No Role for Apology: Remedial Work and the Problem of Medical Injury

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No Role for Apology: Remedial Work and the Problem of Medical Injury

Steven E. Raper∗

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AND there are those who seem so outraged by injury that they become greedy
for revenge, and thus they must ready harm for others.

- Dante, as Vergil

INTRODUCTION

Many commentators endorse apologizing after injuring someone in the
course of medical treatment. The sentiment has been stated in its most elemental
form: “Say you’re sorry when you hurt somebody.” However, an apology has
special linguistic weight: it is an admission of regret, remorse and responsibility.
As such, apologies may prove a case of medical negligence. In an attempt to
decrease the potential harms of saying “I’m sorry” in the healthcare setting, some
state legislatures have enacted statutes intended to protect physicians. The thesis
of this Article is that apologies should not be issued in the medical setting, and
that apology laws are misguided. These laws work against the important social
policy goal of improving patient safety by discouraging healthcare workers from
openly acknowledging and correcting systematic errors and deficiencies in
human performance. Apology laws are also misguided because they bolster the
failed litigation regime of deterrence and corrective justice of medical injuries.
Lastly, these laws may require individual physicians to apologize for the actions
(or inactions) of a complex healthcare delivery system over which physicians
have little authority or control, rendering the apologies contrived and insincere.

Modern health care is a complex enterprise with a large and varied cast. A
non-exhaustive *dramatis personae* would include state and national accreditation
bodies, federal and third-party payers, hospital-wide committees, administrators,
credentialed general care and specialty physicians, advanced practitioners,
nurses, and support personnel. When there is a medical injury ascribed to error,
many—indeed most—of the above-mentioned groups often play roles.

Over the past decade, medical injuries have been a significant societal
problem jeopardizing patients who undergo medical treatment. The Institute of
Medicine, in a landmark book called *To Err is Human: Building a Safer Health
System*, called national attention to the fact that medical errors were among the
top ten leading causes of death, and that the cost of preventable medical injuries

1. DANTE ALIGHIERI, THE DIVINE COMEDY OF DANTE ALIGHIERI: PURGATORIO, 282 (Robert M.

\[\text{ed è chi per ingiuria par ch’aonti}
\]

\[\text{si che si fa de la vendetta ghiotto,}
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\[\text{e tal convien che ‘l male alrui impronti.}
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2. ROBERT FULGHUM, ALL I REALLY NEED TO KNOW I LEARNED IN KINDERGARTEN 6 (Random
was between $17 and $29 billion. Although complex, healthcare systems are amenable to the same systems analyses as other organizational systems. Similarly, principles of human performance as elucidated by cognitive psychology are also adaptable to healthcare professionals and other workers. The types of adverse events that may contribute to excessive cost, preventable injury, and death include diagnostic errors, treatment errors, and preventive errors. Other types of errors, such as equipment failures and failures to communicate, also occur. It is therefore imperative to use modern principles of systems analysis and human performance to understand why medical errors take place and to develop a methodology for identifying and preventing errors from happening in the future.

Surgical procedures are common causes of medical injury. For most procedures, the long list of potential harms includes bleeding, infection, operative site or other organ injury, disability, and death. The likelihood of various complications is increased by pre-existing conditions such as heart disease, emphysema, or diabetes—all widely recognized as lifestyle illnesses. Policies designed to prevent the wrong operation, medication errors, and hospital acquired infections are required for all facilities that perform operations and other invasive procedures. The transfusion of blood and blood products can also cause injuries, such as cardiovascular collapse and death, even though the discipline of transfusion medicine is subject to rigorous safeguards in laboratory testing, patient identification, and administration. Diagnostic and therapeutic radiologic procedures are also fraught with the potential for injury—delayed diagnosis can

3. INST. OF MED., Executive Summary, in TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 2 (Linda T. Kohn et al. eds., 2000).
4. MARILYN SUE BOGNER, Introduction to HUMAN ERROR IN MEDICINE 1, 4 (Marilyn Sue Bogner ed., 1994).
6. Id.
7. See JAMES REASON, HUMAN ERROR 17 (1990) (explaining that hindsight alone does not equal foresight).
8. Knowing surgery best, and the consequences of medical injury in the perioperative setting, the focus of the present analysis will be on injuries in surgical patients. Although the precise types of injury may vary in other medical disciplines, the principles are the same.
arise from a missed finding or a delay in receipt of information by the responsible treating physician. Contrast agents and inaccurate dosages of ionizing radiation also pose risks. Lastly, every medication has side effects, ranging from mild to lethal. In addition, medications pass through physicians, nurses, and pharmacists on their way to patients. At each step along the way—from ordering to transcription to dispensing to administration—the potential for injury is present.

Advising against apology does not mean blocking communication of adverse events to patients. Modern emphasis on patient autonomy means that the patient must be informed of adverse events for the purpose of making informed decisions regarding future care. Better approaches to patient disclosure include institutional use of careful accounts—a type of remedial work—by the responsible healthcare organization and legislative assistance in strengthening privileged communications regarding documents generated in the pursuit of improved patient safety, which would otherwise be admissible as business records under applicable rules of evidence. Concerns of creating moral hazard in physicians emboldened by the absence of a need to apologize when error occurs are abated by increased oversight from government and non-governmental organizations, greater emphasis on credentialing and maintenance of competencies, accountability in medical staff affairs, and identification and management of the impaired physician. Lastly, there is an evolving understanding of professional commitment to the principles of patient safety and improved quality of care.

I. THE COMPLEXITIES OF MODERN MEDICINE

A. Risks of Injury in Contemporary Medical Care

During one year-old Jeanella Aranda’s surgery for a liver tumor, damage to blood vessels left her in a non-survivable condition without a new liver. Her parents were told that one of them might be able to donate part of their own liver to save their daughter’s life. A laboratory error led Baylor University surgeons to surgically remove and transplant half of the father’s liver into Jeanella when in fact the mother should have been the donor. The father survived his unnecessary operation, but the infant died 20 days later. At another hospital in Rhode Island, surgeons operated on the wrong side of the brain in three separate

patients within the course of a year.\(^\text{15}\)

The aphorism “first, do no harm” is well known to all physicians and surgeons.\(^\text{16}\) Yet every surgeon accepts the uncomfortable fact that he or she will make errors leading to complications and death.\(^\text{17}\) There is no such thing as a “mask of infallibility;”\(^\text{18}\) widespread media coverage has unmasked the medical profession—revealing a fallibility that sometimes brings catastrophic results.\(^\text{19}\)

Each step in the medical process imposes the possibility of error and injury. 

*To Err is Human*, published barely a decade ago, documented the rates of medical injury and error and suggested ways to improve patient safety.\(^\text{20}\) It garnered widespread attention from the public, the media, and legislators for its finding that as many as 98,000 people die annually from medical errors in hospitals.\(^\text{21}\) Errors in the delivery of medical care caused more deaths than motor vehicle accidents, breast cancer, or AIDS.\(^\text{22}\)

Three seminal studies provided the support for the conclusions of *To Err is Human*. The first was the largely unheralded Medical Insurance Feasibility Study done in the early 1970s by the California Medical Association and California Hospital Association.\(^\text{23}\) The second, the Harvard Medical Practice Study

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17. Charles L. Bosk, *FORGIVE AND REMEMBER: MANAGING MEDICAL FAILURE* 50 (1979) (citing an anonymous surgeon: “It would look suspicious if you are doing major surgery and, week after week, you have no deaths and complications. You’re going to have these, especially deaths, if you do major surgery.”).


19. Richard I. Cook et al., *A TALE OF TWO STORIES: CONTRASTING VIEWS OF PATIENT SAFETY* (1998), available at www.npsf.org/rc/tts/npsf_w97.doc (documenting a comprehensive bibliography of “celebrated” cases of medical errors leading to injury or death that have attracted a great deal of attention from the public, regulators, the media, and the courts). Willie King (Florida) had the wrong leg amputated. Betsy Lehman (Massachusetts) and Vincent Gargano (Illinois) died of cancer chemotherapy overdoses. Ben Kolb (Florida) died receiving a syringe full of epinephrine rather than a local anesthetic. Libby Zion (New York) died of a drug-drug interaction allegedly due to decisions made by overworked resident doctors. Id.


21. Id.

22. Id.

23. Don Harper Mills, *Medical Insurance Feasibility Study: A Technical Summary*, 128 W.J. MED. 360, 362-64 (1978). The intent of the study was to provide data on the type, frequency, and severity of compensable disabilities in an attempt to estimate the cost of alternatives to the existing medical malpractice regime. Review of records from 20,864 hospital admissions to twenty three California hospitals found that potentially compensable events (similar to current definitions of medical injuries) had occurred in 4.65%. Although the majority, 80%, were temporary, 10.3% were
(HMPS), reviewed 30,195 New York hospital records from the year 1984 and documented a medical injury rate of 3.7%.24 The HMPS was criticized as being from one state and one year. In response, thirteen Utah and fifteen Colorado hospitals were chosen to participate in a similar study for the year 1992.25 This third study, a survey of 1047 patients admitted to two intensive care units and one surgical unit at a large teaching hospital, documented a correlation between the incidence of medical injury and increasing complexity of care.26 In a study of 44,603 patients who underwent surgery between 1977 and 1990 at a large medical center, 2428 patients (5.4 percent) suffered adverse events.27 A study of surgical care from the Colorado and Utah data cited above found that injuries resulting in death, disability, or a prolonged hospital stay were no more likely to permanent, and 9.7% resulted in death. Patients aged 65 or older were statistically more likely to sustain an injury, and nearly 72% of the events occurred in the operating room. Id. 

24. Troyen A. Brennan et al., Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I, 324 NEW ENG. J. MED. 370, 371-72 (1991). Although most of these adverse events gave rise to complete recovery in less than six months, 2.6% involved permanently disabling injuries and 13.6% resulted in death. Further study of these records identified 1133 patients with disabling injuries; drug complications were most common (19%), followed by wound infections (14%), and technical complications (13%). Nearly half were associated with an operation (48%), and the rate of injuries in those aged 64 and over was twice that of patients under age 45. Id. 

25. Eric J. Thomas et al., Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado, 38 MED. CARE 261, 264-67 (2000) (submitting for review non-psychiatric hospital discharge records; 5,000 in Utah and 10,000 in Colorado). Five hundred eighty seven medical injuries were identified; for a rate of 2.9 % of hospitalizations in each state. The rate of injury associated with operations was again nearly half (44.9%). More than four in five of the recorded injuries occurred in the hospital, with the rest occurring prior to admission in non-hospital settings. A lower percentage of deaths due to injuries (6.6%) were found when compared to the HMPS (13.6%). Id.

26. Lori B. Andrews et al., An Alternative Strategy for Studying Adverse Events in Medical Care, 349 LANCET 309, 311-12 (1997). Ethnographers trained in qualitative observational research integrated into physician teams for attending rounds, residents’ work rounds, nursing shift changes, case conferences, and other scheduled meetings, and various departmental and section meetings. Data were collected about health-care providers’ own assessments about the appropriateness of the care that patients received to assess the nature and impact of adverse events and how health-care providers and patients responded to the injury. Of the 1047 patients in the study, 185 (17.7%) were reported to have had at least one serious injury defined along a spectrum from temporary physical disability to death. The likelihood of having a medical injury was linked to the seriousness of the patient’s underlying illness. Patients with long stays in hospital had more injuries than those with short stays. The likelihood of experiencing an injury increased 6% for each day of hospital stay. The most common causes of injury were individuals (37.8%), interactive causes (15.6%), or administrative decisions (9.8%). Injuries discussed in the various settings were recorded and a classification scheme was developed to code the data. A major difference was the real-time nature of the data collection in contrast to the three seminal studies. Id.

27. Hunter H. McGuire et al., Measuring and Managing Quality of Surgery: Statistical vs Incidental Approaches, 127 ARCHIVES SURGERY 733, 734-36 (1992). Somewhat less than one-half of these adverse events were considered attributable to error. During the same hospitalization, 749 patients died during; 7.5 percent of these deaths were attributed to error. Id.
occur with surgical care than with nonsurgical care.\textsuperscript{28}

\textit{To Err is Human} focused widespread attention on the simple fact that patients were not always \textit{safe} in the healthcare setting. There existed a widespread problem of medical injury with and without error. To the public, documentation that doctors, nurses, and others in the healthcare setting could make errors and injure patients was a revelation. However, \textit{To Err is Human} made the novel suggestion that improving patient safety required healthcare leadership to identify and correct faulty systems in which errors could happen, rather than a focus on punitive approaches, like malpractice litigation, when patients were injured by medical diagnosis and treatment. The main message of \textit{To Err is Human} was later elegantly summarized:

\begin{quote}
"Most errors are committed by good, hardworking people trying to do the right thing . . . . It is far more productive to identify error-prone situations and settings and to implement systems that prevent caregivers from committing errors . . . ."\textsuperscript{29}
\end{quote}

And yet, medical injuries appear unavoidable in the healthcare delivery system and occur throughout the spectrum of medical care.\textsuperscript{30} The recognition that patients are injured through error has led to an emphasis on patient safety initiatives. After the publication of \textit{To Err is Human}, the IOM released a second medical error analysis in 2001, \textit{Crossing the Quality Chasm}, which made further recommendations for enhancing patient safety in healthcare institutions.\textsuperscript{31}

\begin{footnotesize}
\textsuperscript{28} Atul A. Gawande et al., \textit{The Incidence and Nature of Surgical Adverse Events in Colorado and Utah in 1992}, 126 Surgery 66, 69-71 (1999). Among surgical injuries, 54\% were considered to be preventable. Fifteen common operations each accounted for 1\% or more of surgical injuries. \textit{Id.}


\textsuperscript{30} To conform to the terminology extant in the patient safety literature, most definitions are derived from the Institute of Medicine (IOM) study \textit{“To Err is Human.”} An adverse event is an injury resulting from a medical intervention, or in other words, it is not due to the underlying condition of the patient.

\textsuperscript{31} \textit{Committee On Quality Of Health Care In America Institute Of Medicine Crossing The Quality Chasm: A New Health System For The 21St Century} (2001) (proposing improvements in six dimensions towards which all healthcare constituencies should strive). These six dimensions are: \textit{Safe}—avoiding injuries to patients from the care that is intended to help them. \textit{Effective}—providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively). \textit{Patient-centered}—providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions. \textit{Timely}—reducing waits and sometimes harmful delays for both those who receive and those who give care. \textit{Efficient}—avoiding waste, including waste of equipment, supplies, ideas, and energy. \textit{Equitable}—providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status. \textit{Id.}
\end{footnotesize}
B. Patient Safety: The Need for Protected Disclosure

1. Health System-based Approaches to Making Patients Safer

Since 2004, there has been a steady decline in the number of reported wrong-site surgeries in Pennsylvania.\textsuperscript{32} Many factors could be contributing to this decrease: implementation of a universal protocol or “pause for safety,” intra-institutional confidential reporting of injuries, mandatory reporting to a state patient safety authority, and root cause analysis to prevent similar events in the future. The patient safety movement is based on concepts learned from diverse disciplines and their disasters, many of which are imprinted on the collective conscience: the nuclear reactor industry (Three Mile Island, Chernobyl),\textsuperscript{33} the chemical industry (Bhopal),\textsuperscript{34} the National Aeronautics and Space Administration (Challenger, Columbia),\textsuperscript{35} and the airlines industry.\textsuperscript{36} The overarching goals of the patient safety approach are to prevent injuries caused during medical diagnosis and treatment and to reduce errors through systemic change. Patient safety advocates push for transparency through confidential reporting requirements, which are required and may even be anonymous. No single data source is sufficient to gain a complete understanding of errors contributing to actual or potential medical injury, so thought has been given to the development of a culture of patient safety:\textsuperscript{37} a culture reconciling professional accountability with the need to create a safe environment to report medical errors.\textsuperscript{38}

Accurate reporting of outcomes is crucial to improving patient safety. Surgeons were first challenged to report procedural outcomes a century ago by Ernest A. Codman.\textsuperscript{39} He chastised public—or “charity”—hospitals for not looking at patient outcomes. Codman charged individual physicians with not wanting to standardize or report how their patients fared because hospitals would

33. REASON, supra note 7, at 189.
34. Id. at 191.
35. Id. at 192; see also Space Shuttle Columbia and Her Crew, NASA, http://www.nasa.gov/columbia/home/index.html (last visited May 5, 2011).
not want the expense.\textsuperscript{40} Codman classified sub-optimal outcomes as due to one or more of several causes: lack of technical knowledge or skill; lack of surgical judgment; lack of care or equipment; lack of diagnostic skill; the patient’s "unconquerable disease;" the patient’s refusal of treatment; those accidents and complications over which there was no known control; and lastly, acknowledgment of the fact that not all sub-optimal outcomes could be attributed to error—"the calamities of surgery."\textsuperscript{41} Codman was blunt in his criticism of his surgical colleagues: "[Y]ou let the members of the medical staff throw away money [by causing] unnecessary deaths, ill-judged operations and careless diagnoses. . . ."\textsuperscript{42} At the turn of the twentieth century, the tools necessary for systems analysis did not exist, and the basic principles of human performance and error were not well understood.

At the turn of the twenty-first century, a systems approach to improving patient safety—as advocated by the IOM in \textit{To Err is Human}—emerged based on three principles: First, error is an inherent, unavoidable aspect of human work. Second, faulty systems allow human error to lead to adverse events. Third, systems can be designed that prevent or detect human error before such adverse events occur.\textsuperscript{43} The systems approach to patient safety is supported by many groups, including professional societies, medical centers, health insurance purchasers, federal and state legislatures, and perhaps most importantly, patients.\textsuperscript{44} Low rates of adverse events now rank among the public's leading measures of healthcare quality.\textsuperscript{45} The results of a survey of over 2000 adults indicate that people are more concerned about mistakes in hospitals than on airplanes.\textsuperscript{46} A majority (71%) of survey respondents say that information about medical errors would be one of the biggest helps in determining the quality of providers.\textsuperscript{47} In sum, there is demand for transparency in medical injury. However, it is crucial for all relevant parties to understand that most medical injuries are attributable to system flaws rather than individual incompetence or neglect.

Any worthwhile effort to improve such systems is likely to require substantial collaboration among parties—with reporting used to guide

\begin{thebibliography}{9}
\bibitem{40}Id. at 53.
\bibitem{41}Id. at 59.
\bibitem{42}Id. at 17.
\bibitem{43}\textsc{Reason}, supra note 7, at 17.
\bibitem{45}\textit{Americans as Health Care Consumers: An Update on the Role of Quality Information}, KAISER FAMILY FOUNDATION AND AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ), http://www.ahrq.gov/qual/kffhigh00.htm (last visited Dec. 24, 2009).
\bibitem{46}Id.
\bibitem{47}Id.
\end{thebibliography}
collaborative quality improvement efforts and not to punish the participants and strictly protect the identity of individual physicians and hospitals. It is also essential to recognize that to maintain or repair public faith in the United States healthcare system, patient safety must be placed among the highest priorities of social policy setting, and transparency must be ensured.

Hence, it seems clear that a systems-based approach is a valuable tool in the battle for medical injury reduction. Safe systems are designed by taking into consideration appropriate credentialing of physicians and surgeons and analyzing how hospital personnel interact with each other in teams and how they use machines and equipment. Output of such analyses includes the training and integration of new staff into existing teams, a reconciliation of medications and allergies, a protocol to prevent operating on the wrong patient or body part, procedures for checking equipment and supplies prior to beginning surgery, and the provision of a blame-free environment for organizational analysis and change to prevent future adverse events.

Physicians have taken the opportunity to improve the safety and quality of care, anticipating the expansion of Internet resources in increasing public awareness of patient safety and quality of care. Growing concerns about patient safety have led to an increase in the percentage of patients who would choose a highly rated surgeon whom they had not seen before over a less highly rated surgeon whom had previously provided care; also a factor of publicly available information. Thus, improving patient safety is a matter of self-interest for the provider as well as a mechanism for improving patient safety.

Patient safety initiatives actually do make patients safer. Arguably the most advanced program for outcomes assessment and safety improvement of surgical outcomes is the National Surgical Quality Improvement Program (NSQIP),

51. INST. OF MED., supra note 3, at 62.
52. Andrew R. Robinson et al., Physician and Public Opinions on Quality of Health Care and the Problem of Medical Errors, 162 ARCHIVES OF INTERNAL MED. 2186, 2189 (2002) (demonstrating that a majority of Colorado physicians and the public believe that reduction of medical errors should be a national priority).
achieving a 27% decrease in thirty-day mortality after major procedures and a 45% decrease in morbidity in Veterans Affairs Medical Centers throughout the country.\footnote{Shukri F. Khuri et al., The Department of Veterans Affairs' NSQIP The First National, Validated, Outcome-Based, Risk-Adjusted, and Peer-Controlled Program for the Measurement and Enhancement of the Quality of Surgical Care, 228 ANNALS SURGERY 491, 507 (1998).} One important aspect of the NSQIP is that data are coded so only the participating healthcare organizations know which data set belongs to them.\footnote{Shukri F. Khuri et al., The Comparative Assessment and Improvement of Quality of Surgical Care in the Department of Veterans Affairs, 137 ARCHIVES SURGERY 20, 22 (2002).} The NSQIP was responsible for identifying intraoperative processes of care and postoperative adverse events as important risk factors for prolonged hospital stay after major elective surgery.\footnote{Tracie Collins et al., Risk Factors for Prolonged Length of Stay After Major Elective Surgery, 230 ANNALS SURGERY 251, 257-58 (1999).} Other notable findings were that for many common procedures, there was no significant association between case volume at a given hospital and thirty-day mortality.\footnote{Katherine S. Rowell et al., Use of National Surgical Quality Improvement Program Data as a Catalyst for Quality Improvement, 204 J. AM. C. SURGEONS 1293, 1293 (2007).} NSQIP has now expanded into the broader community under the auspices of the American College of Surgeons (ACS).\footnote{Bruce L. Hall et al., Does Surgical Quality Improve in the American College of Surgeons National Surgical Quality Improvement Program: An Evaluation of All Participating Hospitals, 250 ANNALS SURGERY 363, 368 (2009).} It has also been used to validate the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators.\footnote{Patrick S. Romano et al., Validity of Selected AHRQ Patient Safety Indicators Based on VA National Surgical Quality Improvement Program Data, 44 HEALTH SERVICES RES. 182, 183 (2009) (comparing AHRQ Patient Safety Indicators (PSI) against NSQIP data and to show that further validation should be considered before most of the PSIs evaluated are used to publicly compare or reward hospital performance).}

Examples of successful safety improvement efforts within surgery in the private sector are also numerous, and they include formalized team training at Beth Israel Deaconess, resulting in a 53% decrease in potential adverse outcomes in high-risk patients.\footnote{Donald W. Moorman, On the Quest for Six Sigma, 189 AM. J. SURGERY 253, 256 (2005).} Using systems principles, and relying heavily on feedback for medical injuries, the Northern New England Cardiovascular Disease Study Group was able to decrease mortality rates 24%.\footnote{Gerald T. O'Connor et al., A Regional Intervention to Improve the Hospital Mortality Associated with Cardiopulmonary Bypass Surgery, 275 JAMA 841, 842 (1996).} Intermountain Health Systems in Utah has developed interdisciplinary care standards,\footnote{Judy Hougaard, Developing Evidence-Based Interdisciplinary Care Standards and Implications for Improving Patient Safety, 73 INT'L J. MED. INFORMATICS 615, 624 (2004).} and the Maine Medical Assessment Foundation has decreased rates of spine surgery and improved
outcomes. These organizations demonstrate four important characteristics: first, frank reporting of adverse events in a protected manner; second, a systems approach to quality improvement rather than placing blame; third, voluntary, physician-led interventions as or more effective as external regulatory mechanisms; and fourth, participation by providers in outcomes research as a response to practice variations. Recently, an explicit link between improvements in patient safety have been shown to result in decreased malpractice claims; an intuitive result but not one for which compelling data exist. Considerable obstacles to improving patient safety still exist. One institutional hindrance to making patients safer is the entrenched notion that the quality improvement methods already available are adequate to address adverse events. The persistence of patient safety problems in the face of such methods should be a sufficient argument for the inadequacy of existing approaches. Departmental morbidity and mortality (M&M) conferences are a traditional venue for discussion of adverse events, but they frequently do not consider all complications, are not consistently well-attended, and often do not involve healthcare providers other than attending surgeons and residents. One study that compared NSQIP data with traditional M&M conferences noted that the latter failed to consider about 75% of the complications and about 50% of the deaths. Further, education is usually stated as an important goal of the M&M conference, which may work against full analysis of an adverse event. Arguably, M&M

64. Steven J. Atlas et al., Long-Term Outcomes of Surgical and Nonsurgical Management of Lumbar Spinal Stenosis: 8 to 10 Year Results from the Maine Lumbar Spine Study, 30 SPINE 936, 943 (2005).


67. Michelle M. Mello & Troyen A. Brennan, Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform, 80 TEX. L. REV. 1595, 1597 (2002); see also Robert S. Galvin, The Business Case for Quality, 20 HEALTH AFF. 57 (2001) (identifying specific obstacles to include a perceived vulnerability to legal discovery and liability, including: a traditional medical culture based on individual responsibility (blame and shame); unreimbursed costs for patient safety initiatives and quality; evolving medical informatics; the time and expense involved in defining and implementing evidence-based practice; the local nature of health care, and the perception of the lack of a business case, or, poor return on investment).

68. Mello & Brennan, supra note 67, at 1598.


70. Matthew M. Hutter et al., Identification of Surgical Complications and Deaths: An Assessment of the Traditional Surgical Morbidity and Mortality Conference Compared With the American College of Surgeons-National Surgical Quality Improvement Program, 203 J. AM. COLLEGE SURGEONS 618, 624 (2006).

71. Id.
conferences present an obstacle to safety improvements by creating an illusion of improvements in patient safety. One can imagine, among others, the following specific obstacles to patient safety: resistance to admitting that errors have occurred; traditional “shame and blame” medical culture based on individuals rather than systems; fears that all discussions regarding injury or error are discoverable and subject to liability; the time and expense of evidence-based practice; inadequate resources due to the perception that a focus on safety is a poor return on investment; and the local, disaggregated nature of healthcare delivery and reporting.

2. Improving Human Performance

In addition to a fuller realization of the importance of systems in the development of medical adverse events, principles of human performance are also now understood to play a role. To be successful, a human task-based performance (e.g., an operation) has three main phases: planning, storage, and execution. Errors resulting from failures in performance may be classified as slips, lapses, or mistakes, depending on which phase of the performance is involved. In one sense, surgeon performance can be a system factor, but in another sense, individual cognitive and technical ability make up a large part of a system’s safety barriers. Overemphasizing an individual physician’s role retards rather than advances understanding of systems failure, evoking defensiveness rather than constructive action. A number of steps have been taken to address problems of human performance.

Continuing medical education (CME) programs attempt to bridge knowledge and quality of patient care, and are generally held confidential. Many states, as a prerequisite for re-licensure, require a certain number of hours of CME programs, yet the structural incentives associated with health care in the United States lead to highly variable patterns of care and a widespread failure to implement evidence-based practice. There is a link between CME participation

72. REASON, supra note 7, at 9. Slips are failures of the execution phase, the storage phase, or both, and lapses are failures of the storage phase both may occur regardless of whether the planned procedure was adequate. Generally, slips are obvious or overt, whereas lapses are often hard to detect, or covert. Mistakes are failures of planning, reflecting basic deficiencies or failures in selecting an objective or specifying the means to achieve it, regardless of how well the plan was executed. Id.

73. Molly J. Coye, No Toyotas in Health Care: Why Medical Care Has Not Evolved to Meet Patient’s Needs, 20 HEALTH AFF. 44, 46 (2001) (discussing lack of a business case for quality in health care, and why each of the strategies intended to improve quality has been less effective than anticipated). A business case for quality would require that purchasers, users, and providers recognize and value advancements in quality outcomes. Id.
and performance on board recertification examinations,\textsuperscript{74} and specialty board certification is linked to improved outcomes.\textsuperscript{75} A direct link between CME participation and safer patient care is not as easy to confirm. Systematic reviews of the differences in the impact various CME strategies have on actual practice change have raised serious concerns about the value of some current CME programs.\textsuperscript{76} The strategies shown to be most effective for practice change (e.g., reminders, patient-mediated interventions, outreach visits, opinion leader input, and multifaceted activities) place substantial emphasis on performance change rather than simply on learning.\textsuperscript{77} There is evidence to suggest that despite some methodological shortcomings, performance on cognitive examinations such as certification and re-certification examinations is related to performance in practice\textsuperscript{78} and that a physician's current certification status should be among the evidence-based measures used in the quality movement.\textsuperscript{79}

Legislative approaches to improvements in safety have also been tried. Congress established the Medicare Utilization and Quality Control Peer Review Program to improve the efficiency, effectiveness, economy, and quality of services delivered to Medicare beneficiaries.\textsuperscript{80} Peer review organizations (PROs), were originally intended as a mechanism for professional self-evaluation but subsequently became subject to anticompetitive abuse and other undesired consequences.\textsuperscript{81} The potential for inequity was a particular concern, in that physicians who relinquished privileges on their own initiative might be treated more leniently than those against whom action was initiated by a peer review

\textsuperscript{74} Robert S. Rhodes et al., \textit{Continuing Medical Education Activity and American Board of Surgery Examination Performance}, 196 J. AM. C. SURGEONS 604, 607 (2003).


\textsuperscript{78} Robyn Tamblyn et al., \textit{Association Between Licensure Examination Scores And Practice In Primary Care}, 288 JAMA 3019, 3024 (2002); see also John J. Norcini & Rebecca S. Lipner, \textit{The Relationship Between the Nature of Practice and Performance On A Cognitive Examination}, 75 ACAD. MED. S68, S70 (2000).

\textsuperscript{79} Troyen A. Brennan et al., \textit{The Role of Physician Specialty Board Certification Status in the Quality Movement}, 292 JAMA 1038, 1040 (2004)

\textsuperscript{80} 42 U.S.C. § 1395 (2006). The Secretary shall, in making the determinations under paragraphs (1) and (9) of subsection (a), and for the purposes of promoting the effective, efficient, and economical delivery of health care services, and of promoting the quality of services of the type for which payment may be made under this title, enter into contracts with utilization and quality control peer review organizations pursuant to part B of title XI of this Act. \textit{Id.}

committee—a result of the loophole created by the physician’s surrendering of clinical privileges before an investigation is started in return for not being reported to the National Practitioner Data Bank.\(^82\) Moreover, the data reviewed by peer review organizations were often legally discoverable, and this lack of anonymity and confidentiality tended to deter voluntary participation. Even when peer review organizations identified problems, they were often unable to implement solutions.\(^83\) Quality improvement organizations (QIO) have largely supplanted peer review organizations, but they have yet to prove effective.\(^84\)

Another way to evaluate physician quality is through physician clinical performance assessment (PCPA), defined as the “quantitative assessment of physician performance based on the rates at which their patients experience certain outcomes of care and/or the rates at which physicians adhere to evidence-based processes of care.”\(^85\) PCPA initiatives have been slow to win acceptance by physicians on the grounds that they could be used as evidence in malpractice litigation.\(^86\) The threshold for admission of such evidence in malpractice litigation is high and the possibility that PCPA data will reach this bar seems remote, at least for the vast majority of injury types that prompt litigation.\(^87\) Unfortunately, some hospitals persist in separating patient safety, risk management and quality-assurance initiatives, to the detriment of each. Hospital incident reports have much the same shortcomings as the peer review process—discoverability by plaintiffs’ attorneys.\(^88\) Individuals also may be reluctant to file reports out of fear that their employment might be jeopardized or that the reported party might seek retribution. Further, such reports are generally not protected by quality assurance privilege and are considered business records.\(^89\)


\(^{83}\) Ilene N. Moore et al., Rethinking Peer Review: Detecting and Addressing Medical Malpractice Claims Risk, 59 VAND. L. REV. 1175, 1177-86 (2006).


\(^{86}\) Id. at 1833 (noting, however, that PCPA actions could still be used against physicians in other circumstances, for example, in proceedings by state licensure boards, hospital review committees, and other adjudicatory bodies).

\(^{87}\) Id. at 1834.

\(^{88}\) Clemon W. Williams, Guide to Hospital Incident Reports, 10 HEALTH CARE MGMT. REV. 19, 23 (1985) (discussing the benefits of—and the limited protections available for—incident reports).

\(^{89}\) FED. R. EVID. 803(6).
3. External Oversight

Although those best able—from a policy standpoint—to enhance patient safety by decreasing adverse events are those within individual healthcare entities, it has been known for nearly a century that physicians left to themselves may not do all that can be done to maintain or improve patient care. There is concern even in the surgical community that voluntary reporting to state licensing boards (or even local credentials committees) is inconsistent. Psychology may also underlie these behaviors, including fear about discussions in an open forum, feelings of denial and infallibility.

The patient safety concept of non-punitive reporting systems aimed at getting doctors and other healthcare workers to disclose has gained momentum in response to interest and pressure from a wide assortment of federal, state and private entities: AHRQ, Centers for Disease Control and Prevention (CDC), Centers for Medicare and Medicaid Services (CMS), the Joint Commission (TJC), American College of Surgeons (ACS), American Medical Association (AMA), American Hospital Association (AHA), American Society of Anesthesiologists (ASA), and the Association of Operative Registered

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90. Walter P. Bowers, Why Medical Malpractice?, 200 NEW ENG. J. MED. 93, 93 (1929) ("[I]n the practice of medicine, there will always be, in the nature of the art, a large field in which if the physician chooses to do wrong, no one but he will know about it until the day of Judgment.").
91. Hutter et al., supra note 70, at 621.
92. Id. at 622.
95. CENTER OF MEDICARE & MEDICAID SERVICES, STATE OPERATIONS MANUAL APP. A §482.25(b)(6)(2009), available at http://www.cms.gov/Manuals/Downloads/som107ap_a_hospitals.pdf (noting that to improve incident reporting the facility should adopt a non-punitive system with the focus on the system and not the involved health care professionals).
Nurses\(^{101}\) (AORN). The rationale is that improved error reporting will make future errors less common and less severe. Unreported errors are more likely to be repeated and cause further injuries.\(^{102}\)

Commentators within the discipline of surgery as well as the community at large have noted it is vital that physicians not use protected disclosure as an excuse for avoiding responsibility for complications.\(^{103}\) Private accreditation, conducted by external associations, has helped alleviate concerns regarding the “self-policing” nature and lack of oversight of most individual and institutional mechanisms for enhancing patient safety.\(^{104}\) To address the issue of medical injury, in 1995 the Joint Commission (TJC), at the time known as the Joint Commission for Accreditation of Healthcare Organizations, adopted a Sentinel Events Policy (hereinafter known as “the Policy”) for TJC-accredited healthcare organizations.\(^{105}\) The Policy requires that healthcare organizations report certain adverse, or sentinel, events to TJC.\(^{106}\) Although TJC representatives claim that adherence to the Policy is voluntary, accreditation and the ability to provide services to at least Medicare and Medicaid patients hinges upon adherence.\(^{107}\) The healthcare organization must then perform a self-critical, systems-based root cause analysis (RCA) of such events, and submit a report on the RCA along with a corrective action plan to TJC for review and approval.\(^{108}\)

There are, however, characteristics of the Policy that are significant obstacles to facilities interested in improving safety. As might be expected, the Joint Commission approach to sentinel event disclosure has raised concerns


\(^{103}\) Wachter & Provonost, supra note 29; see also Keith D. Lillemoe, To Err is Human, but Should We Expect More from a Surgeon?, 237 ANNALS SURGERY 470, 471 (2003) (admonishing surgeons to take responsibility for the safe conduct surgical procedures and the consequences of errors).

\(^{104}\) Barry R. Furrow et al., supra note 82, at 191-94.

\(^{105}\) JOINT COMMISSION HANDBOOK, supra note 102, at SE-9.

\(^{106}\) Sentinel Events Policy and Procedures, THE JOINT COMMISSION, http://www.jointcommission.org/Sentinel_Event_Policy_and_Procedures (last visited Apr. 2, 2011) (defining reportable adverse events as an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof). Serious injury specifically includes loss of limb or function. The phrase, “or the risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called “sentinel” because they signal the need for immediate investigation and response. Accredited organizations have some flexibility in defining “unexpected,” “serious,” and “the risk thereof.” Id.

\(^{107}\) Bryan A. Liang, Comment, Other People’s Money: A Reply to the Joint Commission, 33 J. HEALTH L. 657, 659 (2000).

\(^{108}\) JOINT COMMISSION HANDBOOK, supra note 102, at SE-9.
regarding exposure during litigation and the use of information beyond its intended patient safety purpose, such as TJC sanctions against healthcare organizations.\textsuperscript{109} For example, if the Joint Commission receives an inquiry about an accreditation decision of an organization that has experienced a reviewable sentinel event, the organization’s accreditation decision will be reported in the usual manner without making reference to the sentinel event.\textsuperscript{110} However, if an inquirer specifically references the sentinel event, the Joint Commission will acknowledge that it is aware of the event and currently is working or has worked with the organization through the sentinel event review.\textsuperscript{111} If the adverse report is not made, or the root cause analysis is not considered acceptable after process has been followed, TJC may place an organization progressively on Provisional Accreditation, Conditional Accreditation, and finally, Preliminary Denial of Accreditation.\textsuperscript{112} Ultimately, TJC may revoke the provider’s accreditation, which has major implications for reimbursement.\textsuperscript{113}

The Joint Commission’s accreditation program lacks the ability to identify many patient safety problems, and it is difficult to determine whether the Joint Commission’s reporting policy has prevented adverse events—assuming such prevention is the primary aim of the policy.\textsuperscript{114} Since the inception of TJC’s unanticipated outcomes disclosure policy in 2001, the Elements of Performance have become more exacting.\textsuperscript{115} Therefore, although recognition of the systems

\textsuperscript{110} JOINT COMMISSION HANDBOOK, supra note 102, at SE-14.
\textsuperscript{111} Id.
\textsuperscript{113} A Look at the Joint Commission: CMS Approves Continued Deeming Authority, BULL. AM. C. SURGEONS 49, 49 (2010) (reporting that the Department of Health and Human Services’ Centers for Medicare and Medicaid Services (CMS) has approved the continuation of deeming authority for TJC’s accreditation program, which has held deeming authority since the inception of the Medicare program in 1965). The CMS designation means that hospitals accredited by The Joint Commission applies to be “deemed” as meeting Medicare and Medicaid certification requirements. CMS has found that The Joint Commission’s standards for hospitals meet or exceed those established by the Medicare and Medicaid program. The Joint Commission’s hospital accreditation program had previously been granted unique statutory deeming authority, but this unique status ended with enactment of the Medicare Improvements for Patients and Providers Act of 2008. Accreditation is voluntary and seeking deemed status through accreditation is an option, not a requirement. If hospitals seeking Medicare approval choose to be surveyed by The Joint Commission, all visits are unannounced. \textit{Id.}
\textsuperscript{114} Marlene R. Miller et al., Relationship Between Performance Measurement and Accreditation: Implications for Quality of Care and Patient Safety, 20 AM. J. MED. QUALITY 239, 246 (2005) (noting few relationships between Joint Commission categorical accreditation and Inpatient Quality Indicators or Patient Safety Indicators).
nature of error may represent progress in theory, the shame and blame mechanisms used by the Joint Commission for enforcement represent at least one step backwards. In combination with other medical efforts, progress toward error reduction and patient safety promotion may be significantly retarded.\textsuperscript{116}

In summary, three converging trends have pointed to enhancements in patient safety as a source of reform for healthcare institutions. First, systems analytic quality measurement methods are evolving as a way to quantitatively assess guidelines for care. Second, there are mature methods for analysis of the fundamentals of human performance and failures of health care as a system. Lastly, external oversight of individual healthcare institutions by organizations, such as the Joint Commission, help provide incentives to continuous patient safety goals.

C. Medical Malpractice as Deterrence: A Failed Approach to Patient Safety

The present professional liability system is particularly controversial with respect to whether it facilitates or hinders improvements in patient safety. Implicit in the analysis of medical injury is a genuine desire to reduce such injuries and make patients safer. Injuries are studied not only for their effects on involved individuals, but also for the critical objective of establishing systems to prevent similar injuries. An alternative to the patient safety approach of systems analysis, improved human performance, and external oversight is medical malpractice litigation for a presumed deterrence effect. Negligence tort law claims of medical malpractice have been brought against physicians for nearly a century. In New York City in 1910, 1.1\% of tort cases were for medical malpractice.\textsuperscript{117} In 1929, a physician was sued for malpractice once every four

\begin{footnotesize}
\begin{enumerate}
\item Responsibilities, RI.01.02.01, states: “The hospital respects the patient’s right to participate in decisions about his or her care, treatment, and services.” See also Id, Elements of Performance # 21 (“The hospital informs the patient or surrogate decision-maker about unanticipated outcomes of care, treatment, and services that relate to sentinel events considered reviewable by The Joint Commission”); \textit{Id} # 22 (“The licensed independent practitioner responsible for managing the patient’s care, treatment, and services, or his or her designee, informs the patient about unanticipated outcomes of care, treatment, and services related to sentinel events when the patient is not already aware of the occurrence or when further discussion is needed”).

\item Ed Lovern, \textit{JCAHO’s New Tell-All: Standards Require that Patients Know About Below-Par Care}, \textit{31 Modern Healthcare} 2, 3 (documenting that providers have expressed concerns regarding provider liability for this new policy: e.g., every admission has unanticipated outcomes, the standard will create awkwardness between hospitals and medical staffs, and “the hospital, by definition, is now intruding into the patient-physician relationship if there is a [TJC] documentation process required” for these disclosures).

\item LAWRENCE M. FRIEDMAN, \textit{A HISTORY OF AMERICAN LAW} 521 (3d ed. 2005).
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\end{footnotesize}
days. In 1934 surgeons were cautioned “Secure consent before you operate.”

The care with which clients are selected for medical malpractice litigation notwithstanding, many suits are filed which do not support allegations of negligence. In one reported study, a total of ninety-eight claims were filed against 151 healthcare providers. Of the ninety-eight claims, only forty-seven were confirmed as due to treatment given in the given time period. Eight claims established a negligent adverse event related to treatment, ten claims involved hospitalization that had produced injuries not thought due to physician negligence, and three cases exhibited some evidence of medical causation, but not enough to pass the study’s negligence criteria. Thus, twenty-six claims—more than half—provided no evidence of medical injury or negligence.

Lawyers are generally responsible only to their clients. Plaintiffs attorneys generally take thirty to forty percent of damage awards, plus expenses, but nothing if the jury finds for the defendant. Selecting the right client is therefore a critical part of a plaintiff’s firm’s survival. To be found worthy of representation, a variety of tests have been used, including a pattern of negligence on the part of the defendant, how a case would likely stand up to a jury, and the readiness of a firm to work on a case for years.

As might be expected, the high threshold for filing a claim on behalf of clients leads to a malpractice gap. In the Harvard Medical Practice Study, physician reviewers identified 1133 adverse events out of a sample of 31,429 medical records. Of the documented adverse events, 280 were deemed due to negligence, but in these cases, only eight malpractice claims were filed (1.53%). Another estimate (from 1984), relying on results of the statewide

118. Bowers, supra note 90, at 93 (“The situation at the present time is that about once every four days some patient makes a claim against a physician seeking legal redress for alleged malpractice.”).
119. Halbert G. Stetson & John E. Moran, Malpractice Suits, Their Cause and Prevention, 210 NEW ENG. J. MED. 1381, 1381 (1934) (“[A]pproximately 20,000 suits have been brought against physicians in the United States in the past five years.”).
120. PAUL C. WEILER ET AL., PATIENT INJURY AND LITIGATION, IN A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION 70 (1993).
121. Id.
122. Id. at 71.
124. MODEL RULES OF PROF’L CONDUCT pmbl. (2007) (“A lawyer, as a member of the legal profession, is a representative of clients, an officer of the legal system and a public citizen having special responsibility for the quality of justice.”).
126. Id. at 53.
127. WEILER ET AL., supra note 120, at 69.
128. Localio et al., supra note 123, at 247.
medical chart reviews, found that there were 3571 patient claims from 21,179 estimated negligent injuries (17%). When the authors expressed the claims data in the form of ratios calculated from sampling weights, the chances that a claim would be filed were not 17%, but 2%. As confirmation of the malpractice gap noted in the HMPS study, a similar patient record review of claims filed in Utah and Colorado showed similar results: eighteen malpractice claims were filed from a sample of 14,700 hospital discharges. Fourteen of eighteen were made in the absence of negligence, and ten in the absence of an adverse event. The overall probability of a claim after a negligent adverse event causing significant or major disability was 3.8%. Patients who experienced negligent adverse events but did not sue shared social and demographic factors including being poor, uninsured, beneficiaries of Medicaid or Medicare, and seventy-five years of age or over.

Arguably, not every negligent adverse event would produce a tort claim; most physical disabilities studied in the HMPS were moderate, temporary, or occurred in persons aged seventy or older whose monetary damages would be comparatively low. Such injuries, even if negligent, might not meet a threshold for litigation but would trigger a patient safety review when disclosed. The impetus to study and correct systematic and individual errors would be to prevent similar errors in the future—not a goal of a plaintiff’s attorney—whose responsibility is to represent an individual client. Apologies or other statements—if made and admitted into evidence—could lower one of the other major bars to successful litigation—causation—leading to decreased costs of litigation and more filed claims.

The likely outcome of more disclosure is more litigation. There is little hard data on this point, but surveys of injured patient’s responses to disclosure are suggestive. A survey of sixty-five experts predicted a 95% chance that claims would increase, including a 60% chance that full disclosure of severe injuries would double the annual number of claims nationwide and a 33% chance that volume would increase at least threefold. Among patients, deterrent impact

129. Weiler et al., supra note 120, at 70.
130. Id. at 73.
132. Id. at 253.
133. Id. at 255.
134. Id. at 257.
was perceived to be greater: Disclosure would deter an average of 57% of plaintiffs whose injuries were not due to negligence and prompt 17% of those who were not inclined to file a claim, while there would be essentially no effect on those whose injuries were adjudged due to negligence.138

There are data also to suggest that the poor, the uninsured, and the aged suffer a disproportionate impact under malpractice litigation as currently practiced.139 Lest the outlook on litigation as an approach to decreasing medical injuries appear too bleak, it has been noted that the legal system operates more accurately than the data suggest.140 While the absolute number of claims is considerably larger than the absolute number of valid claims, the likelihood a physician will be sued is greater if negligent treatment is believed to have occurred than if not.141 Further, given the care with which clients are selected by plaintiffs’ attorneys, the success of malpractice claims is modest.142

Studdert has labeled malpractice law as “punitive, individual, [and] adversarial,” seeking to place blame and transform injury into money.143 This system has its basis in the traditional paradigm of surgical care, which holds the individual surgeon solely accountable. The “captain of the ship” paradigm has enabled many great achievements in surgical care, but it has also probably fostered a dangerous sense of infallibility. As a consequence, errors tend to be equated with negligence, and questions of professional liability tend to involve blaming individuals. Indeed, the very willingness of professionals to accept responsibility for their actions makes it convenient to focus more on individual errors than on collective ones;144 an individual surgeon is a more satisfactory target for the anger and grief of a patient or family than a nameless, faceless healthcare organization. This is certainly not to say that surgeons should avoid responsibility. Rather, the point is that focusing on the errors of individual surgeons without addressing flaws in the underlying system does little to improve health care, and increases the likelihood that errors will go under-reported. Multivariate analyses of physician’s answers to hypothetical vignettes showed that a willingness to report errors was positively associated with a belief that such reports improve quality of care, knowledge of the reporting process, and,

138. Id. at 219.
139. Helen R. Burstin et al., Do the Poor Sue More? A Case-Control Study of Malpractice Claims and Socioeconomic Status, 270 JAMA 1697, 1700 (1993).
140. WEILER ET AL., supra note 120, at 74.
141. Id.
142. THOMAS H. COHEN, TORT BENCH AND JURY TRIALS IN STATE COURTS, 2005, (2009), available at http://bjs.ojp.usdoj.gov/content/pub/pdf/tbjtsc05.pdf (reporting 15% of bench and jury trials disposed of in state courts in 2005 were medical malpractice cases; of these, 22.7% had verdicts for the plaintiffs, with an average verdict of $679,000).
144. JAMES T. REASON, Foreword to HUMAN ERROR IN MEDICINE, at vii (Marilyn S. Bogner ed., 1994).
importantly, an expectation of forgiveness.\textsuperscript{145} Where culpable, mechanisms of discipline should be (and are) being implemented by healthcare organizations.\textsuperscript{146}

Another notable flaw in the liability process is that judgments of causality or fault are backward-looking, and prone to hindsight bias, which can prejudice experts’ assessments of quality of care. This tendency was illustrated by a study of anesthetic care in which knowledge of differences in outcome (temporary versus permanent disability) exerted a significant effect on the opinion rendered by the reviewer.\textsuperscript{147} Hindsight bias focuses too narrowly on adverse outcomes and pays insufficient attention to the processes of care. Yet another defect of the liability process is that it can be financially devastating for physicians,\textsuperscript{148} often adversely affecting their problem-solving abilities. To the extent that experience with or fear of a lawsuit deters efforts at quality improvement by encouraging defensive medicine, it adds very little value to health care and is counterproductive from a cost standpoint.\textsuperscript{149} Lastly, the majority of expenditures in the malpractice system go towards litigation; “The overhead costs of malpractice litigation are exorbitant.”\textsuperscript{150} Many believe that major reform of the professional liability system is a prerequisite for achieving any significant improvements in quality.\textsuperscript{151} Undoubtedly, tort reform is highly desirable; however, the real prerequisite for improving identification and correction of system failures is the provision of increased protection for privileged discussion of such failures.

Organized medicine has mounted vigorous resistance to financially driven controls imposed under managed care without clinical justification, but is still in the initial stages of adopting scientifically based practice guidelines and effective accountability measures.\textsuperscript{152} A transparent discussion of errors, complications, and deaths was reported not to lead to an increased risk of lawsuit in the trauma setting.\textsuperscript{153} The improvements in patient safety achieved by anesthesiologists

\textsuperscript{145} Lauris C. Kaldjian et al., Reporting Medical Errors To Improve Patient Safety: A Survey of Physicians in Teaching Hospitals, 168 ARCHIVES INTERN MED. 40, 43 (2008).

\textsuperscript{146} Wachter & Pronovost, supra note 29, at 1405 tbl. 2.


\textsuperscript{148} Nicholas P. Lang, Professional Liability, Patient Safety, and First Do No Harm, 182 AM. J. SURGERY 537, 540 (2001); see also Barry M Manuel, Double-Digit Premium Hikes: The Latest Crisis in Professional Liability, 86 BULL. AM. C. SURGEONS 19, 19-20 (2001).

\textsuperscript{149} David M. Studdert et al., Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment, 293 JAMA 2609, 2616 (2005).

\textsuperscript{150} David M. Studdert et al., Claims, Errors, and Compensation Payments in Medical Malpractice Litigation, 354 NEW ENG. J. MED. 2024, 2024 (2006).

\textsuperscript{151} David M. Studdert et al., Medical Malpractice, 350 NEW ENG. J. MED. 283, 288 (2004).

\textsuperscript{152} Peter P. Budetti, Tort Reform and the Patient Safety Movement: Seeking Common Ground, 293 JAMA 2660, 2661 (2005).

\textsuperscript{153} Ronald M. Stewart et al., Transparent and Open Discussion of Errors Does Not Increase Malpractice Risk in Trauma Patients, 243 ANNALS OF SURGERY 645, 647 (2006) (reporting that in
argue for the benefits of such accountability. Instead of pushing for laws to protect against patients’ malpractice claims, anesthesiologists focused on improving patient safety. As a result, anesthesiologists paid less for malpractice insurance, adjusted for inflation, than they did twenty years prior.\\footnote{154}{Brian A. Liang, Clinical Assessment of Malpractice Case Scenarios in an Anesthesiology Department, 11 J. CLINICAL ANESTHESIOLOGY 267, 270 (1999).}

II. APOLOGY LAW: COMMON LAW AND STATUTE

Case law is well settled on the effect of disclosures by physicians of admissions of liability for various injuries sustained by patients. When a physician makes such an admission, the plaintiff tends to prevail.\\footnote{155}{Giles v. Brookwood Health Servs., Inc., 5 So. 3d 533 (Ala. 2008); Quibodeaux v. Med. Center of Sw. La., 707 So. 2d 1380 (La. App. 3d Cir. 1998); Woods v. Zeluff, 158 P.3d 552 (Utah App. 2007); Phinney v. Vinson, 605 A.2d 849 (Vt. 1992).} Many states have enacted “apology laws,” which are intended to mitigate the conflict that a physician faces when trying to meet the patient’s desire (and perhaps need) for an apology while avoiding self-incrimination. Apology laws change the traditional rule on admissibility of evidence by declaring that apologies are inadmissible in civil actions arising from alleged medical errors.\\footnote{156}{See, e.g., Del. Code Ann. tit. 10, § 4318 (b) (2006) (“Any and all statements, writings, gestures, or affirmations made by a health care provider or an employee of a health care provider that express apology (other than an expression or admission of liability or fault), sympathy, compassion, condolence, or benevolence relating to the pain, suffering, or death of a person as a result of an unanticipated outcome of medical care, that is made to the person, the person’s family, or a friend of the person or of the person’s family, with the exception of the admission of liability or fault, are inadmissible in a civil action that is brought against a health care provider.”).}

Apology laws purport to protect apologies from being entered into evidence, but these protective laws can be separated into those that do or do not protect accompanying acknowledgments of fault. For example, Colorado’s apology statute addresses all civil actions arising out of “unanticipated outcome[s] of medical care” and makes inadmissible as evidence of an admission of liability statements “expressing apology, fault, sympathy, commiseration, compassion, or a general sense of benevolence.”\\footnote{157}{COLO. REV. STAT. ANN. § 13-25-135 (West 2003).} In contrast, an Indiana statute protects the apology, or “communication of sympathy,” but not a “statement of fault,” even if made within the context of the apology.\\footnote{158}{IND. CODE ANN. § 34-43.5-1-3 to -5 (West 2006).}

A. Why Apologizing Won’t Work

His mother said:

an open M&M conference, of 412 cases, only seven claims were filed and of these, six were surprises—having not been presented).
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—O, Stephen will apologise.

Dante said:

—O, if not, the eagles will come and pull out his eyes.159

1. Apology: A Definition

A rational use of apology in the medical care setting requires a careful consideration of what constitutes an apology, and how it is different from other acknowledgements that a patient has suffered. There is a substantial medico-legal literature on the use of apology, and the majority view is that physicians should apologize to patients who have experienced medical injury.160 Commentators have treated the term “apology” rather cursorily, seemingly without a clear understanding of what the offer of an apology entails linguistically, if not morally.161 To obligate clinicians to engage in such endeavors is therefore naïve and possibly counterproductive to the goal of patient safety.

Apology is defined as “a written or spoken expression of one’s regret, remorse, or sorrow for having insulted, failed, injured, or wronged another.”162 Apologies have been operationally defined as “admissions of blameworthiness and regret for an undesirable event, for example, a transgression, a harmful act, an embarrassing incident.”163 Such definitions leave no doubt as to the fact that apologies, as illocutionary acts, include a statement of fault.164 The consensus as to the requirement of admission of fault is also confirmed by empirical studies on the uses of apology in legal settlements. Apologies in the fullest sense include acceptance of responsibility.165

164. KENT BACH, Speech Acts and Pragmatics, in BLACKWELL GUIDE TO THE PHILOSOPHY OF LANGUAGE, 147 (Michael Devitt & Richard Hanley eds., 2006).
Apologies have been described as a form of remedial work, "a gesture through which an individual splits himself into two parts: the part that is guilty of an offense and the part that dissociates itself from the delict and affirms a belief in the offended rule."  

Further, an apology brings heavy moral approbation down on the offender, and has several elements: expression of embarrassment and chagrin; clarification that one knows what conduct had been expected and sympathizes with the application of negative sanction; verbal rejection, repudiation, and disavowal of the wrong way of behaving along with vilification of the self that so behaved; espousal of the right way and an avowal henceforth to pursue that course; performance of penance and the volunteering of restitution.

The apology performs a function by which "an individual splits himself into two parts, the part that is guilty of an offense and the part that dissociates itself from the delict and affirms a belief in the offended rule." In order for a "full apology" to be performed, the speaker must acknowledge responsibility for having committed some offending act, and he or she must express regret about the offense. The admission of responsibility for the adverse event is a necessary feature of an apology because it conveys to the listener that the speaker is aware of the social norms that have been violated, and therefore conveys that the speaker will be able to avoid the offense in future interactions.

The form of an apology is also varied; by saying "I apologize," one makes an explicit performative utterance. Utterances may be considered to be but does not admit responsibility). Partial apologies are contrasted with "full apologies," in which the offender both expresses sympathy and accepts responsibility.

166. Erving Goffman, Remedial Interchanges, in RELATIONS IN PUBLIC: MICROSTUDIES OF THE PUBLIC ORDER 109 (1971) (describing the function of remedial work as "to change the meaning that otherwise might be given to an act, transforming what could be seen as offensive into what can be seen as acceptable" and setting forth three types of remedial work; accounts, apologies and requests).

167. Id. at 113.

168. Id.


170. Steven J. Scher & John M. Darley, How Effective Are the Things People Say To Apologize? Effects of the Realization of the Apology Speech Act, 26 J. PSYCHOLINGUISTIC RES. 127, 128 (1997); see also Jeremy C. Anderson et al., Influence of Apologies and Trait Hostility on Recovery from Anger, 29 J. BEHAV. MED. 347, 348 (2006) (defining the elements of a "genuine" apology to include six verbal components: first, an explicit expression of remorse; second, a specific statement of why one feels remorse and being sorry for the right thing; third, one must accept responsibility for one's actions; fourth, a truthful explanation for the offensive behavior without trying to excuse the offence and shirk responsibility; fifth, a promise of forbearance—a statement that the offensive behavior is not reflective of the offender's true character, therefore the victim can trust the behavior will not recur—and, sixth, an offer of restitution).

171. BACH, supra note 164, at 148.
apologies without the benefit of an explicit statement. Apology utterances have been further classified into three distinct levels of action beyond the act of utterance itself: the act of saying something (I apologize), what one does in saying it (conveying the adverse event to the patient), and the outcome effected by saying it (patient accepts or does not accept the apology). These are dubbed *locutionary, illocutionary,* and *perlocutionary* acts, respectively.

Apologies are therefore different from other statements expressing responsibility, liability, sympathy, commiseration, condolence, compassion or a general sense of benevolence that may be rendered inadmissible as admissions or statements against interest in some state statutes. Psycholinguistic experts have classified apologies and suggested a number of elements which may be included in an apology: illocutionary force indicating devices (for example, "I'm sorry," or "I apologize"), an explanation of the cause which brought about the wrong, an offer of repair, a promise of forbearance, and an expression of the speaker's responsibility for the offense.

2. Points to Consider in Offering Apologies: Not as Easy as One Might Think

Coulmas has described apologies as reactive, making reference to an object of regret. All apology strategies are intended to convey important information to the hearer (e.g., patient or family) about the speaker (e.g., the physician), improving perceptions about the speaker, reducing the intended sanctions, increasing emotions of remorse or regret attributed to the speaker, and enhancing the appropriateness of the apology. Apologies with no acknowledgement of responsibility are not indebting and can merge into other statements, such as expressions of sympathy.

There are several strategies for apologizing in which the speaker explicitly

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172. *Id.* at 149 (noting one can apologize without explicitly using the performative phrase “I apologize” as a “force-indicating device”). Accordingly, Bach believes here is no theoretically important difference between apologizing explicitly (by saying, “I apologize”) and doing it inextricably. *Id.*

173. JOHN LANGSHAW AUSTIN, HOW TO DO THINGS WITH WORDS 94 (2d ed. 1962).


175. Florian Coulmas, “Poison to Your Soul”: Thanks and Apologies Contrastively Viewed, in CONVERSATIONAL ROUTINE, 75-76 (Florian Coulmas ed., 1981) (distinguishing objects of regret as “a kind of damage, annoyance, or inconvenience which is predictable vs. unpredictable; indebting vs. not indebting”). All medical adverse events occur *ex post* and it is only these with which the current paper is concerned.


177. Coulmas, *supra* note 175, at 76.
states that an apology is at issue. Apology strategies that actually use the word “apology” leave little likelihood that the speaker’s intentions are other than to apologize although only in the first, the performative form (e.g., “I hereby apologize . . .”), does she actually say that what she is doing is apologizing. Other choices, such as expressing the obligation to apologize, offering to apologize, or requesting the hearer accept one’s apology do not technically mean the speaker is apologizing. Notice that in none of these four strategies does the speaker explicitly say that she is responsible for or that she regrets or is remorseful for the object of regret, though these two points are certainly contained in the meaning of the words apology or apologize. Although an illocutionary force indicating device, an apology such as “I apologize” or “Pardon me,” unaccompanied by an expression of remorse, does not convey the required information about the emotional state of the speaker.

Remorse, responsibility, and regret are the primary information conveyed by an apology. Expressing regret for the offense with phrases such as “I’m sorry for . . .” or “I regret that I . . .” the speaker explicitly expresses regret for the offense as well as explicitly acknowledges responsibility for the object of regret itself. Goffman has said as much: “Whether one runs over one’s sentence, time, dog or body, one is more or less reduced to saying some variant of ‘I’m sorry.’” Remorse also serves to deflect negative personality judgments and other reactions from the transgressor.

Other strategic decisions are whether to request forgiveness for the offense or to explicitly acknowledge responsibility. By acknowledging responsibility alone or requesting forgiveness the speaker is not explicitly expressing regret. An offer of compensation has an obvious connection to the remedial function of an apology. The speaker certainly implies, but does not make explicit, that she has some responsibility and feels regret by saying “what can I do to amend?” It is

178. Fraser, supra note 169, at 263 (describing four forms of explicit apology: first, announcing that one is apologizing “I (hereby) apologize for . . .”; second, stating one’s obligation to apologize “I must apologize for . . .”; third, offering to apologize “I (hereby) offer my apology for . . .”; “I would like to offer my apology to you for . . .”; fourth, requesting the hearer accept an apology (e.g., “Please accept my apology for . . .”; “Let me apologize for . . .”; “I would appreciate it if you would accept my apology for . . .”).

179. Fraser, supra note 169, at 263-64.

180. Scher & Darley, supra note 170, at 129-30.

181. Fraser, supra note 169, at 264.

182. GOFFMAN, supra note 166, at 117.

183. Scher & Darley, supra note 170, at 130.

184. Fraser, supra note 169, at 263 (giving examples of requesting forgiveness for the offense such as “Please excuse me for . . .” “Pardon me for . . .” “I beg your pardon for . . .” “Forgive me for . . .” and examples acknowledging responsibility for the offending act such as “That was my fault” or “Doing that was a dumb thing to do”).

185. Fraser, supra note 169, at 264.
an offer to try to correct the situation, to try to partially restore the patient to her pre-adverse event condition, which is often difficult if not impossible, and in which case some form of monetary compensation is all that can be provided (for example, cost-free care of the complicating injury). Rarely, however, does the physician have the fiduciary authority on behalf of the healthcare system to make such an offer to repair things so that it is as if the transgression had not occurred. As the physician has no ability to obligate an offer of compensation, one of the purported reasons for the apology to serve as a form of symbolic function of punishment of the “guilty self” cannot take place. 186

3. Malpractice Insurance Coverage and the Physician as Independent Contractor

Among the practical issues that must be understood prior to any consideration of an apology for medical adverse events are the effect on a physician’s malpractice coverage, and any risks to the physician as an independent contractor. Rarely in the healthcare setting is sustaining an adverse event as simple as A injures B, so A must apologize to B. Does the making of an apology void the physician’s malpractice insurance coverage? Does apologizing place the physician at risk to be fired at will?

The concept of moral hazard suggests that insured physicians might feel free to apologize, or worse, take fewer precautions to protect patient safety. Why not? The insurance company, not the physician, may be perceived as liable under such circumstances. However, liability insurance may impose upon the insured a general duty of cooperation with the insurance company to defend claims. 187 Some liability insurance policies also specifically prohibit the insured from voluntarily assuming liability. 188 Cohen suggests two questions need be answered prior to the giving of an apology, both of which are part of a “full apology,” as noted above. 189 First, is an insured’s apology considered a breach of the insured’s general duty of cooperation? Second, would the insured’s apology be taken as assuming liability, again leading to breach? 190

For the insurer to prevail in assertions of breach in the general duty of cooperation, the insurer must show bad faith—hard to prove in the absence of some collusion between the physician and patient (such as an attempt to defraud and share profits). 191 If, instead of apologizing, the insured simply recounts the

186. Scher & Darley, supra note 170, at 130.
188. Id. at 1025 (citing KENNETH ABRAHAM, INSURANCE LAW AND REGULATION 450 (1990)).
189. Id.
190. Id.
191. Id.
facts as known, the insured is offering only evidence that she would likely have to disclose in deposition or at trial.\textsuperscript{192} A harder case for the insured wishing to apologize is when the insurance contract specifically forbids the insured from accepting liability. Would a physician who apologizes and assumes liability without the insurance company’s approval void coverage? There are few cases on this, usually arising from automobile accidents, and the law is not well settled.\textsuperscript{193} One distinction that has been drawn by courts is that statements by the insured that truthfully admit fault may not void coverage, while statements that assume financial liability will void coverage.\textsuperscript{194}

B. Case Law

Case law on the legal liability of apologies and whether physicians’ statements to patients may be admitted as party admissions is variable.\textsuperscript{195} On balance such statements are more likely to be admitted into evidence against physicians to reverse a non-suit than not:

Under well-established rules we must . . . resolve every conflict in their testimonies in favor of plaintiff, consider every inference which can reasonably be drawn and every presumption which can fairly be deemed to arise in support of plaintiff, and accept as true all evidence adduced direct and indirect which tends to sustain plaintiff’s case.\textsuperscript{196}

Physician statements have been allowed in as evidence based on hearsay exceptions, or out of court statements issued to prove the truth of the matter asserted; establishing medical malpractice as defining the standard of care, breach of the standard, and causation, as discussed below. In Colbert v. Georgetown, statements attributed to, but denied by the defendant, were held to be admissions establishing a prima facie case of malpractice, to demonstrate that the standard of care was breached, and to reverse a summary judgment in favor of the defendants.\textsuperscript{197} In Snyder v. Pantaleo, statements by the physician defendant

\textsuperscript{192} Id.

\textsuperscript{193} See, e.g., Annotation, Validity, Construction, and Effect of “No-Consent-To-Settlement” Exclusion Clauses in Automobile Insurance Policies, 18 A.L.R. (1982) (citing cases where courts have variously upheld and rejected such clauses).

\textsuperscript{194} 8 JOHN A. APPLEMAN & JEAN APPLEMAN, INSURANCE LAW AND PRACTICE § 4780 (1981) (admonishing “a policy provision [against assuming liability] does not prohibit the insured from giving the injured person a truthful explanation of the accident and circumstances thereof”).

\textsuperscript{195} Wei, supra note 18, at 110.

\textsuperscript{196} Lashley v. Koerber, 156 P.2d 441, 442 (Cal. 1945) (considering whether the judgment of nonsuit was proper).

\textsuperscript{197} Colbert v. Georgetown Univ., 623 A.2d 1244, 1253 (D.C. 1993), rev’d en banc, 641 A.2d 469 (D.C. 1994) (citing statements such as decision first to perform lumpectomy rather than a mastectomy caused an “enhanced risk of a very high nature;” that defendant conceded to plaintiff’
In a California wrongful death suit, *Sheffield v. Runner*, the defendant stated, regarding a patient with bacterial pneumonia, “I should have put her in the hospital.” The court held that a physician’s statements could not only prove liability, but also be used as expert testimony demonstrating breach of standard of care. According to the testimony of the plaintiff’s husband, the defendant then told plaintiff “to . . . have an X-ray taken, stating that he should have done it in the beginning . . . I know, it is not your fault, Mrs. Lashley, it is all my own.”

An Oklahoma case, *Robertson v. LaCroix*, also held that a surgeon’s statements communicated more than mistaken judgment and constituted an admission of negligence during an operation. In *Woronka v. Sewall*, the plaintiff filed suit for burns she received on her buttocks while giving birth. The defendant doctor examined the patient two days later 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.”

In *Wickoff v. James*, the court held that defendant doctor’s statement to the plaintiff’s husband “Boy, I sure made a mess out of things today, didn’t I, Warren?” could be interpreted to establish a prima facie case of negligence, and a nonsuit in favor of the defendants was reversed.

In *Greenwood v. Harris*, a gynecologist, upon finding that a presumed tumor
was in fact a three-and-one-half months pregnancy, earnestly disclosed the following: “Your wife is approximately three to three and a half months pregnant, 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 am sorry.” The Supreme Court of Oklahoma found that these statements indicated a prima facie case of malpractice and reversed the trial court’s decision sustaining a demurrer.

The use of physician statements not only serves to allow appellate courts to reverse pre-trial judgments for the defense, but also to reverse directed verdicts or have a case remanded for re-trial after a jury has returned a verdict. In Wooten v. Curry, a plaintiff’s husband, on finding his wife’s vagina closed after a hysterectomy, related the following statement regarding a conversation with the gynecologist defendant: “That is the only thing I have to go by, just what he told me. That was the only thing that looked like it caused it. He said he was sorry it happened and could have probably have avoided it if he had checked on her as he should.”

In Woods v. Zeluff, statements made by defendant to the plaintiff during a post-operative visit were excluded as unfairly prejudicial by the trial court: “I jumped the gun,” “I’ve missed something,” and “I don’t think we should have done this surgery.”

Some courts have found that a physician’s out of court statements, including apologies, are insufficient to establish the standard of care or its breach, as discussed below. Unfortunately, statements made by physicians that are not held sufficient to establish the standard of care—or its breach—are extremely difficult to distinguish from those which are sufficient. In general, courts seem divided on whether expert testimony beyond that of statements attributed to the defendant can establish negligence, standard of care, or breach. In Jeffries v. Murdock, the plaintiff’s statement regarding his conversation with a defendant physician included the following: “And I said, ‘Well, how did this all happen?’ He said, ‘I’m sorry, I accidentally cut the nerve to your vocal cord.’” The court held that the significance of the defendant’s alleged statement was negated by the testimony of defense expert witnesses and by the plaintiff’s failure to present any evidence to the contrary. In Senesac v. Associates in Obstetrics & Gynecology, the plaintiff testified that shortly after the operation the defendant “admitted that

207. Wooten v. Curry, 362 S.W.2d 820, 822 (Tenn. Ct. App. 1962) (holding that the statement of the defendant in the absence of any explanation made a prima facie case of negligence and proximate cause, and reversing a directed verdict for the defense).
208. Woods v. Zeluff, 158 P.3d. 552, 554 (Utah Ct. App. 2007) (holding that the trial court erred by excluding, as unfairly prejudicial, post-operative statements allegedly made by Dr. Zeluff and that such error warranted a new trial).
she had made a mistake." The Supreme Court of Vermont affirmed a defendant's motion for summary judgment by holding that, while a defendant's statement might have been admissible, it alone was insufficient to meet plaintiff's burden of production. A plaintiff alleged the defendant said he was told by a second doctor after re-operation on the plaintiff's prostate gland that the defendant had performed an "inadequate resection" and apologized to plaintiff "for his failure to do so." In Giles v. Brookwood Health Services, Inc., the defendant was sued for removing a normal right rather than a diseased left ovary. The defendant admitted that the plaintiff's husband Giles "was absolutely right, that it was the left side that should have been removed. [He said] 'I am so sorry . . . ." However, on appeal, the court held:

Giles submitted no expert testimony indicating that Dr. Perry was in any way negligent with regard to her medical care and treatment . . . Therefore, no genuine issue of material fact exists as to Giles's malpractice claims against Dr. Perry, and Dr. Perry is entitled to judgment as a matter of law on those claims.

In Airasian v. Shaak, evidence of both the doctor's observation and his statement admitting fault was ruled inadmissible at trial under a statute precluding admission of statements or conduct expressing regret, apology, mistake, or error.

Some courts have held that physicians' out-of-court statements describing adverse events as "mistakes" or "accidental" are not enough to establish a prima facie case in the absence of expert testimony. In Maxwell v. Women's Clinic, P.A., the court held that, in the absence of expert testimony, the plaintiff's statement and act of non-billing for the surgery together would not be sufficient

210. Senesac v. Assocs. in Obstetrics & Gynecology, 449 A.2d 900, 903 (Vt. 1982) (holding that the asserted statements of defendant "made a mistake, that she was sorry, and that it [the perforation of the uterus] had never happened before" did not establish a departure from the standard of care).
211. Phinney v. Vinson, 605 A.2d 849, 849 (Vt. 1992) (holding that while defendant's statement may have been admissible, it was insufficient by itself to meet plaintiffs' burden under 12 V.S.A. § 1908 (1975)).
212. Id.
213. Giles v. Brookwood Health Services, Inc., 5 So. 3d 533, 540 (Ala. 2008) (holding that in the light most favorable to plaintiff, defendant's apologies did not constitute expert testimony that he injured Giles by breaching the standard of care).
214. Id. at 540.
215. Id. at 548-49.
to create the required inference about failing to meet the community standard.\textsuperscript{217} In Locke v. Pachtman, a gynecology resident acting under the supervision of an attending surgeon, who was not present, broke a needle in the plaintiff's tissues. The resident defendant made statements that plaintiff argued established a prima facie case of negligence: "I knew that needle was too small when the new scrub nurse handed it to me. It wasn't her fault because she was new, but I chose to use it anyway and it's my fault and I am really sorry . . . ."\textsuperscript{218} In a federal diversity case, Sutton v. Calhoun, the appellate court held it proper for the lower court to refuse to give an instruction to the jury that if the "mistake" statement was made it was an admission of negligence.\textsuperscript{219} Lastly, in Quickstad v. Tavenner, the appellate court held that the defendant's statements were not enough to support a prima facie case for the plaintiff after a needle was retained in the chest cavity during thoracentesis.\textsuperscript{220} In some instances, written documents or statements provided by the physician—whether spontaneously or in response to a patient's request after an "apology" or other verbal act is made—have been held inadmissible.\textsuperscript{221}

In some of the cases discussed above, statements attributed to defendant physicians were denied, but still admitted into evidence. In some circumstances the statements were admitted as proofs of negligence, and in some cases, not. As a result, circumspection in disclosure to patients is still advised. The idea is that this should reassure physicians and allow them to feel safer in apologizing to patients. But to follow this 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. Apology laws will not make case law more predictable by barring admission of apologies into evidence; as the cases cited above show, there is a particularized fact assessment that is difficult to reconcile with any given state statute.

\begin{itemize}
\item \textsuperscript{217} Maxwell v. Women's Clinic, P.A., 625 P.2d 407, 408 (Idaho 1981) (quoting the plaintiff's husband as testifying, "[A]nd he said, the way I remember it, he said, I obviously messed up on the first one, and another surgery has to be done to repair the damage").
\item \textsuperscript{218} Locke v. Pachtman, 521 N.W.2d 786, 789 (Mich. 1994) (holding that while the statements may have indicated defendant's belief that she made a mistake, a jury could not reasonably infer from those statements alone that defendant's actions did not conform to standards of professional practice).
\item \textsuperscript{219} Sutton v. Calhoun, 593 F.2d 127, 127 (10th Cir. 1979) (involving family members of the plaintiff who alleged that after the operation the defendant came to them and said he had "made a mistake," that he should not have cut the common bile duct).
\item \textsuperscript{220} Quickstad v. Tavenner, 264 N.W. 436, 437 (Minn. 1936) (involving a plaintiff who alleged the doctor stated that "he broke the needle"; he "should have used a stronger needle"; he "shouldn't have done it"; and would "never try it again").
\item \textsuperscript{221} Smith v. Karen S. Reisig, M.D., Inc., 686 P.2d 285, 289 (Okla. 1984) (holding that the defendant doctor's statement in the medical record that injury to plaintiff's bladder was "inadvertent" was not an admission of negligence).
\end{itemize}
Further, apology laws are not necessary to enable doctors to deliver statements of empathy and understanding in the everyday situation; physicians frequently and without hesitation may say to their patients that they are sorry that their patients are experiencing pain or suffering. These are not the scenarios with which the apology laws are concerned. By attempting to bar the introduction of statements by physicians communicating with patients who have been injured, apology laws are supposed to encourage doctors to 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 and healthcare institutions are obliged to disclose of medical errors.

C. How Exactly Does “Sorry” Work?

The concept of disclosure and apology gained momentum based on reports from the Lexington Veterans Affairs Medical Center (LVAMC) a decade ago. After LVAMC lost two major malpractice cases in the mid-1980s, to the tune of $1.5 million, its leadership started taking a more proactive approach in identifying and investigating incidents that could result in litigation. The shift in focus evolved into an organization-wide full disclosure policy and procedure.222 The policy is excerpted in part:

The [disclosure] meeting is with the chief of staff, the facility attorney, the quality manager, the quality management nurse, and sometimes the facility director. At the meeting, all of the details are provided as sensitively as possible, including the identities of persons involved in the incident (who are notified before the meeting). Emphasis is placed on the regret of the institution and the personnel involved and on any corrective action that was taken to prevent similar events.223

An analysis of claims experience at LVAMC, compared to thirty-five other similar VAMCs, showed that Lexington was in the top quartile of claims but the bottom quartile in payments.224 Recently, out of seven veterans who were notified by VA of substandard eye care, three have filed suit.225 The LVAMC experience was also tried in the academic setting at the University of Michigan, and reported survey results suggest physicians and plaintiffs’ attorneys alike were

224. Id. at 965.
225. John Maa & Kristen Hedstrom, College Advocates for Ensuring Quality Eye Care for America's Veterans, 95 BULL. AM. C. SURGEONS 8, 9 (2010).
satisfied with the approach.\textsuperscript{226} Recent experience with the Michigan data further suggests that a disclosure-with-offer policy has decreased both claims and payments; however, the precise role of apology is not clearly defined.\textsuperscript{227} The authors note that causality was not established due to study design,\textsuperscript{228} but during the latter part of the study malpractice claims in Michigan generally declined.\textsuperscript{229} The authors also note that the University of Michigan Health System has a closed staff with a captive insurance company that assumes legal responsibility; the findings might not apply to other health systems.\textsuperscript{230} Settlements were generally made in the institution’s name; consequently, reporting of individual caregivers to the National Practitioner Data Bank was rare.\textsuperscript{231}

Another recent private sector medical center also has touted a disclosure policy with the following recommendations given to staff: “Avoid words such as error, mistake, fault, and negligence unless you are absolutely certain that an error or mistake has occurred. Don’t confess. Apologies for having caused the outcome should be avoided unless responsibility is unmistakably clear.”\textsuperscript{232}

One of the most strident voices for requiring physicians to say “I’m sorry” is that of the “Sorry Works!” coalition.\textsuperscript{233} “Sorry Works!” has proposed that after patients experience adverse events, root cause analyses would need to be performed—presumably by a panel of members of the healthcare organization—to determine if the standard of care was met. The performance of root cause analysis for sentinel events is not controversial; The Joint Commission requires similar actions for all accredited facilities.\textsuperscript{234} “Sorry Works!” does not define which events or outcomes would require such analysis; if all such events were to be subject to root cause analysis, the effort would be staggering.\textsuperscript{235}

A more troubling aspect of the “Sorry Works!” agenda is the requirement for determining whether the appropriate standard of care was met. The Coalition notes such analysis may take weeks to months and may involve the assistance of

\textsuperscript{227} Allen Kachalia et al., Liability Claims and Costs Before and After Implementation of a Medical Error Disclosure Program, 153 ANNALS INTERNAL MED. 213, 215-17 (2010).
\textsuperscript{228} Id. at 220.
\textsuperscript{229} Id.
\textsuperscript{230} Id.
\textsuperscript{231} Id. at 214.
\textsuperscript{234} JOINT COMMISSION HANDBOOK, supra note 102, at SE-2.
\textsuperscript{235} JOINT COMMISSION HANDBOOK, supra note 102, at SE-1.
"outside experts." A root cause analysis showing that the standard of care was not met due to medical error or negligence would require providers to admit fault, apologize to the patient and/or family, fully disclose the sequence of actions which led to the event, describe changes in hospital policy and procedure made to try and prevent the same event from happening to other patients, and make a fair offer of up-front compensation. The attorneys representing the plaintiffs and providers would negotiate the compensation. Conversely, if the root cause analysis finds that the standard of care was met, the providers would not admit fault or offer to negotiate up-front compensation. In all respects, the "Sorry Works!" approach is that of an extrajudicial legal proceeding.

The "Sorry Works!" approach suggests that each healthcare organization should develop a "panel" to investigate each occurrence of an adverse event. Struve has given considerable attention to the use of such panels, albeit in a more formal extra-institutional setting, and has concluded that such screening panels are unlikely to provide meaningful assistance in the analysis and disposition of claims, concluding that: "[N]either theory nor experience strongly supports proponents' optimistic view of screening panels." Further, a significant number of the states that adopted screening panel provisions subsequently repealed or invalidated them. Although her study is somewhat dated when compared to the current malpractice climate, Patricia Danzon analyzed insurance company data on claims closed throughout the 1970s in response to a previous malpractice crisis in 1975. She found that pretrial screening panels had no significant effect on malpractice claims frequency or severity. The use of such panels would not be expeditious (weeks to months as conceded by "Sorry Works!") or low-cost. Panels would need to hold meetings, and conduct discovery (documents, participants, witnesses, and experts) in order to gather the facts. In jurisdictions where such findings are admissible as evidence trials,

236. Breach of standard of care is one element of negligence, a legal term which can only be determined by finders of fact in a court of law.
237. Wojcieszak et al., supra note 233, at 345.
239. Id. at 57.
241. Patricia M. Danzon, The Frequency and Severity of Medical Malpractice Claims: New Evidence, 49 L. & CONTEMP. PROBS. 57, 78 (1986) (concluding that the effect of screening panels on claim severity is not consistent across the different equations, but there is no evidence that screening panels consistently reduce claim severity).
panels are likely to "entail the costs and delay that panels are intended to prevent." 242

D. Statutory Approaches: The "Apology" Laws

Federal Rule of Evidence 408, which has been widely adopted into state law, generally prevents an offer of consideration to compromise a claim from being admitted. 243 Rule 408, however, is limited to offers of settlement, and apologies are not specifically included. Even in this setting, an apology could be taken as evidence of an admission of fault while other aspects of the negotiation would be protected. A survey of states enacting apology laws identified thirty-four states and the District of Columbia as having some protected disclosure of certain statements made by putative offenders to victims. 244 Of the thirty-five identified statutes, twenty-five explicitly mention the word "apology." 245 Only Montana defines apology and includes in this definition expressions of regret, but not responsibility. That the Montana legislature chose to exclude responsibility from its definition suggests that the remaining states, in their statutes, intended to keep the term "apology" as expressing responsibility, regret, and remorse; this is evidence of a desire to keep apologies separate from other statements, as admissions of fault. 246

Eight states do not explicitly mention healthcare providers or patients, 247


243. FED. R. EVID. 408 ("Compromise and Offers to Compromise(a) Prohibited uses.—Evidence of the following is not admissible on behalf of any party, when offered to prove liability for, invalidity of, or amount of a claim that was disputed as to validity or amount, or to impeach through a prior inconsistent statement or contradiction:(1) furnishing or offering or promising to furnish—or accepting or offering or promising to accept—a valuable consideration in compromising or attempting to compromise the claim; and (2) conduct or statements made in compromise negotiations regarding the claim, except when offered in a criminal case and the negotiations related to a claim by a public office or agency in the exercise of regulatory, investigative, or enforcement authority.").

244. For a detailed list of states that were identified as having disclosure statutes, see infra app. 1. The state, identifying statute section, types of inadmissible statements, by whom the statements can be made, to whom they can be made, and additional notes on specific aspects of the individual state laws are also provided. For purposes of the text, the states will be identified by name, not individual statute section numbers.


246. Fraser, supra note 169, at 262; Coulmas, supra note 175, at 76; Scher & Darley, supra note 170, at 129. See also Lee Taft, Apology Subverted: The Commodification of Apology, 109 YALE L.J. 1135, 1139-43 (2000).

247. CAL. EVID. CODE § 1160 (West 2001); FLA. STAT. ANN. § 90.4026 (West 2001); HAW. REV. STAT. § 626-1 (2007) IND. CODE ANN. § 34-43.5-1-3 (West 2006); MASS. GEN. LAWS ch. 233.
instead choosing to use the same standard of disclosure for medical adverse events as for car accidents or any other civil action. The Vermont legislature saw fit to limit apologies and other statements to those made orally, while most states have expanded such statements to include gestures and writings.

The state statutes also differ in who can make statements that are protected. Most state statutes allow healthcare providers or healthcare professionals, as well as employees or agents of healthcare providers or healthcare professionals to make protected statements. Oregon requires the person by or on whose behalf statements are made to be a licensed professional. North Carolina and Louisiana restrict the making of protected statements only to healthcare providers. Vermont and Washington statutes require that for statements—including apologies—to be deemed inadmissible, they have to be made within thirty days of when the provider knew, or should have known, about the consequences of the adverse event. Utah awaits the bringing of a claim, and limits protective statements made by, or on behalf of, defendants who are healthcare providers. Only New Hampshire is completely silent, which presumably means any individual is able to make a protected statement.

States also vary in defining to whom protected statements may be made. In all cases the alleged injured individual is included, as are those persons defined as relatives and/or family members. A subgroup of states has also included a variety of other representatives. South Carolina requires that, in order to be protected, the statements must be made during a designated meeting to discuss the unanticipated outcome.

§ 23D (West 2000); MO. REV. STAT. § 538.229 (West 2005); TENN. R. EVID. 409.1; TEX. CIV. PRAC. & REM. CODE ANN. § 18.061 (Vernon 1999).


250. N. C. GEN. STAT. ANN. § 8C-1 (West 2004); LA. REV. STAT. ANN. § 3715.5 (2005).

251. VT. STAT. ANN. tit. 12, § 1912 (West 2005); WASH. REV. CODE ANN. § 5.64.010 (West 2006). Illinois had shortened the time frame to 72 hours but this statute was, as noted in Table 1, declared unconstitutional.

252. UTAH CODE ANN. § 78B-3-422 (West 2006).


254. States use, variously, the term victim, patient, plaintiff, or person.

255. Various states include “health care decision-maker,” “representative,” “friend,” “any individual who claims damages by or through that victim,” “legal representative,” or “decision maker for plaintiff.” Utah defines patient as “any person associated with the patient.”

The circumstances under which statements are rendered admissible or inadmissible have also been addressed. Most states have limited the admissibility of statements—or their content—only when such statements constitute admissions of liability or admissions against interest. These are narrow restrictions; in fact, given the rarity with which a declarant (i.e. defendant) is unavailable in a malpractice action as required for a statement against interest, the only real function of such statutes is to preclude statements as admissions of liability. Idaho and Montana specifically exclude statements as evidence, including apologies, for any reason. Oregon, by law, precludes depositions of Oregon Medical Board licensed practitioners or those making statements on their behalf that have made expressions of regret or apology. Vermont has similar provisions. Virginia protects the making of such statements only if death has occurred.

Thirteen states allow various admissions of liability, fault, negligence, or culpable conduct. Delaware, Indiana, Louisiana, Maine, and Nebraska are particularly problematic, as in these states apologies may be protected as statements, but may also be admitted as admissions of fault in part or in whole. In summary, apology holds a special place in the universe of statements that are intended to express some form of sympathy towards a patient who has sustained a medical care related injury. The stance of commentators and other interested parties covers a wide spectrum of views on whether or not to apologize as a specific form of remedial work. Taft would argue that the avoidance of consequences by protective statutes strips the apology of a moral dimension: “What elevates [an apology] to a truly moral and corrective communication is the offending party’s willingness to accept the consequences that flow from the

257. Fed. R. Evid. 804 ("Hearsay Exceptions: Declarant Unavailable (b)(3) Statement against interest. A statement which was at the time of its making so far contrary to the declarant’s pecuniary or proprietary interest, or so far tended to subject the declarant to civil or criminal liability, or to render invalid a claim by the declarant against another, that a reasonable person in the declarant’s position would not have made the statement unless believing it to be true.").
wrongful act." Any of a number of commentators have casually assumed that apology is equivalent to other statements. Robbenolt has put forth empirical evidence that a “partial apology” may be an acceptable compromise between circumspection and disclosure. However, “the effects of partial apologies on settlement decision making appear to be much more complicated than the effects of full apologies.” Lastly, Jesson and Knapp have noted that the patchwork of apology laws throughout the United States has led to the need to involve legal counsel in the decision of what to disclose and who to tell. Precisely defining the contours of healthcare apologies would create at least three types of problems for effective communication between physicians and patients or their families. Trying to craft a healthcare apology, regardless of statutory text, should create a role for lawyers in the process of before any claims are brought or anticipated. Retaining counsel will delay and change the nature of physician-patient communication and cause delay. The Joint Commission has maintained that effective apologies are made as quickly as possible after the adverse event occurs—within twenty-four hours. A second problem is that the beneficial effects of apologies, whether intended to promote healing or to avoid litigation, stem from the openness of communication. Asking the lawyer to review a proposed apology text invites revision and possible change of intended meaning. Lastly, apologies will essentially fit the contours of any statutory protection for healthcare apologies will result: “Simply put, once there is a safe harbor, all boats


265. MICHAEL S. WOODS, HEALING WORDS: THE POWER OF APOLOGY 14 (Joint Commission Resources 2d ed. 2007) (stating that the five “R’s” of an effective apology are recognition, regret, responsibility, remedy, and remaining engaged); Ken Braxton & Kip Poe, How Should Hospital Policy Address Apologies to Patients?, 9 HOOPS. & HEALTH SYS. RX 22, 22 (2007) (“Hospitals must ensure that their risk management and legal staff fully understand their applicable state law regarding ‘I am Sorry’ guidelines . . . .”); Kathy Wire, Apology Just First Step In Event Management, 30 MED. LIABILITY MONITOR 8, 8 (2007) (suggesting that in cases of a clear error, the accountable party should accept both error and responsibility. Such apologies could come from the physician, hospital representatives or, most often, both).

266. Robbenolt, supra note 165, at 484.
267. Id. at 506.
269. Id. at 1447.
270. Id.

will moor there.²⁷³ Once again, promptness of response and open communication will be sacrificed in attempts to protect any intended statement. In summary, apologies won’t work, and attention should be placed in other directions.

III. RATIONAL ALTERNATIVES TO AN APOLOGY

A. Promote Establishment of a National “Patient Safety Reporting System”

Leveling fault at an individual physician or other healthcare worker for the occurrence of a complex systems error will not prevent the same or similar errors from happening again.²⁷⁴ The physician may have not have made a mistake; or a mistake may have been made but without causation in injury or death; or a mistake was made, and causation shown, but a systems error was responsible. “[E]rror identification requires a comfortable and candid relationship among members of a healthcare team, built on trust among members that errors may be openly discussed without fear of sanction in all but the most egregious cases.”²⁷⁵ Both mandatory and voluntary reporting systems—which complement each other—are required to make systems-based approaches to safety reporting, improved patient safety, and error prevention and effect change that contribute to decreased adverse events.²⁷⁶

To achieve the requisite understanding of how an adverse event occurred and how best to prevent it from happening to others, it is necessary for each institution to have a patient safety program reporting system that collects, tabulates, analyzes and reports data on the frequency and nature of adverse events as well as near misses.²⁷⁷ The primary function of a patient safety reporting system should be to identify both real and potential adverse consequences of overt as well as latent errors and make them visible to others.²⁷⁸

²⁷³. Id. at 1451.
²⁷⁴. INST. OF MED., supra note 3, at 4.
²⁷⁶. INST. OF MED., supra note 3, at 87.
²⁷⁸. Lucinda Glinn, Navigating Provider Protections for Quality of Care Reports—From Peer Review Statutes to Common Law Privileges, 9 HOSPS. & HEALTH SYS. RX 16, 17 (2007) (advising that reports critically analyzing adverse events that show imperfect processes or failures to follow proper policies should be analyzed at the outset to ensure that the entirety of the quality review process from gathering, to investigating and drafting the resultant report, is conducted by the proper individuals and for the express purpose of quality of care, in hopes of maintaining a modicum of protection from disclosure).
Once adverse events are identified and analyzed, healthcare systems can be redesigned so as to eliminate or minimize them. The highly successful Aviation Safety Reporting System (ASRS) is a good example of the type of reporting system needed in health care. The ASRS receives, processes and analyzes voluntarily submitted reports of incidents from those in the airline industry. Submitted reports describe crashes, other unsafe occurrences and “near miss” hazardous situations.

A successful reporting system such as the ASRS is typically nonpunitive, confidential, anonymous, independent, timely, systems oriented, and responsive to issues of human performance. The absence of a punitive focus reduces healthcare workers’ concerns that reports might be used against them and thus minimizes underreporting. In addition, it includes expert analysis, meaning that reports are evaluated by persons who understand the relevant circumstances and are trained to recognize underlying system-based causes. A successful reporting system usually also tabulates seemingly rare incidents (including near misses) even if there seems to be little direct or immediate benefit to doing so; in addition to their potential value in larger contexts, such analyses may help institutions predict and thereby avoid errors and system failures. The concerns about the possible adverse consequences of a reporting system are quite strong. Andrus believes that a healthcare reporting system can succeed only if legal immunity is available: “A medical error-reporting system without absolute anonymity and nondisclosability that does not ensure absolute immunity from punitive results for the reporter will not succeed.”

The fear of being sued is widespread among physicians; however, the perceived risk of being sued is threefold greater than the actual risk. Whether adverse event reporting should be voluntary or mandatory is still a matter of debate. On one hand, voluntary reporting has a high inaccuracy rate even when mandated by state or federal regulations. However, unless strict confidentiality

279. REASON, supra note 7, at vii.
283. John W Senders, Medical Devices, Medical Errors, and Medical Accidents, in HUMAN ERROR IN MEDICINE 159 (Marilyn S. Bogner ed., 1994); see also Error Reporting Does a Turn Around, 23 HOSP. PEER REV. 121, 122 (1998).
285. Emily R. Carrier et al., Physicians’ Fears of Malpractice Lawsuits are Not Assuaged by Tort Reforms, 29 HEALTH AFF. 1585, 1588 (2010).
is the standard, many surgeons fear reporting may increase the pressure to conceal errors rather than study them; that it is unworkable in the current legal regime of deterrence; and that it may result not in constructive patient safety improvement, but punishment or censure:

The current culture of blame and litigation also works against the use of voluntary error reporting. As several respondents indicated, until the legal system is changed to protect physicians' rights and hospital administrators' rights to maintain private data on errors and near-misses, it is less likely that such data will be collected and analyzed. 287

B. Strengthen Protections for Reporting of Adverse Events

Rather than focus on legislation that "protects" apologies from admission into evidence, a better strategy might be to strengthen protections in other rules of evidence, such as FRE 803(6), which addresses hearsay exceptions for records of regularly conducted activity. 288 Currently, both of these Rules allow statements to be admitted as evidence; hence most information obtained as a means to study medical errors is admissible. The systems approach of patient safety to reducing error is incompatible with the deterrence approach of medical malpractice liability. A disciplined, systematic approach of empathy, coupled with competent patient service immediately after an injury, an investigation (root cause analysis), and a resolution are all within the limits of reasonableness given the complexities of modern medicine. There are a variety of issues regarding requiring physicians to apologize as opposed to having healthcare institutions disclose an error.

Patient safety can only be enhanced in a setting of protected disclosure not only of successful initiatives but also injuries and "close calls" related to adverse events. Healthcare professionals are best positioned to make patients safer—certainly so with respect to plaintiff's attorneys and legislators. The federal

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287. Lori A. Roscoe & Thomas J. Krizek, Reporting Medical Errors: Variables in the System Shape Attitudes Toward Reporting, 87 BULL. AM. C. SURGEONS 12, 16 (2002).

288. FED. R. EVID. 803 ("Hearsay Exceptions; Availability of Declarant Inmaterial (6) Records of regularly conducted activity. A memorandum, report, record, or data compilation, in any form, of acts, events, conditions, opinions, or diagnoses, made at or near the time by, or from information transmitted by, a person with knowledge, if kept in the course of a regularly conducted business activity, and if it was the regular practice of that business activity to make the memorandum, report, record or data compilation, all as shown by the testimony of the custodian or other qualified witness, or by certification that complies with Rule 902(11), Rule 902(12), or a statute permitting certification, unless the source of information or the method or circumstances of preparation indicate lack of trustworthiness. The term 'business' as used in this paragraph includes business, institution, association, profession, occupation, and calling of every land, whether or not conducted for profit.").
government appears to understand the need for a protected discussion of medical adverse events to foster a culture of safety. Congress has been cautiously moving in the direction of making patients safer by protecting those documents that result from analysis of adverse events. On December 6, 1999, President Clinton signed the Healthcare Research and Quality Act of 1999, reauthorizing the Agency for Health Care Policy and Research and changing the name to Agency for Healthcare Research and Quality (AHRQ).\textsuperscript{289} AHRQ is charged with improving patient safety by promoting research on healthcare outcomes and other measures.

Of even greater import, the Patient Safety and Quality Improvement Act (PSQIA) of 2005 was enacted for the purpose of improving patient safety by encouraging voluntary, confidential reporting of events that adversely affect patients.\textsuperscript{290} The act required the creation of patient safety organizations to collect, aggregate, and analyze confidential information reported by healthcare providers. PSQIA also calls for establishing a network of patient safety databases as an interactive, evidence-based management resource. However, there are shortcomings in the level of protection provided by the act. Under a number of circumstances, patient safety organizations can be compelled to produce documents otherwise protected, including information that is identified, is not work product, and “not reasonably available from another source.”\textsuperscript{291} Further, any information shared with patients or families, whether a limited factual disclosure or an apology, is not protected.

In the healthcare setting, safety can be defined as freedom from accidental injury.\textsuperscript{292} This definition recognizes that avoidance of accidental injury is an overarching goal from the patient’s perspective. In the past decade, the definition

\textsuperscript{289}. Reauthorization Fact Sheet, Agency for Healthcare Research and Quality, http://www.ahrq.gov/about/ahrqfact.htm (last visited Dec. 1, 2009) (describing AHRQ as the lead agency of the U.S. Department of Health and Human Services charged with supporting research designed to improve the quality of healthcare, reduce its cost, improve patient safety, decrease medical errors, and broaden access to essential services. AHRQ sponsors and conducts research that provides evidence-based information on healthcare outcomes; quality; and cost, use, and access).

\textsuperscript{290}. Patient Safety and Quality Improvement Act of 2005, Pub. L. No. 109-41, 119 Stat. 424. (“Amends the Public Health Service Act to designate patient safety work product as privileged and not subject to: (1) a subpoena or discovery in a civil, criminal, or administrative disciplinary proceeding against a provider; (2) disclosure under the Freedom of Information Act (FOIA) or a similar law; (3) admission as evidence in any civil, criminal, or administrative proceeding; or (4) admission in a professional disciplinary proceeding”). Defines “patient safety work product” as any data, reports, records, memoranda, analysis, or written or oral statements which: (1) are assembled or developed by a provider for reporting to a patient safety organization (PSO); (2) are developed by a PSO for patient safety activities and which could result in improved patient safety or health care quality or outcomes; or (3) identify or constitute the deliberations or analysis of, or identify the fact of reporting pursuant to, a patient safety evaluation system. Id.


\textsuperscript{292}. Richardson et al., supra note 3, at 18.
of patient safety has been expanded to acknowledge patient safety as both emerging discipline and a process. A number of states have begun to protect patient safety analyses from discovery or as evidence in most civil proceedings. Individual state laws, however, can be quite different. As an example, the Oregon legislature protects patient safety data and reports, but the privilege does not apply to records of a patient’s medical diagnosis and treatment or to records created in the ordinary course of business. In Vermont, original source information, documents, and records are not immune from discovery or use in any other action merely because they were made available to the department’s patient safety surveillance and improvement system. In Virginia, no privilege to a healthcare provider, emergency medical services agency, community services board, or behavioral health authority for medical records kept in the ordinary course of business precludes or affects discovery of or production of evidence relating to hospitalization or treatment of any patient in the ordinary course of hospitalization of such patient. However, for such reports to be comprehensive and “kept in the course of a regularly conducted business activity,” the protections regarding discovery and admissibility should be further strengthened.

C. Remedial Work and Disclosure of the Adverse Event: Account, Not Apology

As errors—i.e., injury related and “near misses”—are documented and analyzed, the disclosure of such errors to patients is being required with increasing frequency. The Joint Commission approach requires disclosure by the attending physician at the time the confidential report is submitted for patient safety and

293. Linda Emanuel et al., What Exactly is Patient Safety?, INFORMED 2010-2011 PENNSYLVANIA PATIENT SAFETY UPDATE, http://pa.cme.edu/index.aspx (last visited July 5, 2010) (defining patient safety as “[a] discipline in the health care sector that applies safety science methods toward the goal of achieving a trustworthy system of health care delivery”). “Patient safety is also an attribute of health care systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.” Id.


297. VA. CODE ANN. § 8.01-581.17 (2010).
298. FED. R. EVID. 803(6).
risk management review. Pennsylvania has enacted Act 13 M-CARE legislation, which requires the disclosure of medical injury to a mandated state reporting recipient—the patient safety authority—and the affected patient and/or family. M-Care also requires the establishment of patient safety committees for each healthcare facility. In addition to the non-statutory and disclosure requirements listed above, a number of other states are also getting into the act, with at least six states enacting some form of mandatory disclosure. 299

Encouraging physicians to apologize for adverse events is counterproductive to the goal of improving patient safety. Physicians should, however, be involved in a process of disclosure to ensure patients understand the medical implications of the adverse event. Such information is important so the affected patient and their families can make rational future decisions regarding their health. An explanation or account, while often given in conjunction with an apology, is not an apology. An “account,” as used in this paper, is the offering of external, mitigating circumstances and is a form of remedial work that seeks to reduce the responsibility of the transgressor for the transgression. 300 The reduction of responsibility entailed by an honest account of the events leading to the patient’s adverse event, may improve judgments made about the speaker and his or her relationship to the transgression, however, it does so through mechanisms that are distinct from apologies.

Accounts are intended to provide a fair analysis of the steps leading to adverse events and in an attempt to counter accusations or claims brought into courts adjudicate can usually be challenged or opposed in two ways. First, by stating the facts and correcting misperceptions which a patient may have of events which have occurred, and secondly, by leading to a frank discussion in which the healthcare providers state that although all the elements on which a claim could succeed are present, yet in the particular case of a specific patient, the claim or accusation should not succeed because other circumstances are present which makes the adverse event an exception, the effect of which is either to defeat the patient’s accusation or claim, or to ‘reduce’ it so that only a weaker claim can be sustained. 301 Austin has further separated such accounts, or in his


300 ERVING GOFFMAN, RELATIONS IN PUBLIC: MICROSTUDIES OF THE PUBLIC ORDER 109 (1971); C. R. SNYDER ET AL., EXCUSES: MASQUERADES IN SEARCH OF GRACE 300 (1983); Marvin B. Scott & Stanford M. Lyman, Accounts, 33 AM. SOC. REV. 46, 46 (1968) (defining accounts as statements made to explain untoward behavior and bridge the gap between actions and expectations).

No ROLE FOR Apology

vernacular, excuses, into several types of speech acts. 302 One may discuss having performed an action, but also justify, or give reasons for the action. 303 One may discuss that the adverse event was not a good thing to have happened, but it is not correct to say that one individual was responsible, or a slip occurred, or there was an accident, or, that the provider was doing something different than the patient perceived. 304 In other words, the intent is to agree the adverse event is a bad outcome, but it is not correct to think in terms of full or even partial responsibility. 305 Austin argues against easy solutions:

[I]f we can only discover the true meanings of each of a cluster of key terms... that we use in some particular field (as, for example, ‘right’, ‘good’ and the rest in morals), then it must without question transpire that each will fit in place into some single, interlocking, consistent, conceptual scheme. Not only is there no reason to assume this, but all historical probability is against it... 306

The same is arguably true for the wide variety of terms that can be applied to conversations with patients who have sustained adverse events terms such as statement, affirmation, gesture or conduct expressing apology, responsibility, liability, sympathy, commiseration, condolence, compassion or a general sense of benevolence. Apology, given the charged legal nature of the term particularly seems not to fit into “some single, interlocking, consistent, conceptual scheme” 307 and stands alone as a strategy more harmful to patient safety and more likely to condemn healthcare providers to costly, painful and often undeserved claims of individual negligence and malpractice.

Accounts, on the other hand, can bridge the gap between adverse events and patient expectations. 308 The development of an account is not to be taken lightly and falls generally into one of two broad categories, both of which are

303. Id. at 124.
304. Id.
305. AUSTIN, supra note 302 (discussing a wide variety of strategies for giving accounts: use of modifying expressions; limitation of application; emphasis on negation; the “machinery of action”; listing of standards of the unacceptable; combination, dissociation, or complication; gradations of distinction; precise phrasing and style of performance; or the “trailing clouds of etymology”); see also GOFFMAN, supra note 166, at 109 (noting the purpose of remedial work is to change the meaning that might otherwise be given to an act).
306. Id. at 151 n.1.
307. Id. at 151 n.1.
308. Scott & Lyman, supra note 300, at 46 (noting accounts are important speech acts which can be employed whenever adverse events occur and are, inevitably, subject to “evaluative inquiry”).

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underutilized in modern discourse: excuses and justifications. Accounts are particularly useful in the disclosure of an adverse event noting the ability of an account to "bridge the gap between action and expectation" such as when a medical injury occurs. Scott and Lyman have suggested five linguistic styles—intimate, casual, consultative formal, and frozen—which can be employed in the giving of accounts. These styles are intended to represent points in a spectrum of speech that are acknowledged to merge into each other when reduced to real-world situations. Some variation of three of the styles—consultative, formal, and frozen—are likely to be useful in giving an account of an adverse event after medical injury.

CONCLUSIONS

Apologies—statements of regret, remorse and responsibility—do little to achieve the policy goal of making patients safer in the healthcare setting. Modern health care is delivered in a highly complex system, and medical injuries occur as a sequence of errors from blunt end to sharp. Those who work in the healthcare field are best situated to identify, report and correct system errors which injure patients; these individuals are best positioned to make patients safer. A variety of approaches are being used to improve systems and decrease errors that lead to injury: root cause analyses, peer reviews, and morbidity and mortality conferences are but a few. The principles of human performance are being used to minimize the "human factors" that are a critical part of healthcare systems. External organizations play an increasingly important role in monitoring and analyzing injuries, with the purpose of identifying common errors that lead to injury, and then establishing standards for minimizing variations in medical practice.

Essentially all of the approaches to decreasing injuries rely on protected disclosure and frank discussion regarding individual injuries and how to prevent similar injuries in the future. Apologies, by chilling the open disclosure of sensitive information and accompanying frank discussion, run counter to the

309. Id. at 247 (describing excuse as “a socially approved vocabulary[y] for mitigating or relieving responsibility when conduct is questioned”). Four modal forms are described: appeal to accident, defeasibility, biologic drive, and scapegoating. Id. See also HART, supra note 301, at 160 (providing further discussions of defeasibility “the capacity of being voided”).

310. Scott & Lyman, supra note 300, at 46.

311. Id. at 55-56 (distinguishing three of the styles as: consultative, a verbal form ordinarily employed when the amount of knowledge available to interactants is unknown or problematic, and there is a definite element of objectivity; formal, often used when there are rigidly defined status (i.e., physician and patient) or when the discussant is responding to six or more; and frozen, occurring when immovable barriers exist (i.e., a prisoner of war giving only name, rank, and serial number to interrogators)).

312. Id.
goals of improving patient safety. Unlike other forms of disclosure of the events surrounding an injury, apologies also establish responsibility. In many circumstances individual assignment of “shame and blame” unfairly open up the involved individuals and organizations to liability and loss. Malpractice litigation has often been justified as a deterrent to medical injury, however the ex post nature of lawsuits, the focus of the plaintiff’s attorney upon the individual client, and the malpractice gap in which few are compensated and the high overhead costs make litigation an inefficient—if not ineffective—way to make patients safer; rather the intent of healthcare organizations to “do the right thing” coupled with the knowledge of administrative action affecting licensing or accreditation makes such an approach effective. For purposes of maintaining autonomy, the patient must be offered an account of what happened, so they can make rational decisions about their future care. However, such disclosure should be a carefully scripted interaction, with input from all relevant sources.

There are rational and achievable alternatives to the use of apology in the setting of medical injury. First, the development of a “Patient Safety Reporting System” modeled along the lines of the Airline Safety Reporting System (ASRS) should be developed. Such national reporting will be able to assess trends at a macro level that would be difficult to discern within individual institutions. A second alternative is to strengthen protections for FRE803(6) business records. Other than peer review documents, essentially all medical documents are discoverable under the business records exception. By increasing protection for frank, open discussions of what went wrong and how to fix it, lines of communication can be opened. Many states, through mandatory disclosure statutes and private accreditation bodies, such as The Joint Commission, are increasingly able to maintain oversight and encourage widespread participation.

Lastly, although apologies should be avoided, for purposes of maintaining individual autonomy the patient must be offered an account of what happened, so they can make rational decisions about their future care. Such accounts are a second kind of remedial work that has not received enough study in the setting of medical injury disclosure to patients. However, such disclosure should be a carefully scripted interaction, with input from all relevant sources. In the vast majority of injuries, it will not be possible to lay the blame upon one individual. Attempts at assigning such blame will—counter to the need for open discussion to decrease errors that lead to injury—drive the causes of error underground. An account provided to the injured individual is morally praiseworthy, but in a complex, imperfect system such as that of modern healthcare, there is no role for apology.
### APPENDIX 1

<table>
<thead>
<tr>
<th>State/Statute</th>
<th>Considered Inadmissible</th>
<th>By whom</th>
<th>To whom</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARIZ. REV. STAT. ANN. § 12-2605 (2009) Evidence of admissions; civil proceedings; unanticipated outcomes; medical care</td>
<td>any statement, affirmation, gesture or conduct expressing apology, responsibility, liability, sympathy, commiseration, condolence, compassion or a general sense of benevolence</td>
<td>a health care provider or an employee of a health care provider</td>
<td>the patient, a relative of the patient, the patient’s survivors or a health care decision maker for the patient</td>
<td>inadmissible as evidence of an admission of liability or as evidence of an admission against interest.</td>
</tr>
<tr>
<td>CAL. EVID. CODE § 1160 (West 2001) Admissibility of expressions of sympathy or benevolence; definitions (repealed)</td>
<td>A portion of 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</td>
<td>made to that person or to the family of that person</td>
<td>Not explicit as to patients or health care;</td>
<td></td>
</tr>
<tr>
<td>COLO. REV. STAT. ANN. § 13-25-135 (West 2003) Evidence of admissions—civil proceedings—unanticipated outcomes—medical care</td>
<td>any and all statements, affirmations, gestures, or conduct expressing apology, fault, sympathy, commiseration, condolence, compassion, or a general sense of benevolence</td>
<td>health care provider or an employee of a health care provider</td>
<td>the alleged victim, a relative of the alleged victim, or a representative of the alleged victim</td>
<td>inadmissible as evidence of an admission of liability or as evidence of an admission against interest.</td>
</tr>
<tr>
<td>CONN. GEN. STAT. ANN. § 52-184d (West 2006) Inadmissibility of apology made by health care provider to alleged victim of unanticipated outcome of medical care</td>
<td>any and all statements, affirmations, gestures or conduct expressing apology, fault, sympathy, commiseration, condolence, compassion or a general sense of benevolence</td>
<td>health care provider or an employee of a health care provider</td>
<td>alleged victim, a relative of the alleged victim or a representative of the alleged victim and that</td>
<td>inadmissible as evidence of an admission of liability or as evidence of an admission against interest.</td>
</tr>
<tr>
<td>DEL. CODE ANN. tit. 10, § 4318 (2006) Compassionate communications</td>
<td>Any and all statements, writings, gestures, or affirmations made by a health care provider or an employee of a health care provider that express apology</td>
<td>health care provider or an employee of a health care provider</td>
<td>the person, the person’s family, or a friend of the person or of the person’s family</td>
<td>expressions or admissions of liability or fault are admissible</td>
</tr>
<tr>
<td>Law Code</td>
<td>Description</td>
<td>Example</td>
<td>適用於</td>
<td>Nothing herein shall preclude the court from permitting the introduction of an admission of liability into evidence</td>
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<tr>
<td>D.C. Code § 16-2841 (2007)</td>
<td>Inadmissibility of benevolent gestures.</td>
<td>an expression of sympathy or regret made in writing, orally, or by conduct</td>
<td>by or on behalf of the healthcare provider</td>
<td>a victim of the alleged medical malpractice, any member of the victim’s family, or any individual who claims damages by or through that victim</td>
</tr>
<tr>
<td>FLA. Stat. Ann. § 90.4026 (West 2001)</td>
<td>Statements expressing sympathy; admissibility; definitions.</td>
<td>The portion of statements, writings, or benevolent gestures expressing sympathy or a general sense of benevolence</td>
<td>made to that person or to the family of that person</td>
<td>A statement of fault, however, which is part of, or in addition to, any of the above shall be admissible</td>
</tr>
<tr>
<td>GA. Code Ann. § 24-3-37.1 (West 2006)</td>
<td>Statements or activities constituting offers of assistance or expressions of regret, mistake, etc.; not admission of liability.</td>
<td>any and all statements, affirmations, gestures, activities, or conduct expressing benevolence, regret, apology, sympathy, commiseration, condolence, compassion, mistake, error, or a general sense of benevolence</td>
<td>a health care provider or an employee or agent of a health care provider</td>
<td>the patient, a relative of the patient, or a representativ e of the patient</td>
</tr>
<tr>
<td>HAW. Rev. Stat. § 626-1 409.5 (2007)</td>
<td>Admissibility of expressions of sympathy and condolence.</td>
<td>Evidence of statements or gestures that express sympathy, commiseration, or condolence concerning the consequences of an event in which the declarant was a participant</td>
<td></td>
<td>The General Assembly issued findings regarding this statute. Statements are inadmissible as evidence and shall not constitute an admission of liability or an admission against interest</td>
</tr>
</tbody>
</table>

This rule does not require the exclusion of an apology or other statement that acknowledges or implies fault even though contained in, or part of, any statement or gesture excludable under this rule.

319
| IDAHO CODE ANN. § 9-207. (2006) Admissibility of expressions of apology, condolence and sympathy | all statements and affirmations, whether in writing or oral, and all gestures or conduct expressing apology, sympathy, commiseration, condolence, compassion, or a general sense of benevolence, including any accompanying explanation | made by a health care professional or an employee of a health care professional | a patient or family member or friend of a patient | inadmissible as evidence for any reason including, but not limited to, as an admission of liability or as evidence of an admission against interest |
| 735 ILL. COMP. STAT. ANN. § 5/8-1901 (West 2005) Admission of liability—Effect. Ruled unconstitutional | The providing of, or payment for, medical, surgical, hospital, or rehabilitation services, facilities, or equipment by or on behalf of any person, or the offer to provide, or pay for, ... shall not be construed as an admission of any liability ... Testimony, writings, records, reports or information with respect to the foregoing shall not be admissible in evidence as an admission of any liability in any action of any kind in any court or before any commission, administrative agency, or other tribunal in this State, except at the instance of the person or persons so making any such provision, payment or offer. | a “health care provider” (any hospital, nursing home or other facility, or employee or agent thereof, a physician, or other licensed health care professional.) | a patient, the patient’s family, or the patient’s legal representativ e about an inadequate or unanticipated treatment or care outcome that is provided within 72 hours | This section was found unconstitutional due to inseverability with other sections of the law. It is included as an example of a statute that attempts to do something different than most of the other “Apology” laws. |

Nothing precludes the discovery or admissibility of any other facts regarding the patient’s treatment or outcome as otherwise permitted by law. The disclosure of any such information, whether proper, or improper, shall not waive or have any effect upon its confidentiality or inadmissibility.
<table>
<thead>
<tr>
<th><strong>IND. CODE ANN. § 34-43.5-1-3</strong>&lt;br&gt;(West 2006)</th>
<th><strong>IND. CODE ANN. § 34-43.5-1-4</strong>&lt;br&gt;(West 2006)</th>
<th><strong>IND. CODE ANN. § 34-43.5-1-5</strong>&lt;br&gt;(West 2006)</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Communication of sympathy” defined; <strong>IND. CODE ANN. § 34-43.5-1-4</strong>&lt;br&gt;(West 2006)</td>
<td>Admissions into evidence; <strong>§ 1 IND. CODE ANN. § 34-43.5-1-5</strong>&lt;br&gt;(West 2006)</td>
<td>Statements of fault</td>
</tr>
<tr>
<td><strong>A court may not admit into evidence a communication of sympathy</strong> (“communication of sympathy” means a statement, a gesture, an act, conduct, or a writing that expresses: (1) sympathy; (2) an apology; or (3) a general sense of benevolence.)</td>
<td><strong>A court may admit a statement of fault into evidence,</strong> including a statement of fault that is part of a communication of sympathy, if otherwise admissible under the Indiana Rules of Evidence.</td>
<td>that relates to causing or contributing to: (1) a loss; (2) an injury; (3) pain; (4) suffering; (5) a death, or (6) damage to property</td>
</tr>
<tr>
<td><strong>IOWA CODE ANN. § 622.31</strong>&lt;br&gt;(West 2007) Evidence of regret or sorrow</td>
<td>that portion of a statement, affirmation, gesture, or conduct expressing sorrow, sympathy, commiseration, condolence, compassion, or a general sense of benevolence</td>
<td>against a person in a profession regulated by one of the [professional boards] boards or in any other licensed profession recognized in this state, a hospital licensed . . . , or a licensed health care facility</td>
</tr>
<tr>
<td><strong>the plaintiff, relative of the plaintiff,</strong> or decision maker for the plaintiff</td>
<td>Any response by the plaintiff, relative of the plaintiff, or decision maker for the plaintiff to such statement, affirmation, gesture, or conduct is similarly inadmissible as evidence.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>LA. REV. STAT. ANN. § 3715.5 (2005) Confidentiality of communication from health care provider</td>
<td>Any communication, including but not limited to an oral or written statement, gesture, or conduct... expressing or conveying apology, regret, grief, sympathy, commiseration, condolence, compassion, or a general sense of benevolence</td>
</tr>
<tr>
<td></td>
<td>ME. REV. STAT. ANN. tit. 24, § 2907 (2009) Communications of sympathy or benevolence</td>
<td>any statement, affirmation, gesture or conduct expressing apology, sympathy, commiseration, condolence, compassion or a general sense of benevolence</td>
</tr>
</tbody>
</table>
### MD. CODE ANN., CTS. & JUD. PROC. § 10-920 (2005)

| Health care providers; expression of regret or apology | an expression of regret or apology, . . . including an expression of regret or apology made in writing, orally, or by conduct, made by or on behalf of the health care provider | Inadmissible as evidence of an admission of liability or as evidence of an admission against interest. Inadmissible as evidence of an admission of liability in a civil action. An admission of liability or fault that is part of or in addition to a communication made . . . is admissible as evidence of an admission of liability or as evidence of an admission against interest |

### MASS. GEN. LAWS ch. 233 § 23D (West 2000)

| Admissibility of benevolent statements, writings or gestures relating to accident victims | Statements, writings or benevolent gestures (actions which convey a sense of compassion or commiseration emanating from humane impulses) expressing sympathy or a general sense of benevolence | person or to the family of such person |

### MO. ANN. STAT. § 538.229 (West 2010)

| Certain statements, writings, and benevolent gestures inadmissible, when—definitions | The portion of statements, writings, or benevolent gestures (actions which convey a sense of compassion or commiseration emanating from humane impulses) expressing sympathy or a general sense of benevolence | that person or to the family of that person |

Inadmissible as evidence of an admission of liability in a civil action. Nothing in this section shall prohibit admission of a statement of fault.
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Party</th>
<th>Not Admissible for Any Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>MONT. CODE ANN. § 26-1-814 (2010)</td>
<td>Statement of apology, sympathy, or benevolence—Not admissible as evidence of admission of liability for medical malpractice</td>
<td>the person, the person’s family, or a friend of the person’s family</td>
<td>any purpose in a civil action for medical malpractice.</td>
</tr>
<tr>
<td>NEB. REV. STAT. § 27-1201 (2010)</td>
<td>Unanticipated outcome of medical care; civil action; health care provider or employee; use of certain statements and conduct; limitations.</td>
<td>a health care provider or an employee of a health care provider</td>
<td>A statement of fault which is otherwise admissible and is part of or in addition to any such communication shall be admissible.</td>
</tr>
<tr>
<td>N. H. REV. STAT. ANN. § 507-E:4 (West 2010)</td>
<td>Evidence of Admissions of Liability.</td>
<td>the alleged victim, a relative of the alleged victim, or a representative of the alleged victim</td>
<td>Inadmissible as evidence of an admission of liability or as evidence of an admission against interest.</td>
</tr>
<tr>
<td>N. C. GEN. STAT. ANN. § 8C-1 (West 2004)</td>
<td>Statements ... apologizing for an adverse outcome in medical treatment, offers to undertake corrective or remedial treatment or actions, and gratuitous acts to assist affected persons</td>
<td>shall not be admissible to prove negligence or culpable conduct by the health care provider in an action brought under Article 1B of Chapter 90 of the General Statutes.</td>
<td></td>
</tr>
<tr>
<td>N. D. CENT. CODE § 31-04-12 (2010)</td>
<td>Expressions of empathy</td>
<td>A statement, affirmation, gesture, or conduct... that expresses apology, sympathy, commiseration, condolence, compassion, or benevolence</td>
<td>a health care provider, or health care provider's employee or agent</td>
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<tr>
<td>OHIo REV. CODE ANN. § 2317.43 (West 2010) Use of defendant’s statement in medical liability action prohibited</td>
<td>any and all statements, affirmations, gestures, or conduct expressing apology, sympathy, commiseration, condolence, compassion, or a general sense of benevolence</td>
<td>a health care provider or an employee of a health care provider</td>
<td>the alleged victim, a relative of the alleged victim, or a representati ve of the alleged victim</td>
</tr>
<tr>
<td>OKLA. STAT. ANN. tit. 63 § 1-1708.1H. (West 2010) Statements, conduct, etc. expressing apology, sympathy, etc.—Admissibility—Definitions</td>
<td>any and all statements, affirmations, gestures, or conduct expressing apology, sympathy, commiseration, condolence, compassion, or a general sense of benevolence</td>
<td>a health care provider or an employee of a health care provider</td>
<td>the plaintiff, a relative of the plaintiff or a representati ve of the plaintiff</td>
</tr>
</tbody>
</table>
For the purposes of any civil action against a person licensed by the Oregon Medical Board, any expression of regret or apology made by or on behalf of the person, including an expression of regret or apology that is made in writing, orally or by conduct, does not constitute an admission of liability for any purpose.

A person who is licensed by the Oregon Medical Board, or any other person who makes an expression of regret or apology on behalf of a person who is licensed by the Oregon Medical Board, may not be examined by deposition or otherwise in any civil or administrative proceeding including any arbitration or mediation proceeding with respect to an expression of regret or apology made by or on behalf of the person, including expressions of regret or apology that are made in writing orally or by conduct.

any and all statements, affirmations, gestures, activities, or conduct expressing benevolence, regret, apology, sympathy, commiseration, condolence, compassion, mistake, error, or a general sense of benevolence, a health care provider, an employee or agent of a health care provider, or by a health care institution, the patient; a relative of the patient, or a representative of the patient and which are made during a designated meeting to discuss the unanticipate d outcome, SC legislature issued findings regarding this statute.

shall be inadmissible as evidence and shall not constitute an admission of liability or an admission against interest.

The defendant in a medical malpractice action may waive the inadmissibility of the statements.
## No Role for Apology

<table>
<thead>
<tr>
<th>TENN. RULES OF EVIDENCE; Article IV. Relevance; Rule 409.1. Expressions Of Sympathy Or Benevolence</th>
<th>TENN. RULES OF EVIDENCE; Article IV. Relevance; Rule 409.1. Expressions Of Sympathy Or Benevolence</th>
<th>TENN. RULES OF EVIDENCE; Article IV. Relevance; Rule 409.1. Expressions Of Sympathy Or Benevolence</th>
</tr>
</thead>
<tbody>
<tr>
<td>That portion of statements, writings, or benevolent gestures (actions which convey a sense of compassion or commiseration emanating from humane impulses) expressing sympathy or a general sense of benevolence</td>
<td>Not specific to health care, patients, or physicians. A statement of fault that is part of, or in addition to, any of the above shall not be inadmissible.</td>
<td></td>
</tr>
<tr>
<td>a communication (a statement; a writing; or a gesture that conveys a sense of compassion or commiseration emanating from humane impulses) that: expresses sympathy or a general sense of benevolence relating to the pain, suffering, or death of an individual involved in an accident;</td>
<td>Not explicit as to health care, patients, or physicians. a statement or statements concerning negligence or culpable conduct pertaining to an accident or event, is admissible to prove liability of the communicator.</td>
<td></td>
</tr>
<tr>
<td><strong>UTAH CODE ANN. § 78B-3-422 (West 2010) Evidence of disclosures—Civil proceedings—Unanticipated outcomes—Medical care</strong></td>
<td>UTAH CODE ANN. § 78B-3-422 (West 2010) Evidence of disclosures—Civil proceedings—Unanticipated outcomes—Medical care</td>
<td>UTAH CODE ANN. § 78B-3-422 (West 2010) Evidence of disclosures—Civil proceedings—Unanticipated outcomes—Medical care</td>
</tr>
<tr>
<td>any unsworn statement, affirmation, gesture, or conduct [that] expresses apology, sympathy, commiseration, condolence, or compassion; or a general sense of benevolence; or describes the sequence of events relating to the unanticipated outcome of medical care; or the significance of events; or both the defendant (defendant in a malpractice action against a health care provider (includes an agent of a health care provider)) the patient (defined as any person associated with the patient)</td>
<td>Does not alter any other law or rule that applies to the admissibility of evidence in a medical malpractice action</td>
<td>Does not alter any other law or rule that applies to the admissibility of evidence in a medical malpractice action</td>
</tr>
<tr>
<td><strong>Vt. Stat. Ann. tit. 12 § 1912 (West 2010)</strong></td>
<td><strong>Expression of regret or apology by health care provider inadmissible</strong></td>
<td><strong>Expression of regret or apology by health care provider inadmissible</strong></td>
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<tr>
<td>An oral expression of regret or apology, including any oral good faith explanation of how a medical error occurred</td>
<td>made by or on behalf of a health care provider or health care facility, that is provided within 30 days of when the provider or facility knew or should have known of the consequences of the error</td>
<td>does not constitute a legal admission of liability for any purpose and shall be inadmissible in any civil or administrative proceeding against the health care provider or health care facility, including any arbitration or mediation proceeding.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Va. Code Ann. § 8.01-52.1 (West 2011)</strong></th>
<th><strong>Admissibility of expressions of sympathy</strong></th>
<th><strong>Admissibility of expressions of sympathy</strong></th>
<th><strong>Admissibility of expressions of sympathy</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>the portion of statements, writings, affirmations, benevolent conduct, or benevolent gestures expressing sympathy, commiseration, condolence, compassion, or a general sense of benevolence, together with apologies</td>
<td>health care provider or an agent of a health care provider</td>
<td>a relative of the patient, or a representative of the patient about the death of the patient</td>
<td>Pertains only to death, shall be inadmissible as evidence of an admission of liability or as evidence of an admission against interest. A statement of fault that is part of or in addition to any of the above shall not be made inadmissible by this section.</td>
</tr>
</tbody>
</table>

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**WASH. REV. CODE ANN. § 5.64.010 (West 2010)**

Civil actions against health care providers—Admissibility of evidence of furnishing or offering to pay medical expenses—Admissibility of expressions of apology, sympathy, fault, etc.

Evidence of furnishing or offering or promising to pay medical, hospital, or similar expenses occasioned by an injury is not admissible.

A statement, affirmation, gesture, or conduct (Any statement, affirmation, gesture, or conduct expressing apology, fault, sympathy, commiseration, condolence, compassion, or a general sense of benevolence; or any statement or affirmation regarding remedial actions that may be taken to address the act or omission that is the basis for the allegation of negligence.) . . . is not admissible as evidence if it was conveyed by a health care provider to the injured person, or to [other statutorily defined] person . . . within thirty days of the act or omission that is the basis for the allegation of professional negligence or within thirty days of the time the health care provider discovered the act or omission that is the basis for the allegation of professional negligence.

**W. VA. CODE ANN. § 55-7-11a (West 2005)**

Settlement, release or statement within twenty days after personal injury; disavowal; certain expressions of sympathy inadmissible as evidence

Statement, affirmation, gesture or conduct . . . expressing apology, sympathy, commiseration, condolence, compassion or a general sense of benevolence a healthcare provider who provided healthcare services to a patient, to the patient, a relative of the patient or a representative of the patient shall not be admissible as evidence of an admission of liability or as evidence of admission against interest in any civil action.
| WYO. STAT. ANN. § 1-1-130. (2009) Actions against health care providers; admissibility of evidence | any and all statements, affirmations, gestures or conduct expressing apology, sympathy, commiseration, condolence, compassion or a general sense of benevolence | health care provider or an employee of a health care provider | the alleged victim, or to a relative or representative of the alleged victim | inadmissible as evidence of an admission of liability or as evidence of an admission against interest. |