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Forgive and Forget: Recognition of Error and Use of Apology as Preemptive Steps to ADR or Litigation in Medical Malpractice Cases

Ashley A. Davenport¹

I. INTRODUCTION

Medical malpractice cases are a special breed within the field of tort jurisprudence as mistakes in the medical field are regrettably inevitable. Medical universities use some of the greatest hospitals in this country as interactive classrooms to teach future physicians.² A vast number of people are treated in hospitals throughout the United States every day,³ and of those treated, a number are neglected under the confines of the law.⁴ The

1. Ashley A. Davenport is a juris doctorate candidate at the Pepperdine University School of Law who will graduate in May 2006. Ms. Davenport is currently also pursuing a certificate at the Center for Entrepreneurship and Technology Law. She would like to thank her family and friends, especially her Mom, Dad, Brent and Michael, for their love and continued support in all her endeavors. "Forgive and forget" dates from the 1300s and was a proverb by the mid-1500s meaning "[b]oth pardon and hold no resentment concerning a past event." THE AMERICAN HERITAGE DICTIONARY OF IDIOMS, 220 (Houghton Mifflin 1997).

2. A "teaching hospital" is defined as "a hospital that is affiliated with a university medical school and provides the means for medical education to students, interns, and residents, and sometimes postgraduates." WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY OF THE ENGLISH LANGUAGE UNABRIDGED, 2346 (Merriam-Webster 2002). Cedars-Sinai Hospital in Los Angeles, California, is just one example of a prominent facility that is used as a teaching hospital for a medical university. CEDARS-SINAI, *Training for Residents and Fellows*, <http://www.cedars-sinai.edu/2810.html> (last visited Jan. 25, 2006).

3. In 1996, approximately seven percent of Americans spent at least one night in the hospital. CTRS. FOR DISEASE CONTROL & PREVENTION, U.S. DEP'T OF HEALTH & HUMAN SERVS., HEALTH CARE IN AMERICA: TRENDS IN UTILIZATION, 34 (2004). "The overall number of procedures, ambulatory and inpatient combined, performed in the United States increased from about 3 million in 1980 to 31.5 million in 1996." *Id.* at 36.

4. Douglas W. Taylor, Comment, *Assessment and Plan for Medical Malpractice: Quality Improvement Through Mediation*, 6 DEPAUL J. HEALTH CARE L. 343, 343-44 (2003). In recognition

American public expects infallible care from our health care system and any deviation from perfection may result in legal action.⁵ Those wronged seek litigation primarily as a means to punish the hospital and physician and to prevent that physician from being a threat to future patients.⁶ Patients also seek for their physicians to admit that they made a mistake.⁷ Those attorneys that specialize in medical malpractice lawsuits know that amidst the current hospital culture of “shame and blame,” the hospitals and physicians rarely admit to their mistakes.⁸ Thus, such a lawsuit will only provide monetary compensation to the patient or the estate that suffered injury as a result of the malpractice, neglecting the patient’s fundamental reasons for bringing the lawsuit.⁹

Physicians and hospitals across the country are also facing drastically increasing medical malpractice premiums in many practice areas.¹⁰ The United States General Accounting Office’s 2003 report on escalating medical malpractice premiums found the primary reason for the rise in premium rates was the losses incurred by insurance companies in medical malpractice litigations.¹¹ Ever-increasing premiums are causing some

of the incidences of medical errors, Taylor references the Harvard Medical Practice Study (*Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation and Patient Compensation in New York*, The Report of the Harvard Medical Practice Study to the State of New York (1990)), which examined 31,000 cases in New York in the year 1984. *Id.* at 343. Through Harvard Medical School’s analysis, with the aid of medical record administrators, as well as board-certified physicians and nurses, it was identified that 3.7% of hospitalizations in New York in 1984 experienced an “adverse event.” *Id.* at 343-44. Of those adversely affected, the study concluded that 27.6% (or 1% of all hospital discharges) were the result of negligence. *Id.* at 344.

5. Taylor, *supra* note 4, at 344. A physician noted that “[t]o err is indeed human, yet physicians, more so than most professionals, are expected to make no mistakes.” Mark Rosenbloom, MD, MBA, FACEP, Review Article, *Medical Error Reduction and PDAs*, 18 INT’L PEDIATRICS 69, 70 (2003).

6. Symposium, *Medical Malpractice: Innovative Practice Applications*, 6 DEPAUL J. HEALTH CARE L. 249, 265-66 (2003) [hereinafter Symposium].

7. *Id.* at 266.

8. *Id.* See Bryan A. Liang, *A System of Medical Error Disclosure*, 11 QUALITY & SAFETY IN HEALTH CARE 64, 64 (2002) [hereinafter Liang, *A System of Medical Error Disclosure*]. Dr. Rosenbloom also notes that “[c]urrent medical error handling practice in the United States typically begins with the so-called ‘shame and blame’ method, where physicians are held personally responsible for mistakes.” Rosenbloom, *supra*, note 5, at 70.

9. Symposium, *supra* note 6, at 266.

10. U.S. GEN. ACCOUNTING OFFICE, REPORT TO CONGRESSIONAL REQUESTERS, MED. MALPRACTICE INS.: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATE, 3 (June 2003).

11. U.S. GEN. ACCOUNTING OFFICE, *supra* note 10, at 3-4. The increase in “paid losses” increases premiums for several reasons:

First, higher paid losses on claims reported in current or previous years can increase insurers’ estimates of what they expect to pay out on future claims. Insurers then raise premium rates to match their expectations. In addition, large losses . . . on even one or a

physicians to leave their career-long practices to open new offices in jurisdictions with more reasonable insurance premiums or leave the medical profession altogether.¹² Because the verdicts of monetary compensation are ineffective in addressing the true desires of patients who are initiating lawsuits and the effect of these verdicts on physician's premiums, hospitals and patient safety groups have looked to alternative means of resolving these disputes.¹³ One must question, however, if a preemptive measure is available for hospitals and their staff to alleviate the overall amount of medical malpractice claims. This article will analyze the current system of addressing medical malpractice lawsuits and look to the components of a medical system that accepts apology as a means to preempt the claims from ever arising.

II. THE PROBLEM

A major complaint of patients who suffer from adverse medical treatment, as well as their family members, is the inadequate quantity and quality of physician-patient communication.¹⁴ This reasoning is extremely important in that approximately one-third of the lawsuits are filed on the advice of acquaintances.¹⁵ The effect of continued lack of communication is demonstrated in patients' opinions that the physician does not listen, does not speak openly, attempts to mislead the family and does not warn about long-term problems.¹⁶ Any new system instituted by hospitals must rectify such grievances based on lack of physician-patient communication in order to limit the overall number of claims against the hospital.

few individual claims can make it harder for insurers to predict the amount they might have to pay on future claims.

Id. at 22. The tendency to expect higher losses intuitively results in higher premium rates. *Id.* at 8.

12. Amanda Craig, Introduction, *A Physician's Perspective on the Medical Malpractice Crisis*, 13 ANNALS HEALTH L. 623, 624 (2004).

13. See *infra* notes 24-42 and accompanying text.

14. Gerald B. Hickson et al., *Factors That Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries*, 10 JAMA 1359, 1361 (1992). This study looked to cases in Florida between 1986 and August of 1989 that involved permanent injuries or death to infants and closed malpractice claims. *Id.* at 1359-60. The study questioned the mothers of the injured infants as to the reasons for filing the medical malpractice claims. *Id.* at 1361.

15. *Id.* at 1361.

16. *Id.*

The resulting medical malpractice lawsuits are the disdain of physicians, insurance companies and hospital management.¹⁷ Society, however, cannot handily push aside such litigation as completely frivolous, as adverse medical events can result in lost wages, permanent damage requiring continuing medical care, or personal pain and suffering for the patient.¹⁸ The system must ensure that those persons affected by adverse medical events are sufficiently compensated for their losses and suffering.¹⁹

It is important to recognize the difference between those medical malpractice claims brought because of negligence or mismanagement on the part of the physician or hospital and those claims based on an unintended outcome of the procedure. In that the human body is a fickle machine and physicians cannot predict to a certainty the exact result of any given procedure, those claims based on unintended outcome need not be the basis of traditional medical malpractice claims, as the “unintended result” was generally outside of the acting physician’s control.²⁰ Medical errors, on the other hand, have been defined “as the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim.”²¹ The Institute of Medicine also defines the negative consequences, or “adverse

17. Monique A. Anawis, *Medical Malpractice: Innovative Practice Applications: Transcript: Presentation: Tort Reform 2003*, 6 DEPAUL J. HEALTH CARE L. 309 (2003).

18. Taylor, *supra* note 4, at 345. Society as a whole feels an impact through lost productivity of the patient while unable to work and becoming a part of the escalating insurance premiums for insured persons in America. *Id.*

19. Hospital errors are an integral part of modern society as current studies place the number of preventable hospital errors resulting in death in the U.S. anywhere between 98,000 (INSTITUTE OF MEDICINE, *To Err is Human: Building a Safer Health System* 26, 31 (LT Kohn et al. eds., 1999)) and 195,000 (Health Grades, Inc., *Patient Safety in American Hospitals* (2004)). Such numbers make hospital errors the third leading cause of death in the United States, behind heart disease and cancer. Jean Hellwege, *Deaths from Hospital Errors Double 1999 Estimates*, TRIAL, Oct. 2003, at 82. Using the 98,000 figure from the Institute of Medicine (IOM), the United States has an average of 270 deaths every day of the year that are the result of hospital error, as the IOM report did “not take into account preventable failures in care in ambulatory settings, nursing homes, or the home health care arena.” Bryan A. Liang & Steven D. Small, *Communicating About Care: Addressing Federal-State Issues in Peer Review and Medication to Promote Patient Safety*, 3 HOUS. J. HEALTH L. & POL’Y 219, 220 (2003) [hereinafter Liang, *Communicating About Care*]. In relative terms, using the IOM’s figure of 98,000, it “amounts to an average of 270 deaths per day, equivalent to the number of passengers on a fully-loaded 757 aircraft.” Rosenbloom, *supra* note 5, at 69.

20. Symposium, *supra* note 6, at 252. Max Brown, who is General Counsel to Rush-Presbyterian-St. Luke’s Medical Center in Chicago, Illinois, which has instituted the innovative two-party mediator forum for medical malpractice cases, supports such a distinction in cases. *Id.* Mr. Brown estimates that only five percent of the cases against his hospital are the clear-cut doctor/hospital negligence medical malpractice cases. *Id.* More importantly to the present analysis, Mr. Brown states that approximately seventy-five percent of the cases brought against the hospital are what he would deem “poor result” cases. *Id.*

21. INSTITUTE OF MEDICINE, *supra* note 19, at 4.

events,” as an injury caused by the medical management rather than the underlying condition of the patient.²²

III. CURRENT SYSTEMS IN PRACTICE

Medical malpractice itself is not a new problem, as it was first recorded in the United States case law in the 1794 Connecticut case of *Cross v. Guthery*.²³ The methodology used by hospitals to deal with such situations, on the other hand, has evolved over time.

A. California's Medical Injury Compensation Reform Act

In 1975, the State of California passed the Medical Injury Compensation Reform Act (MICRA) in response to the perceived health care crisis in the state caused by what the Legislature perceived as “skyrocketing malpractice premium costs and resulting . . . potential breakdown of the health delivery system, severe hardships for the medically indigent, a denial of access for the economically marginal, and depletion of physicians such as to substantially worsen the quality of health care available to citizens of this state.”²⁴ MICRA has helped to turn around the medical malpractice crisis in California by greatly limiting increases in physicians’ liability premiums, and other states are now looking to legislation of this type to extinguish the medical liability fires within their own states.²⁵

22. *Id.*

23. Richard G. Roberts, *Seven Reasons Family Doctors Get Sued and How to Reduce Your Risk*, 10 FAM. PRAC. MANAGEMENT 29, 31 (2003). *Cross v. Guthery* (2 Root 9 (Conn. 1794)) involved a man suing his physician for the death of his wife after the physician’s unskillful operation on his wife. *Id.*

24. 6 WITKIN SUM. CAL. LAW TORTS § 778 (quoting Stats. 1975, Second Extraordinary Session, Chap. 2, § 1(b)). Some major provisions of MICRA: A cap of \$250,000 on non-economic damages (i.e., pain and suffering, loss of consortium), disclosure to the jury of collateral sources of payment (other sources of health insurance payments for the same injury), limits on attorney fees, periodic payments for future damages, a requirement that plaintiffs give a 90-day warning of an impending claim to the provider so that the provider has a chance to settle the claim out of court, and a strengthened physician discipline system. Kendra Mayer, *MICRA: The Golden State’s Golden Rule*, TEXAS ACADEMY OF FAMILY PHYSICIANS, <http://www.tafp.org/TFP/ond2002/micra.htm> (last visited Jan. 25, 2006).

25. Mayer, *supra* note 24, <http://www.tafp.org/TFP/ond2002/micra.htm>. Mayer emphasizes MICRA’s benefits by stating that from 1976 to 2000 “liability rates in California have increased 167 percent, while rates in the rest of the country have gone up 505 percent, according to the National Association of Insurance commissioners. For example, an obstetrician in Florida pays around \$166,368, while the premium for a California obstetrician is \$57,473.” *Id.*

B. Veterans Affairs Medical Center in Lexington, Kentucky

In 1987, the Veterans Affairs Medical Center in Lexington, Kentucky (the “Lexington VA”) established an innovative system of apology when adverse events occurred in the hospital.²⁶ The Lexington VA system seeks out the patient and family after an adverse event so that the hospital can acknowledge their mistake, make recommendations for legal representation, and offer financial compensation.²⁷ The hospital takes such actions in order to accept responsibility for its mistakes and to use honesty to restore a mutual feeling of trust with the patient.²⁸ After informing the patient that the error had occurred, and if the Lexington VA’s risk management committee

26. Jonathan R. Cohen, *Apology and Organizations: Exploring an Example from Medical Practice*, 27 *FORDHAM URB. L.J.* 1447, 1447-48 (2000) [hereinafter Cohen, *Apology and Organizations*]. The Lexington VA system may be better suited in a government setting rather than the private sector, however, as the government-run hospital has limited liability under the Federal Tort Claims Act. *Id.* at 1451. Also, the hospitals are self-insured and the physicians serve as employees of the hospital, thus their malpractice insurance premiums are not adversely affected by a costly settlement by the hospital. *Id.* The Federal Tort Claims Act protects the United States government from being liable for punitive damages. Steve S. Kraman & Ginny Hamm, *Risk Management: Extreme Honesty May Be the Best Policy*, 131 *ANNALS INTERNAL MED.* 963 (1999).

27. Cohen, *Apology and Organizations*, *supra* note 26, at 1448-50. “The essence of the policy was to maintain a care-giving relationship toward the patient following medical error rather than adopting an adversarial one.” *Id.* at 1451. The formal policy of the Lexington VA was called “Patient Safety (Integrated Risk Management Program)” and was enacted in response to two budget-breaking failed medical malpractice defenses totaling \$1.5 million. *Id.* When the policy was implemented in 1987, to introduce the innovative policy, the hospital posted excerpts on placards at the hospital entrances:

2. PHILOSOPHY: Human error is inevitable, even among the most conscientious professionals practicing the highest standard of care. Identification and reporting of adverse events, including those that result from practitioner error, are critical to our efforts to continuously improve patient safety. Likewise, medical managers have a duty to recognize the inevitability of human error and attempt to design systems that makes such errors less likely; and to avoid punitive reactions to honest errors.

3. POLICY: Key components of the patient safety/risk management policy an approach are:

a. All employees and practitioners are responsible for fully cooperating in efforts to improve patient safety and eradicate potential risks. This includes the reporting of events which results in actual or potential injury to a patient.

b. Patients and their families will be informed about injuries resulting from adverse events and the options available to them.

c. The Risk Management Committee is [the] hub of responsibility for patient safety activity. This includes overseeing the investigation, reporting and analysis of patient safety and adverse event data as well as orchestrating family notifications and interventions when warranted.

Id. at 1451, n.9.

28. *Id.* at 1450. The hospital creates a culture that does not place blame on a physician’s mistakes and instead acknowledges why the mistake was made and uses that information to prevent recurrences of the same or similar mistakes. *Id.*

determined that the hospital was at fault, the hospital would offer an apology to the patient and family and admit fault both verbally and in writing.²⁹ The hospital staff would then work with the victim to obtain any disability benefits to which he or she may be entitled due to the adverse event.³⁰ Most important in controlling medical malpractice lawsuits is that when the committee determines that the hospital was at fault, a fair settlement offer is given to the patient and family and is generally accepted quite quickly.³¹ However, one should not analyze the Lexington VA system of disclosure merely as a means to save money for the hospital.³² The most recognizable collateral benefit of a system of apology in a hospital setting is the ability to learn from such mistakes and prevent future errors.³³

C. Medical Care Availability and Reduction of Error Acts

In March 2002, Pennsylvania became the first state to statutorily require hospitals to notify patients or their family of a serious event within seven days.³⁴ Florida and Nevada followed suit and imposed a statutory duty on

29. *Id.* at 1452-53.

30. *Id.* at 1452-53. The disability benefits are given because the Veterans Affairs caused the injuries, and it is important to remember that this is another distinction from the private sector. Kraman, *supra* note 26, at 966-67. Describing the system in the Lexington VA system:

The . . . 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. The committee offers to answer questions and may make an offer of restitution, which can involve subsequent corrective medical or surgical treatment, assistance with filing for service connection under 38 United States Code, section 1151 (a law that confers service connection on the basis of disability resulting from medical care), or monetary compensations.

Id. at 967.

31. Cohen, *Apology and Organizations*, *supra* note 26, at 1453. The importance of such a settlement is evident from the numbers: In 1985 and 1986, the hospital paid the two malpractice verdicts totaling \$1.5 million that instigated the culture change within the hospital. *Id.* By comparison, from 1990 to 1996, after this policy was implemented in 1987, the hospital paid malpractice claims of only \$190,113 per year. *Id.*

32. Although saving money is an obvious benefit of the system.

33. *Id.* at 1464-65. "As part of its approach of 'assuming responsibility,' the Lexington VA undertook a 'root cause' analysis once an error was reported and, on multiple occasions, implemented systemic changes to prevent such future errors." *Id.* at 1465.

34. Carol B. Liebman & Chris Stern Hyman, *A Mediation Skills Model to Manage Disclosure of Errors and Adverse Events to Patients: A quicker, less alienating route to closure than*

the medical facility to notify patients, in person rather than in writing, after a serious event resulting in injury.³⁵ In practice, such legislation is beneficial as it instigates communication between the physician and the patient regarding adverse events.³⁶ However, such communications, when initiated by untrained physicians and hospital staff, may lead to increased lawsuits and blame by the patients and their families because of the perception that the hospital has admitted fault.³⁷

D. Other Systems and Legislation

Various other states and organizations have recognized the importance of apology and admission of errors in the overall reduction in medical malpractice lawsuits. Legislation has been passed in both Colorado and Oregon that specifically allow for physicians and hospitals to make apologies without fear of such statements being used in court as evidence of liability.³⁸ The Joint Commission on Accreditation of Healthcare Organizations took action in 2001 to improve its standards for patient safety

malpractice litigation, 23 HEALTH AFF. 22, 23, July-Aug. 2004. The Pennsylvania statute defined the "serious event" as "an event, occurrence, or situation involving the clinical care of a patient in a medical facility that results in death or compromises patient safety and results in an unanticipated injury requiring the delivery of additional health care services to the patient." *Id.* (quoting Pennsylvania *Medical Care Availability and Reduction of Error Act (Mcare)* (2002), Act 13, Sec. 302). The Pennsylvania statute stated:

- (1) It is the purpose of this act to ensure that medical care is available in this Commonwealth through a comprehensive and high-quality health care system.
- (2) Access to a full spectrum of hospital services and to highly trained physicians in all specialties must be available across this Commonwealth.
- (3) To maintain this system, medical professional liability insurance has to be obtainable at an affordable and reasonable cost in every geographic region of this Commonwealth.
- (4) A person who has sustained injury or death as a result of medical negligence by a health care provider must be afforded a prompt determination and fair compensation.
- (5) Every effort must be made to reduce and eliminate medical errors by identifying problems and implementing solutions that promote patient safety.
- (6) Recognition and furtherance of all of these elements is essential to the public health, safety and welfare of all the citizens of Pennsylvania.

2002 Pa. Laws 13, § 102 Declaration of Policy.

35. Liebman, *supra* note 34, at 23. The Florida statute is Florida *Revised Statutes* title 29, sec. 395.1051 (2003) and the Nevada statute is Nevada *Revised Statutes* title 40, sec. 439.835 (2003).

36. Liebman, *supra* note 34, at 23. The author refers to such discussions as "disclosure conversations." *Id.*

37. *Id.* at 24-25. Physicians are experienced in delivering bad news to patients, but formal training by a mediator or conflict resolver would allow information regarding the adverse event to be communicated in the most appropriate way. *Id.*

38. Rachel Zimmerman, *Doctors' New Tool to Fight Lawsuits: Saying 'I'm Sorry': Malpractice Insurers Find Owning up to Errors Soothes Patient Anger 'The Risks are Extraordinary*, WALL ST. J., May 18, 2004, at A1.

by requiring physicians and hospitals to disclose all unanticipated outcomes of care.³⁹

An April 2000 investigation into state trends with regard to reporting errors found that the fifteen states that had mandatory reporting systems used the compiled information very differently.⁴⁰ Ten states collected the information to ascertain any trends in errors, nine of the states used the information for the imposition of sanctions, and nine states assured corrective actions.⁴¹ The most striking figure from the investigation was that only two states used the compiled information to develop methods to improve the quality of their care, while four states did not conduct analysis on their collected data.⁴²

IV. ELEMENTS OF AN IDEAL SYSTEM

While these states and hospitals are on the right track with their plans for management of the medical malpractice system, such legislation can only be the first step in the development of a new approach to adverse events in the hospital setting. The Lexington VA system is the closest to implementing a culture of full recognition of error without placing blame on a single individual, but it is still unknown how such a system would operate in a private sector hospital.⁴³ The Institute of Medicine, in its report on the prevalence of medical error in America, also focused on the need for open and honest communications and discussions about error and safety in the

39. Rae M. Lamb et al., *Hospital Disclosure Practices: Results of a National Survey; Most Hospitals Disclose Harm to Patients at Least Some of the Time, This 2002 Survey Finds*, HEALTH AFF., Mar.- Apr. 2003. The original policy of the JCAHO does not mention the need to disclose poor outcomes to patients, but has since been amended to state that “accredited organizations must tell patients when harms occur to them in the course of treatment.” *Id.* It has been pointed out, however, that “the JCAHO’s ability to release all hospital data to third parties (including the media), coupled with the risk of the scrutinized hospital losing its accreditation in like manner, preclude effective reform.” Rosenbloom, *supra* note 5, at 70-71.

40. HEALTH ECONOMICS PROGRAM, MINNESOTA DEPARTMENT OF HEALTH, ISSUE PAPER, MEDICAL ERRORS AND PATIENT SAFETY: KEY ISSUES, 3 (Dec. 2000) (referencing data from Jill Rosenthal et al., *State Reporting of Medical Errors and Adverse Events: Results of a 50-State Survey*, NAT’L ACAD. STATE HEALTH POLICY 15 (Apr. 2000)).

41. *Id.*

42. *Id.*

43. Cohen, *Apology and Organizations*, *supra* note 26, at 1460. “Culture” is defined as “the body of customary beliefs, social forms, and material traits constituting a distinct complex of tradition of a racial, religious, or social group” and “a complex of typical behavior or standardized social characteristics peculiar to a specific group, occupation, or profession” WEBSTER’S THIRD NEW INTERNATIONAL DICTIONARY, *supra* note 2, at 552.

hospital setting.⁴⁴ Thus, my analysis will now delve into the component parts of a system that would seemingly address the complaints and desires of the patient who suffered the adverse event, while protecting the hospital from unlimited liability and damages.

A. Recognition of the Error

Professor James Reason, a leading investigator of human error, states that “[e]rrors arise from two major sources: unintentional actions in the performance of routinized tasks and mistakes in judgment or inadequate plans of action.”⁴⁵ Professor Reason also recognizes that many human errors are the result of malfunctions within a complex organization or systemic process.⁴⁶ Health care is unquestionably a complex systemic process and inasmuch possesses a great potential for error.⁴⁷

In that errors in the health care field will unavoidably occur, it is important for the hospitals to recognize that such errors are the result of the system and not any one individual within that system.⁴⁸ The current culture of many hospitals is the “shame and blame” placed on the physician that last

44. INSTITUTE OF MEDICINE, *supra* note 19, at 178.

45. Liang, *Communicating About Care*, *supra* note 19, at 222.

46. *Id.* at 222-23. Professor Reason presents an interesting “Swiss-cheese” analogy to such breakdowns stating that “systems in which humans operate generally do have ‘several layers of activity’ and, importantly, defenses against the potential adverse consequences of error. *Id.* at 223. In his analogy,

‘each layer of activity has holes and solid areas—holes which represent active and latent failures within the system,’ and ‘solid areas which represent barriers against the occurrence of adverse events associated with error.’ When the failure holes line up, an error penetrates the entire system’s layers and defenses, ‘resulting in an accident or adverse event.’

Id. at 223 (quoting Bryan A. Liang, *The Adverse Event of Unaddressed Medical Error: Identifying and Filling the Holes in the Health-Care and Legal Systems*, 29 J.L. MED. & ETHICS 346, 347 (2001); see JAMES REASON, HUMAN ERROR 2 at 207-09 (1990)).

47. *Id.* at 223. The characteristics that make the health care system complex and susceptible to error are listed as: “high-level technical needs, the need for quick reaction times, twenty-four-hour-a-day, seven-day-a-week operations, long hours, and trade-offs between service and safety.” *Id.* at 223-24. The emergency department of a hospital is often the site of the errors and also possesses characteristics that demonstrate why such departments are prone to error: “the simultaneous management of several ill patients, a limited knowledge of patients’ preexisting medical conditions, high levels of diagnostic uncertainty, and high decision density” in the “loud and busy setting, where patients are often treated in crowded conditions with inadequate equipment.” Armando Hevia & Cheri Hobgood, *Medical Error During Residency: To Tell or Not to Tell*, 42 ANNALS EMERGENCY MED. 565 (2003).

48. Liang, *Communicating About Care*, *supra* note 19, at 224. See Liang, *A System of Medical Error Disclosure*, *supra* note 8, at 64-65.

worked with the patient who subsequently suffered from an adverse event.⁴⁹ In order to achieve such a change in culture, hospitals must work as a system to remove the stigma of failure that is currently placed upon physicians when errors are revealed.⁵⁰ Exemplifying such change in action, “some medical schools, including Vanderbilt University School of Medicine in Nashville, [Tennessee,] courses in communicating errors and apologizing are now mandatory for medical students and residents.”⁵¹

As such a cultural revolution becomes part of the medical school curriculum and residency, it will begin to effectuate change in new generations of physicians.⁵² A culture change with the focus on the system as a whole requires physicians to also refrain from claiming the undivided success for positive patient interaction or procedure.⁵³ Such successes must also be viewed as a victory for the team.⁵⁴ Liang views the team as consisting of, at minimum, physicians, nurses, administrators, and the patient.⁵⁵ On the contrary, a physician should not be expected to bear the full burden for a negative patient outcome.⁵⁶ In analyzing that “one individual cannot solely be responsible for the outcome of the entire system,” commentators have compared the health care system to that which is involved in aviation.⁵⁷ The pilot is not the only person involved in airplane travel who takes responsibility for the outcome, positive or

49. Liang, *A System of Medical Error Disclosure*, *supra* note 8, at 64. Liang recognized that this perception of error exists in some ways because of the pressure by other physicians, lawyers, and insurance agents to determine the origin of the error without focusing on the underlying misunderstanding that led to the error. *Id.*

50. *Id.* Liang cites to Virginia Sharpe’s notion of “gentlemanly honour” as the model of medicine that focuses on the individual error of the physician as the root cause of the overall error. *Id.* (citing Virginia A. Sharpe, *Behind Closed Doors: Accountability and Responsibility in Patient Care*, 25 J. MED. & PHIL. 28 (2000)). One study has recognized that “physicians can foster emotions such as guilt, fear, and anger in response to a medical error for days to years.” Hevia, *supra* note 47, at 566 (citing John F. Christensen et al., *The Heart of Darkness: The Impact of Perceived Mistakes on Physicians*, 7 J. GEN. INTERNAL MED. 424 (1992)).

51. Zimmerman, *supra* note 38.

52. Hevia, *supra* note 47, at 568. “To ensure that the educational atmosphere is conducive to enhancing resident disclosure of error to attending physicians and patients, it is critical that attending physicians are actively involved in creating a positive, supporting educational culture surrounding resident error.” *Id.*

53. Liang, *A System of Medical Error Disclosure*, *supra* note 8, at 64.

54. *Id.*

55. *Id.* The patient is included in recognition of the patient’s role in seeking out the treatment and following the physician’s orders for any part of treatment. *Id.*

56. *Id.*

57. Liang, *Communicating About Care*, *supra* note 19, at 224.

negative.⁵⁸ Quite like the health care system, “the pilot, the air traffic controllers, the maintenance crew, the stewards, and the ground staff” are all responsible for carrying the passengers safely to their destination.⁵⁹ “Thus, neither the last person to touch the controls nor the last person to touch the patient is fully and solely responsible for the outcome.”⁶⁰ Such a comparison is interesting as we can conceptualize our response to news of an airplane crash. We likely think of the system failure causing the crash and not the wrongdoing of the pilot or any one part of that system. One must then ask why it is the natural response to an error in the health care system to inevitably blame the physician.

Aside from changing the focus of the blame of any single medical error, the health care system must address the physician’s fear that admitting error will increase the likelihood of a lawsuit stemming from the error.⁶¹ The physician’s fear of admission is fascinating given that a multitude of studies and investigations have concluded exactly the opposite.⁶² A physician’s general fear of litigation is compounded by “the widespread myth that disclosure will increase the likelihood that patients will retaliate against physician error with legal action.”⁶³ Only through acceptance of what the studies already demonstrate can physicians integrate the recognition of hospital errors in their own health care system. “If [physicians] are to take seriously [their] patient care obligations, [they] should disclose system errors to those who have been adversely affected as a matter of mutual respect, trust, responsibility, and partnership.”⁶⁴ Leading health care institutions

58. *Id.*

59. Liang, *A System of Medical Error Disclosure*, *supra* note 8, at 64.

60. *Id.*

61. Hevia, *supra* note 47, at 566-67. Also important in the reduction of hospital errors is for the physicians to “become more comfortable with their fallibility.” *Id.* at 569 (quoting Lucian L. Leape, *Error in Medicine*, 272 *JADA* 1851 (1994)).

62. See, e.g., Amy B. Witman et al., *How do Patients Want Physicians to Handle Mistakes? A Survey of Internal Medicine Patients in an Academic Setting*, 156 *ARCHIVES INTERNAL MED.* 2565 (1996) (patients were less likely to file lawsuits if they learned of the hospital error from the physician or hospital staff rather than from other avenues); Kraman, *supra* note 26 (examined the success of the disclosure of all errors to patients at the Lexington VA hospital in reducing the cost of medical errors per case and malpractice rates for the hospital); Charles Vincent et al., *Why do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action*, 343 *LANCET* 1609 (1994) (Study of patients who filed lawsuits named the lack of honesty on the part of the physician and hospital and the lack of apology as the main instigators for such a lawsuit).

63. Hevia, *supra* note 47, at 566-67.

64. Liang, *A System of Medical Error Disclosure*, *supra* note 8, at 65. Liang recognizes “mutual respect, trust, responsibility, and partnership” as common themes that are the basis of the foundational philosophy and ethics of the majority of hospitals. *Id.*

have taken notice, and since 2001, a vast number have instated policies that urge physicians and staff to admit to their mistakes and apologize.⁶⁵

B. Properly Trained Hospital Staff

Hospitals must undertake the disclosure of the adverse event that occurred at the fault of the hospital to the patient and his or her family in an appropriate manner and with the proper personnel.⁶⁶ The composition of this group is current a matter of debate among researchers and commentators.⁶⁷

Professor Liang's ideal arrangement creates various "teams" within the hospital setting to ensure that people are aptly suited for their positions.⁶⁸ Liang first proposes the creation of an "Error Investigation Team" to step in the situation as soon as a physician or other hospital staff member discloses the occurrence of an error.⁶⁹ Members of the investigation team should "have the relevant expertise to investigate errors that result in adverse events and those that do not; the composition must therefore be adjusted for the error in question."⁷⁰ In that an investigation should commence as soon as possible after disclosure of the error, the investigation team should always have members on duty within the hospital to ensure an accurate and timely investigation.⁷¹ Professor Liang also recommends the implementation of a "System Disclosure Team" which should be comprised of "a high level representative of the administration, a patient care liaison, and a clinically trained individual in the relevant specialty relating to the potential error/adverse event, assuming disclosure will be to a patient or his/her family."⁷²

65. Zimmerman, *supra* note 38. Zimmerman references such institutions as the Dana-Farber Cancer Institute in Boston to the Johns Hopkins Hospital in Baltimore as instigating such changes. *Id.*

66. Liang, *A System of Medical Error Disclosure*, *supra* note 8, at 65. "The task of disclosing a medical error or adverse event is difficult, and the consequence of doing it badly can be severe: breakdown in relationship, failure to prevent future error, increased emotional stress and litigation." Liebman, *supra* note 34, at 25.

67. *See infra* notes 68-82 and accompanying text.

68. *See* Liang, *A System of Medical Error Disclosure*, *supra* note 8, at 65.

69. *Id.* Liang suggests that such a team could be "part of the standard peer review/quality assurance body" which is likely already within the existing system in the majority of hospitals. *Id.*

70. *Id.*

71. *Id.*

72. *Id.* Liang involves the specialist in the disclosure team in order to answer, with clarity and specificity, any questions that the family may have regarding the nature of the error. *Id.* The

One debate with regard to the disclosure team is the exclusion or inclusion of the physician who was working with the patient before or during the error.⁷³ Some commentators believe that physicians may have sufficient skills from communicating unfortunate news to patients that can be used to convey their apology for the error that occurred.⁷⁴ However, this physician would have the most available information as to the events that occurred and will have the best ability to explain the situation to the patient and family.⁷⁵ Physicians have extensive skills in disclosure from their everyday practices, but further training and education in mediation skills should be given in order to ensure their stake in the outcome does not alter the tone or content of their apology.⁷⁶ The problem in requiring such training for physicians is justifying the time commitment with the reality of the limited occasions in which such physicians will be party to disclosure discussions.⁷⁷ The implementation of communication-based studies at

presence of such specialized staff may also encourage participation of the patient and family which may further the goal of continued communications with the family after the initial dialogue. Liebman, *supra* note 34, at 25. Another analyst lists factors to weigh when determining who should be included in the disclosure team: "who has the best relationship with the patient or family, who has good process skills, and who is emotionally able to handle the conversation." *Id.* at 26.

73. See Liebman, *supra* note 34, at 26 and Liang, *A System of Medical Error Disclosure*, *supra* note 8, at 65-66 for a discussion of opposing viewpoints on this topic.

74. Liebman, *supra* note 34, at 24.

75. *Id.* at 26. Liebman believes that the treating physician should be included in such communications, based upon the attribution theory, which states that

Most people tend to attribute other people's negative behavior to the others' innate disposition, while attributing their own behavior to circumstances. The person harmed by negative behavior attributes the behavior to causes under the control of the other and responds with anger. At the same time, the person who has caused an injury attributes his or her behavior to circumstances beyond his or her control. The resulting difference 'in judgment of the harm doer's responsibility . . . can lead to the most destructive kinds of anger-driven-conflict.'

Id. (summarizing Keith G. Allred, *Anger and Retaliation in Conflict: The Role of Attribution*, in THE HANDBOOK OF CONFLICT RESOLUTION: THEORY AND PRACTICE 236, 245 (Morton Deutsch & Peter T. Coleman eds., Jossey Bass 2000)). Given what we know about the attribution theory, it seems to be the best choice for the hospital and physician to divulge any and all information that is known about what happened during the error or adverse event, especially if the error was beyond the control of the physician. *Id.* Without such information, the family will likely assume blame is upon the physician and act accordingly. *Id.*

76. See Liebman, *supra* note 34, at 24-27. Such mediation skills of active listening are not inherent in the training for physicians. *Id.* at 24. Thus, such skills must be developed in order for the physician "to show attentiveness to the patient and family members, to check on whether the physician is accurately gauging their concerns, to acknowledge the patient's or family member's feelings, and to encourage their participation in the conversation." *Id.* at 26. Active listening, at its fundamental level, involves use of a summary to show the act of listening while acknowledging the thoughts and feeling of the other parties to the conversation. *Id.* at 27.

77. *Id.* at 25.

American medical universities such as Vanderbilt University may prove to be the solution to this time commitment dilemma.⁷⁸

Other commentators believe that the physician who was last involved with the patient who suffered from the error or adverse event should not initially be involved in the disclosure conversation.⁷⁹ The basis for such a determination is that the communication likely takes place within a short period of time after the error and thus the physician will be experiencing emotional pangs of guilt, shame and remorse that will hinder his or her ability to properly address the issue.⁸⁰ Furthermore, “the presence of the provider may incite high levels of conflict and devolve the disclosure effort into a finger pointing and blame reaction.”⁸¹ Although these analysts believe the physician should not be party to the initial disclosure conversation, it is generally accepted that the physician should be an integral player in continuing communication and mediation if necessary.⁸²

The team involved in the disclosure of the error or adverse event should develop a plan of communication based upon the circumstances of the given situation.⁸³

[I]t is helpful to be aware of the useful insight provided by Douglas Stone and colleagues that each difficult conversation has three components: a conversation about what happened; a conversation about the feelings being experienced by the participants; and an identity conversation, which is each person’s internal conversation about what this situation means to his or her self-image.⁸⁴

In planning the conversation, the disclosure team should be mindful to address each of the three component parts as put forth by Stone in order to have the most effective communication possible.⁸⁵ The disclosure team should also be certain to speak to all members of the family to ensure that no single party is harboring feelings of resentment or hatred towards the

78. See *supra* note 51 and accompanying text.

79. Liang, *A System of Medical Error Disclosure*, *supra* note 8, at 65.

80. *Id.* at 65-66. Even these analysts who disagree with the inclusion of the physicians who last dealt with the patient in these discussions believe that the physicians should be allowed to attend after completing the proper training and education. *Id.* at 66.

81. *Id.*

82. *Id.*

83. Liebman, *supra* note 34, at 25-26

84. *Id.* at 26 (referencing DOUGLAS STONE ET AL., *DIFFICULT CONVERSATIONS: HOW TO DISCUSS WHAT MATTERS MOST* 7-17 and throughout (Penguin USA 2000)).

85. *Id.*

physician or hospital that are not being addressed in the initial meeting.⁸⁶ A successful communication will convey to the patient and family an accurate reflection of the immediate and ongoing investigation by all parties and this communication must remain ongoing as further details are uncovered.⁸⁷ The continuing interactions may best be conducted by a “patient care liaison” who would maintain consistent contact between the patient and the hospital.⁸⁸

C. Proper Apology

“An apology often cannot substitute for compensation for the injury but can be a way of avoiding compounding insult upon the injury—insult that can prevent settlement.”⁸⁹ In implementing a culture change from the age-old “defend and deny” tactics employed by hospitals, many hospitals and organizations are embracing apology as a means to suppress hostile feelings

86. *Id.* at 26-27 “Inviting patient and family input also may reveal concerns about how they were treated, which, while not material to health outcomes, may be critical to how families interpret and respond to adverse events.” *Id.* at 27.

87. Liang, *A System of Medical Error Disclosure*, *supra* note 8, at 66. Such an ongoing communication schedule will avoid the anger of the patient and family of not being able to learn of any discoveries in the investigation. *Id.*

88. *Id.* Thus, the “Error Disclosure Team” should have policies implemented that ensure that they

meet with the patient or family when the adverse event is detected or as soon as practically possible. The team should indicate to the patient/family that there might have been a systems problem, which may have adversely affected the patient/family member. The family should be told that the on call investigator, providers, and team are undertaking the investigation and will continue until the causes are determined. The team should then describe to the patient/family the steps that are being taken: whether the adverse event is a result of a medical error or complication associated with the patient’s clinical condition and the specific investigation methods that will be or are being used to investigate the event (generally a description of systems assessments and root cause analyses as relevant to the clinical and administrative circumstance). The patient care liaison should indicate to the patient/family that he/she will be communicating with the family on a regular basis (as defined in the policies and procedures) regarding the error investigation, and that the patient/family should feel free to contact the patient care liaison at any time. The patient care liaison should also assist the patient/family in any additional care access that might be needed, even if the negative patient outcome is a result of underlying disease rather than medical error.

Id.

89. Cohen, *Apology and Organizations*, *supra* note 26, at 1459. It is important to remember that in order for a legal dispute to arise, injury alone is not sufficient; the injured party must also make the decision to bring the lawsuit. Jonathan R. Cohen, *Advising Clients to Apologize*, 72 S. CAL. L. REV. 1009, 1022 (1999) [hereinafter, Cohen, *Advising Clients to Apologize*]. Thus, the apology after the error may be able to compel the injured party not to bring a legal claim at all.

towards the physician and hospital when an error is committed.⁹⁰ Michael Woods, a Colorado surgeon, lecturer and author on the importance of apology in medicine, has recognized that “nothing is more effective in reducing liability that ‘an authentically offered apology.’”⁹¹ On the contrary, the lack of such apology can be the main factor of an intensifying conflict between the physician and the patient.⁹²

As aforementioned, the reluctance to apologize is rooted in the physician’s and hospital’s fear of liability based upon the apology.⁹³ However, the interpretation of an apology as an admission of liability is fundamentally important because the Federal Rules of Evidence contains an exception to the hearsay rules that allows out of court statements that are admissions by a party opponent to be admitted into evidence for the truth of the matter asserted.⁹⁴ Therefore, physicians generally have an interest in phrasing their apologies in terms of a proposed settlement in an attempt to use Rule 408 of the Federal Rules of Evidence to circumvent the admissibility of the apology as an admission.⁹⁵ Some states are recognizing

90. Zimmerman, *supra* note 38. Zimmerman recognizes a link between the history of open and honest communications and a reduction in lawsuits, but also acknowledges that the use of apologies in the health care arena is a recent addition. *Id.*

91. *Id.* Michael Woods is the author of HEALING WORDS: THE POWER OF APOLOGY IN MEDICINE (Doctors in Touch 2004) and began his work in this area after an enlightening experience.

Woods was overseeing surgery to remove a patient’s appendix. A medical resident accidentally punctured an artery, which led to a more extensive operation. The patient was unhappy with how Woods handled the aftermath Wood said he wanted to apologize, but legal advisers recommended breaking off contact with the patient when she threatened to sue.

Lindsey Tanner, *Doctors Advised: An Apology a Day Keeps the Lawyer Away*, The Associated Press, <http://www.law.com/jsp/article.jsp?id=1100137001367> (last visited Jan. 25, 2006).

92. Cohen, *Advising Clients to Apologize*, *supra* note 89, at 1010. Such information bears on what can quickly become a circle of logic: “An offender who wants to apologize, but fears being sued, may refrain from apologizing – and the absence of an apology is precisely what triggers the suit.” *Id.* at 1011.

93. *See supra* notes 61-65 and accompanying text.

94. As a general matter, under the Federal Rules of Evidence and most analogous state evidentiary rules, statements made out of court that are “offered in evidence to prove the truth of the matter asserted” are inadmissible as hearsay. FED. R. EVID. 801(c), 802. There is an exception, however, for statements made by a party to the litigation. *Id.* at 801(d)(2). The physician would be a party opponent when defending against the patient in a lawsuit. *Id.*

95. Under Federal Rule of Evidence 408, statements that are made during such settlement negotiations are inadmissible:

Rule 408. Compromise and Offers to Compromise. Evidence of (1) furnishing or offering or promising to furnish, or (2) accepting or offering or promising to accept, a valuable consideration in compromising or attempting to compromise a claim which was disputed

this predicament and have passed legislation that specifically disallows a patient from using a physicians' apology against them in court.⁹⁶ Massachusetts was foremost in adopting a rule of evidence in 1986 that prohibited the admission of apologies, stating:

Statements, writings, or benevolent gestures expressing sympathy or a general sense of benevolence relating to the pain, suffering or death of a person involved in an accident and made to such person or to the family of such person shall be inadmissible as evidence of an admission of liability in a civil action.⁹⁷

Since Massachusetts passed this landmark legislation, other states, including Texas, California, Florida, and Washington have set up laws that protect apologies that express sympathy from admission into evidence, but these statutes leave open the possibility for statements of fault to be admitted into evidence.⁹⁸ Recent Colorado legislation seemingly takes it a step further, by protecting statements that accept fault from liability in court:

In any civil action brought by an alleged victim of an unanticipated outcome of medical care, or in any arbitration proceeding related to such civil action, any and all statements,

as to either validity or amount, is not admissible to prove liability for or invalidity of the claim or its amount. Evidence of conduct or statements made in compromise negotiations is likewise not admissible. This rule does not require the exclusion of any evidence otherwise discoverable merely because it is presented in the course of compromise negotiations. This rule also does not require exclusion when the evidence is offered for another purpose, such as proving bias or prejudice of a witness, negating a contention of undue delay, or proving an effort to obstruct a criminal investigation or prosecution.

FED. R. EVID. 408; *see also* Cohen, *Advising Clients to Apologize*, *supra* note 89, at 1033-36, 1061-63 (looking to the common law rules of statements made during settlement and the problems that were corrected and still remain in the Federal Rule of Evidence 408); FED. R. EVID. 409 ("Rule 409. Payment of Medical and Similar Expenses. Evidence of furnishing or offering or promising to pay medical, hospital, or similar expenses occasioned by an injury is not admissible to prove liability for the injury."). It is also important to note that Rule 408 does not preclude admission for purposes other than to prove liability, such as impeachment. *See* FED. R. EVID. 408.

96. Zimmerman, *supra* note 38.

97. Jennifer K. Robbennolt, *Apologies and Legal Settlement: An Empirical Examination*, 102 MICH. L. REV. 460, 471 (2003) (quoting MASS. GEN. LAWS ch. 233, § 23D (2002)).

98. *Id.* at 471-72. Texas passed its legislation in 1999, California in 2000, Florida in 2001, and Washington in 2002. *Id.* The Florida statute explicitly maintains that apologies admitting fault remain admissible:

The 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 and made to that person or to the family of that person shall be inadmissible as evidence in a civil action. A statement of fault, however, which is part of, or in addition to, any of the above shall be admissible pursuant to this section.

Id. at 471-72 (quoting FLA. STAT. ch. 90.4026(2) (Supp. 2004)). *See also* CAL. EVID. CODE § 1160(a) (West Supp. 1995); TEX. CIV. PRAC. & REM. CODE ANN. § 18.061 (Vernon 2004); WASH. REV. CODE § 5.66.010(1) (2002). The California, Washington, and Texas statutes are markedly similar to the Florida statute above.

affirmations, gestures, or conduct expressing apology, fault, sympathy, commiseration, condolence, compassion, or a general sense of benevolence which are made by a health care provider or an employee of a health care provider to the alleged victim, a relative of the alleged victim, or a representative of the alleged victim and which related to the discomfort, pain, suffering, injury, or death of the alleged victim as the result of the unanticipated outcome of medical care shall be inadmissible as evidence of an admission of liability or as evidence of an admission against interest.⁹⁹

The recent legislation and rules make evident the undeniably significant role that verbal syntax plays in the admissibility and effectiveness of an apology.¹⁰⁰ Commentators demonstrate the fine-line distinctions between a manifestation of sympathy and an admission of fault through a series of example phrases.¹⁰¹ An offer of sympathy may state, “I am sorry that you are hurt,” and would be inadmissible under many of the aforementioned state laws, while “I am sorry that I hurt you” would be deemed a declaration of responsibility or fault and admissible under some of the statutes.¹⁰² It is important not to forget the necessary integration of a culture change that diffuses fault away from the individual and to the health care system as a whole.¹⁰³ Fear of liability aside, such statements as “I’m sorry that I made a mistake that injured you” is in conflict with the idea of systemic rather than individualized blame.¹⁰⁴ Professor Liang finds “We are so sorry that this event has occurred to you” as an ideal statement of sympathy while holding the system accountable for the error.¹⁰⁵

99. Robbenolt, *supra* note 97, at 472-73 (quoting COLO. REV. STAT. § 13-25-135 (2003)). The Colorado law is important in that it is the first of its kind to shield statements of fault, but only those made by health care providers. *Id.* at 473. The foregoing legislations and rules are generally referred to as “Sorry Works” legislation. Tanner, *supra* note 91. This movement traces its genesis to the success at the Lexington VA as was first reported in report by Steve S. Kraman, et al. in *Annals of Internal Medicine* in December 1999. See Kraman, *supra* note 26 and accompanying text; Tanner, *supra* note 91.

100. See Liang, *A System of Medical Error Disclosure*, *supra* note 8, at 67; Liebman, *supra* note 34; Zimmerman, *supra* note 38.

101. See *infra* note 102 and accompanying text.

102. Robbenolt, *supra* note 97, at 471. Such a simple distinction demonstrates the shortcoming of the Florida type legislation and the precision of the newly enacted Colorado law. Another interestingly worded example demonstrates the difficulty in stating sympathy without fault: “Don’t say ‘I’m sorry I cut the wrong blood vessel,’ say, ‘I’m sorry you had bleeding.’” Zimmerman, *supra* note 38. Such a necessary distinction makes a mockery of the entire system of legal evidence.

103. See *supra* notes 45-65 and accompanying text.

104. Liang, *A System of Medical Error Disclosure*, *supra* note 8, at 67.

105. *Id.*

Physicians wanting to apologize to their patients must also understand the parameters of their malpractice insurance coverage.¹⁰⁶ Many medical malpractice contracts include a physician's duty to cooperate with the insurance company in the defense of a claim of error.¹⁰⁷ However, such a requirement does not forbid a physician from apologizing for an error that occurred during the treatment of a patient when the physician is acting in good faith in his or her apology.¹⁰⁸ Furthermore, the physician could simply point to the studies referenced in this article in his or her defense that the apology was an attempt to "minimize the loss to the insurance company by apologizing."¹⁰⁹ Another assessment that must be made is whether the insurance policy prohibits the physician from assuming liability, and whether an apology by the physician would breach such a condition.¹¹⁰ There is little, if any, established law in this arena, but it would seemingly be against public policy to find that a physician's apology could annul the insurance coverage.¹¹¹ "The purpose of insurance, after all, is to pay for damages when a mishap has occurred rather than to discourage moral behavior following the mishap."¹¹² Similar to the distinction in determining the admissibility of evidence in the courtroom between statements of sympathy and those of fault, the question of insurance coverage requires a

106. Cohen, *Advising Clients to Apologize*, *supra* note 89, at 1025. "Nearly all health care providers, such as physicians and hospitals, purchase insurance that covers expenses related to medical malpractice claims, including payments to claimants and legal expenses. The most common physician policies provide \$1 million of coverage per incident and \$3 million of coverage per year." U.S. GEN. ACCOUNTING OFFICE, *supra* note 10, at 6.

107. Cohen, *Advising Clients to Apologize*, *supra* note 89, at 1025.

108. *Id.*

109. *Id.* at 1026. See Hickson, *supra* note 14, at 1361 (study of parents of perinatal malpractice victims found that 24% of claims were filed because the families felt the physician had lied about what happened or misled them); Vincent, *supra* note 62, at 1612 (study of British patients and families finding 37% may not have brought malpractice suits had there been a full explanation and apology, more significant factors than monetary compensation); and Witman, *supra* note 62, at 2568 (survey of moderate physician error case found that only 12% would sue if physician informed patient of error, whereas 20% would sue if physician did not initially inform patient of error and then later learned of the error).

110. Cohen, *Advising Clients to Apologize*, *supra* note 89, at 1025-26.

111. *Id.* at 1026. Extensive research by Cohen did not produce a case in which a physician's malpractice insurance was invalidated due to an apology. *Id.* at 1027.

112. *Id.* at 1026. As one jurist explained:

[Suppose] A is injured by B. A, without thinking of whether or not B is protected by insurance, says to B, "I think you were at fault." B truthfully answers, "Yes, I was at fault." A makes demand on B. B refers the matter to his insurer. The insurer, after investigating, finds that B was at fault, but that has admitted his fault. The insurer, therefore, refuses to make payment because of B's statement admitting fault. *We cannot bring ourself [sic] to bring about such a result.*

Id. (emphasis in original) (quoting U-Drive-It Car Co., Inc. v. Friedman, 153 So. 500, 501 (1934)).

distinction between admissions of facts and assumptions of liability.¹¹³ One commentator noted, “[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.”¹¹⁴

Through all the fear of insurance and liability, however, the medical provider must remember the fundamental purpose of the apology—to offer condolences and remorse for the injury or loss and to absolve the injured party and their family from any residual guilt. The story of Linda Kenney and her routine ankle surgery is an example of the power of apology.¹¹⁵ During her surgery, Ms. Kenney’s anesthesiologist, Frederick van Pelt “inadvertently injected a painkilling drug in the wrong place, causing [her] heart to stop.”¹¹⁶ To remedy the situation, doctors had to split open Ms. Kenney’s ribcage, a surgery from which she ultimately recovered.¹¹⁷ The anger over the entire situation drove Ms. Kenney and her husband to seek legal representation.¹¹⁸ Dr. van Pelt, however, refused to follow his hospital’s protocol following the accident and “wrote Ms. Kenney a personal letter saying he was ‘deeply saddened’ by her suffering.”¹¹⁹ Ms. Kenney and her former doctor later met for coffee where he apologized for the incident.¹²⁰ Through these interactions, Ms. Kenney realized that the doctor “was a real person” and she was impressed that “[h]e made an effort to seek

113. *Id.* at 1026-27.

114. *Id.* at 1027 (quoting 8 JOHN APPLEMAN & JEAN APPLEMAN, INSURANCE LAW AND PRACTICE § 4771 (1981)). Thus, the favored approach is: “Don’t bind the insurance company to a financial settlement to which it has not consented, but don’t prevent the insured from telling the truth either.” *Id.* Furthermore, the culture change must also occur within the insurance industry.

[I]f offenders refrain from apologizing out of fear of voiding their insurance coverage, this does not mean that apology has no role to play. Rather, it is the insurance company that must now think seriously about apology. For example, if many patients would not sue physicians were they to apologize for their mistakes, but physicians who make mistakes don’t apologize for fear that apologizing will jeopardize their insurance coverage or otherwise backfire against them, a forward-looking insurance company might do well to encourage physicians to apologize.

Id.

115. *See* Zimmerman, *supra* note 38.

116. *Id.*

117. *Id.*

118. *See id.*

119. *Id.*

120. *Id.*

[her] out and say he was sorry [she] suffered,” and she ultimately abandoned her plans to sue.¹²¹

D. Offer of Settlement

According to the studies referred to in this paper, a proper apology can diffuse an angry patient and dissuade him or her from filing a lawsuit.¹²² There have been very few empirical investigations into the exact effects of an apology in determinations of legal settlements.¹²³ A 1994 study examined whether an apology had an impact upon a litigant’s decision to settle and found that those participants that had been given an apology were more likely to accept a settlement offer when given.¹²⁴

Professor Jennifer Robbenolt conducted a study on the effects of apology on settlement decision making using a basic personal injury dispute as her example.¹²⁵ When the participants receiving no apology were compared with the groups receiving partial (expressing sympathy only) and full (expressing both sympathy and responsibility) apologies, the study found stark contrasts in the final acceptance of the settlement offer.¹²⁶ A full apology persuaded the most participants to accept the settlement offer, while a partial apology influenced the least amount of people to accept.¹²⁷ Thus, this study demonstrated that a full apology is a better aid to settlement than

121. *Id.*

122. *See supra* note 109.

123. Robbenolt, *supra* note 97, at 480. Studies into the exact nature of apologies and legal settlement are of a different nature than apologies in different contexts. *Id.*

124. *Id.* (referencing Russell Korobkin & Chris Guthrie, *Psychological Barriers to Litigation Settlement: An Experimental Approach*, 93 MICH. L. REV. 107, 148 (1994)). Participants in the study were undergraduates and “assume[d] the roles of a tenant in a landlord-tenant dispute over a broken furnace and to indicate their willingness to accept a settlement offer from the landlord.” *Id.* While “[s]ome participants were told that ‘the landlord apologized to you for his behavior. ‘I know this is not an acceptable excuse,’ he told you, ‘but I have been under a great deal of pressure lately.’” *Id.* Questions arose, however, whether the students deemed the statement of the landlord to be a valid apology. *Id.*

125. *Id.* at 484-91. In the study, all 145 participants received the same pedestrian-bicycle accident scenario and settlement offer. *Id.* at 484. The control participants were not offered any apology. *Id.* Other participants were given apologies, with varied nature of apology and applicable evidentiary rule. *Id.* Overall, there were seven different variations of the accident scenario evaluated. *Id.*

126. *Id.* at 485-86.

127. *Id.* No apology group: 52% of participants would “definitely or probably accept the [settlement] offer, [] 43% would definitely or probably reject the offer,” leaving 5% unsure. *Id.* Partial apology group: 35% of participants would definitely or probably accept the settlement offer, 25% would definitely or probably reject the offer, leaving 40% of the participants unsure. *Id.* at 486. Full apology group: 73% of respondents would definitely or probably accept the settlement offer, 13-14% each for rejecting the offer and unsure. *Id.*

either no or a partial apology.¹²⁸ This is a significant discovery given the laws regarding admission of evidence in some states that allow or disallow the admittance of evidence based upon the content of either sympathy or responsibility.¹²⁹ Also important is the fact that “[p]articipants expressed greater sympathy and less anger at the offender who offered a full apology than they did at offenders who offered either a partial or no apology.”¹³⁰

The aforementioned Lexington VA system is an excellent example of the powerful combination of apology and settlement.¹³¹ “[A]fter first confirming the accuracy of the clinical information volunteered by the facility, [the plaintiff’s attorneys] are willing to negotiate a settlement on the basis of calculable monetary losses rather than on the potential for large judgments that contain a punitive element.”¹³² Reasonable settlements provide fair compensation to the injured party and such settlements are rarely offered upfront to the patient.¹³³ Those patients seeking redress for the alleged wrongs of the medical system also seldom recognize the exorbitant costs of medical malpractice litigation.¹³⁴ Because of the high costs of engaging in these trials, attorneys are selective in patients’ cases that

128. *Id.* at 487. Reasons that the full apology garnered such high settlement acceptance rates: the full apology “was seen as experiencing more regret, as more moral, and as more likely to be careful in the future than one offering a partial or no apology . . . the conduct of the full apologizer was judged more favorably than that of offenders who offered either a partial or no apology.” *Id.* at 487-88. It is important to recognize that the reasons presented above counter the sentiments expressed by patients who raised lawsuits for medical malpractice. See *supra* note 6 and accompanying text.

129. See *supra* notes 94-101 and accompanying text; Robbenolt, *supra* note 97, at 490-91 (finding that the participant’s assessment of the applicable evidentiary rule did not impact their response to inquiry as to acceptance of the settlement).

130. Robbenolt, *supra* note 97, at 488. A subsequent study by Robbenolt questioned whether the extent of the injuries or blatancy of fault altered the participants’ perceptions of apology. *Id.* at 492-501. This study reinforced the power of a full apology and shed light upon the partial apology participants. *Id.* at 500. “[T]here were patterns in the data suggesting both that partial apologies may negatively impact perceptions where responsibility is relatively clear or where the injury is more severe and that partial apologies may positively impact perceptions where responsibility is relatively less clear or where the injury is relatively minor.” *Id.*

131. See *supra* notes 26-33 and accompanying text.

132. Kraman, *supra* note 26, at 966. The obvious benefit derived from such a system is the limited judgments rendered allow hospitals to make reasonable financial arrangements for the decisions. *Id.*

133. *Id.*

134. Symposium, *supra* note 6, at 264-65. These expenses are admittedly “substantial.” Kraman, *supra* note 26, at 966. The Kraman article estimates that in the VA system, “it costs the government \$250,000 for a single malpractice case (from initiation through an appeal, including costs of medical experts, travel, and other incidental expenses).” *Id.*

they are willing to take.¹³⁵ This infers that there are many patients who have valid claims against medical facilities, but are not guaranteed victories for the attorney, and are thus left with absolutely nothing without the settlement system.¹³⁶ Therefore, the settlement system is an efficient compliment to the implementation of the apology system as it allows the hospital to provide compensation to a greater number of patients for the wrongs committed.¹³⁷

E. Mediation

If the patient and the medical facility are unable to reach a mutually agreed compensation package through the aforementioned procedures,¹³⁸ the hospital may choose to have a system of mediation in place to ensure avoidance of the previously mentioned exorbitant costs associated with medical malpractice litigation.¹³⁹ Mediation, as defined by the Uniform Mediation Act, is “a process in which a mediator facilitates communication and negotiation between parties to assist them in reaching a voluntary agreement regarding their dispute.”¹⁴⁰ Mediation “simply represents another aspect of patient advocacy, for those who are injured are those least able to confront the array of legal [maneuvers], time commitments, and uncomfortable personal scrutiny required to sustain a highly complex lawsuit.”¹⁴¹ The step towards mediation is also advantageous as it allows

135. Symposium, *supra* note 6, at 266. Most of the plaintiffs’ attorneys work on a contingent fee basis as the “clients can’t afford to pay the cost of investigating and pursuing a case.” *Id.*

136. The average compensation per claim in the Lexington VA system during the seven year period following the institution of the new apology/settlement system (1990-1996) was \$15,622. Kraman, *supra* note 26, at 964. This amount would seemingly compensate (if not fully, at least partially) for the injury, whereas litigation would have left many of these patients with absolutely nothing. *Id.* at 966.

137. *Id.*

138. Generally, the cases that go to mediation are those with unpredictable results. Symposium, *supra* note 6, at 268.

139. See *supra* notes 127-29 and accompanying text.

140. UNIF. MEDIATION ACT § 2(1) (2002). Mediation is differentiated from arbitration in that arbitration involves the neutral party making a decision based on the facts presented. *Id.*

Mediation is a method that addresses patient concerns, including facilitation of communication (a critical issue for patients that is the basis of many conflicts and decisions for suits), resolution of uncertainty, allowance for venting and to be heard, acknowledgement of suffering, and creation of a dynamic that fosters a future relationship, healing, and flexibility in settlement.

Liang, *A System of Medical Disclosure*, *supra* note 8, at 67.

141. *Id.* The United States General Accounting Office Study found that “most medical malpractice claims take an average of more than 5 years to resolve” and that “some claims may not be resolved for as long as 8 to 10 years.” UNITED STATES GENERAL ACCOUNTING OFFICE, *supra* note 10, at 8.

mediators who have not been involved with the apology in the hospital setting offer to give the case a fresh look and determine its viability.¹⁴²

The Rush-Presbyterian-St. Luke's Medical Center in Chicago, Illinois has a system of mediation that was initiated in 1995¹⁴³ and is now one of the most well regarded and thoroughly researched medical mediation systems in the United States.¹⁴⁴ In the Rush system, the plaintiff chooses two mediators¹⁴⁵ who are generally well-respected plaintiff and defense attorneys from throughout the city.¹⁴⁶ The mediation system usually commences after discovery has begun or ended so that both sides are fully aware of the facts of the case.¹⁴⁷ The greatest benefit of the mediation system is the speed of resolution, as the practiced mediators can work out most cases within three to four hours.¹⁴⁸ This quick outcome is attributed to the experience of the attorneys serving as mediators, in that they have handled these types of cases in the past and can contemplate their prospective result in court.¹⁴⁹ Overall, the mediation system is an effective means to settle cases and avoid litigation if the parties are unable to agree on a settlement themselves.¹⁵⁰

V. CONCLUSION

This country is currently facing a crisis with regard to its medical malpractice litigation. As jury verdicts continue to rise without a ceiling in the forecast, physicians and hospitals face exorbitant medical malpractice insurance premiums, which ultimately forces able and experienced physicians away from the field of medicine.¹⁵¹ As political parties make

142. Symposium, *supra* note 6, at 269. As people get caught up in their cases, they lose focus with what the case is actually about. *Id.* Arbitrators come into the case and "bring up things and point out things to both sides that may not have actually occurred to them." *Id.*

143. Jerome Lerner, *The Rush Initiative for Resolution of Medical Malpractice Claims*, CHICAGO BAR ASS'N REC., Jan. 1997, at 40, 42.

144. See Symposium, *supra* note 6, at 249-50.

145. Most mediation systems throughout the country involve one mediator, making the Rush system unique. *Id.* at 270.

146. *Id.* at 253. The plaintiff selects one attorney from the plaintiff's bar and the other from the defense bar. *Id.*

147. See *id.* at 271.

148. *Id.* at 253.

149. *Id.* at 253, 266. "All of the lawyers who act as mediators understand the realities of the system and the value of cases, and for that reason, . . . [they have been] able to work towards an amicable agreement." *Id.* at 266-67.

150. *Id.* at 267.

151. See Craig, *supra* note 12.

these colossal verdicts an issue every four years, a possible solution lies within the walls of the hospital itself. A culture change must occur in which blame for any adverse event falls not only into the hands of the person who last treated the patient, but rather upon the medical system as a whole.¹⁵² Such a culture allows the hospital to step back from the incident and instigate whatever alterations are needed to alleviate the chance of similar adverse events from happening in the future. Unfortunately, medical errors will inevitably occur, as the human body will always remain unpredictable.¹⁵³ Such a change in culture, however, will allow the medical center to have a system in place to fairly compensate the victims and their families.¹⁵⁴

A recent example of a medical center adapting because of a mistake to ensure that future adverse events of the same nature do not reoccur was in 2003 when Duke University Medical Center inadvertently transplanted a heart and lungs into a seventeen-year-old girl with a different blood type than the organs, resulting in her death.¹⁵⁵ Following the incident, the hospital created the position of “Chief Patient Safety Officer,” who will have the responsibility of guaranteeing that the hospital is complying with their safety protocols.¹⁵⁶ The hospital has also formulated a new system for organ transplants in which several doctors will guarantee a blood type match before the operation takes place.¹⁵⁷ The ability of hospitals to ameliorate problems as they are identified is one of the major reasons that medical malpractice litigation is complex and expensive—no two cases are the same.¹⁵⁸

152. See *infra* notes 45-65 and accompanying text.

153. See Symposium, *supra* note 6, at 274.

154. See *id.*

155. *Transplant Medicine: Duke University Health System Hires Patient Safety Officer in Wake of Teen's Death*, HEALTH INSURANCE WEEK, Nov. 21, 2004, at 91. The original operation on Jessica Santillan took place on February 7, 2003.

The organs supplied by the New England Organ Bank were removed from an individual with Type A blood and were intended for one or two other Duke University patients with compatible blood types. However, one of the patients was not medically ready for a transplant and the size of the heart was too big for the other patient. Jessica, who had Type O blood, ultimately received the organs. While in a coma-like state from the first operation, Jessica received a second set of donated heart and lungs on February 20. Although this set was described as “an incredibly good match” Jessica’s brain began to bleed and swell after the second operation, causing severe and irreversible brain damage. This tragic story came to an end on February 22 when Jessica was declared brain dead and removed from life support.

Symposium, *supra* note 6, at n1.

156. *Transplant Medicine*, *supra* note 155, at 91.

157. Symposium, *supra* note 6, at 274.

158. *Id.*

Another problem with litigation in the field of medical malpractice is the inability to address the wants and concerns of those patients and families bringing the lawsuit. A practice that recognizes the occurrence of errors and manages the errors through a system of trained hospital staff that understands how and when to apologize effectively, the patient who has been wronged is less likely to raise a lawsuit against the hospital. "Such a system can result using clear disclosure policies and procedures sensitive to patient and family needs, open communication with concerned, committed, and compassionate system representative, and use of mediation methods that foster communication, allow for venting, and are flexible in their approach to resolving conflict, including using apology."¹⁵⁹ Through this process, the patient can be satisfied that the hospital and its staff have admitted their wrongdoing and this satisfaction can reduce the likelihood that the patient will want to seek retaliatory damages from the hospital. While the hospitals will incur costs in training their staff in dispute resolution techniques and bringing about this change in culture, the result is a team-based atmosphere that ultimately reduces errors and protects patients.¹⁶⁰ There are various hospital systems throughout the country that have been pioneers in their implementation of honesty and apology when adverse medical events occur and the continuing success of these programs should serve as models for other medical centers looking to end their medical malpractice nightmares.

159. Liang, *A System of Medical Disclosure*, *supra* note 8, at 64.

160. *Id.*

