68-79.

<sup>244</sup> Charles, *supra* note 158.

<sup>245</sup> *Id.* at 75.

that this is not the full story. These reforms do not touch the internal professional norms and incentives to disclose or apologize.

## **B. Hospital Policies of Disclosure, Mediation, and Communication**

Hospitals have tried to change risk management and compensation for patients in order to encourage disclosure. Some hospitals, like the national system of Veterans Affairs hospitals, have implemented policies that mandate disclosure and apologies.<sup>246</sup> But I have already discussed how physicians at VA hospitals are treated very differently by the law, and these results should not be extended to nongovernmental hospitals.

The most recent example of a change in policy is the release of the Harvard Hospitals consensus statement on disclosure in March 2006. This statement recommends that physicians to take four steps to communicate adverse events: 1) tell the patient and family what happened; 2) take responsibility; 3) apologize; and 4) explain what will be done to prevent future events. It is unclear how physicians of these hospitals will learn of the existence of this policy in the first place.<sup>247</sup> It is even more uncertain, once they find out about it, whether it will change their attitudes or behaviors toward disclosure. The policy does not have an enforcement mechanism.<sup>248</sup> This policy, like other hospital policies, is a top-down approach that is unlikely to affect the underlying resistance to disclosure.

Others have recommended that hospitals use mediation to resolve claims.<sup>249</sup> They have also suggested a consult service of communication experts to support physicians.<sup>250</sup> These

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<sup>246</sup> Department of Veterans Affairs, *Disclosure of Adverse Events to Patients*, VHA Directive 2005-049, October 27, 2005, available at <http://www1.va.gov/vhaethics/download/AEPolicy.pdf>.

<sup>247</sup> As of May 2006, none of the interns or residents of these teaching hospitals that I talked to were aware of this new policy.

<sup>248</sup> Barnes et al., *supra* note 28.

<sup>249</sup> Liebman & Hyman, *supra* note 4, at 31-56 (discussing disclosure and apology policies in health care systems and recommending consult service for communication experts).

<sup>250</sup> *Id.* at 31-45

services would advise physicians on when and how to discuss errors with the patient.<sup>251</sup> These services may be helpful and may facilitate those physicians who are willing to consult the service. But the underlying problem will still be in getting physicians to use these services. These remedies do not adequately identify or address the source of the problem. The problem is not merely that physicians don't know how to say that they are sorry or that they don't know how to discuss errors, although this may be contributing factor. Again, this paper suggests that the lack of disclosure is not that simple.

### **C. Medical Education and Training**

Another strategy to encourage disclosure and apologies is a bottom-up approach through medical education.<sup>252</sup> There are few, if any, places in medical education or clinical training that acknowledge that medical errors occur. Medical schools and residency training do not typically train physicians to disclose errors to patients. There are also many questions under this approach that will be difficult to address. What should students and physicians-in-training learn about medical errors? Should they learn how to deliver apologies? Will these sessions require a tradeoff from learning clinical material? Will education on medical errors compel more physicians to disclose? The M & M conference shows us how physicians can speak about error for the sake of education in a way that still fails to acknowledge responsibility or admit the uncertainty in medicine. Furthermore, it is not clear that an education that directly teaches taking responsibility will in fact change the attitudes or behavior of physicians when they practice. Nevertheless, despite the difficulty in changing actual behavior, there may be symbolic importance and moral worth for medical schools to demonstrate their normative commitments,

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<sup>251</sup> *Id.* at 31-45.

<sup>252</sup> Liebman & Hyman, *supra* note 4, at 17-29.

encourage apologies as the virtuous thing to do, and to put increasing moral pressure against the silence that surrounds mistakes.

It is important to note in closing that whether an education that focuses on training physicians to come to terms with their fallibility is one that will serve the doctor-patient relationship. It is possible that the kind of denial and anxieties that cause physicians to be reluctant to disclose errors actually serve its own functions. Ignoring the fact that mistakes will inevitably be made, that diagnoses will always be uncertain, or even avoiding disclosing a mistake to the patient may be defense mechanisms necessary to being a good doctor: they may give doctors the confidence they need to carry many of the emotional burdens and stresses of medicine. The inability to admit anything less than perfection—both to others and themselves—may be a nature that is both functional and dysfunctional for good medical practice. This paper therefore does not argue that more medical education may actually be the right answer, since the tradeoffs to such a system are unknown. The norms in medicine may be the root of the problem of silence, but it is a different and separate question whether a change in norms or habits of physicians is in fact desirable—a question that should be considered further in subsequent analysis.