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, M.D.

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 Vergil1

ABSTRACT

The past decade has produced ample evidence that patients are injured by medical care. A landmark document “To Err is Human” articulated a way to protect patients based on analysis of health care organizations according to complex systems and principles of human performance rather than “blame and shame”. To understand how to prevent injury, full – but protected – disclosure is required as well as institutional will to change. The literature is full of success stories all of which are based on frank and honest reporting of adverse events. Central to such reporting and analysis is the ability to discuss such events in the correct forum.

In this Article, I argue that physicians should not apologize to patients who sustain medical adverse events. There are three main problems with the use of apologies. First, medical injuries usually occur at the “sharp end” of complex systems where more than one latent failure has also happened. The idea of one individual apologizing to another for a medical injury sustained as the result of medical care is therefore contrived and insincere. Second, apologies - as opposed to other forms of remedial work – have a chilling effect on medical injury reporting and operates against the important social goal of increasing patient safety and third, legislatures attempting to enact common law and statutes - to make apologies inadmissible in litigation - vary widely among the states and render any attempted protections illusory.

The main alternative approach to improving patient safety is that of deterrence and corrective justice as sought in medical malpractice litigation. With its selectivity, long time line, and individual client-focused approach, malpractice litigation cannot

ed è chi per inquiuria par ch’aonti
siche si fa de la vendetta ghiotto,
et al convien che ’l male altrui impronti:
be expected to impact patient safety in any meaningful way. Only patients with severe to catastrophic injury can get their cases tried, leaving the vast majority of those sustaining medical injuries without compensation.

The last section of this article discusses three main alternatives to ongoing legislative attempts to protect apology. First, state and federal evidentiary rules such as FRE 803(6) should be changed to strengthen protections for documents generated to improve patient safety. Second, legislative efforts such as the Patient Safety and Quality Improvement Act (PSQIA) of 2005 should be expanded into the states and directed at strengthening protection of peer review and institutional processes which are designed to get at the root cause of injuries as they happen, and to prevent similar injuries in the future. Third, physicians should be taught to disclose relevant details of injuries sustained by patients with accounts, an alternative type of remedial work which allows a focus on the injury but without the requirement of admitting regret, remorse, or responsibility.
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Abstract

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Introduction

A great many commentators have endorsed the offering of apologies in the face of injury caused by 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 attempts to decrease the potential harms of saying “I’m sorry” in the health care setting, state legislatures have enacted various statutes to “protect” physicians. The thesis of this paper is that apologies should not be issued in the medical setting, and “apology” laws are misguided for a variety of reasons. Such laws work against the important social policy goal of improving patient safety by discouraging health care workers to openly acknowledge and correct systems 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, such laws may require individual physicians to apologize for the actions (or inactions) of a complex health care delivery system in ways over which those physicians have minimal to no authority or control; rendering such “apologies” contrived and insincere.

A modern health care system is not kindergarten. 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, third party payors, hospital-wide committees, administrators, credentialed general care and specialty physicians, advanced practitioners, nurses, and support personnel (pharmacists, radiology technicians,

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pathology technicians). In addition to the core mission of clinical care of most modern health care centers, a research mission is usually accompanied by interventional, drug, or device clinical trials. Educational efforts inevitably entwine patient care with learning; the presence of fellows, resident physicians, and students of every description. When there is a medical injury ascribed to error, many – indeed most - of the above mentioned groups often play roles. State legislatures have tried a variety of legislative approaches to exclude from evidence statements made by physicians to patients and significant others. Data have been published purporting to show that apologizing decreases the cost of claims. There is even a foundation lobbying to promote “Sorry Works!”

Over the past decade, the occurrence of medical injuries has been shown to be a significant societal problem jeopardizing patients who undergo medical treatment. The Institute of Medicine, in a landmark book *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 the cost of preventable medical injuries is approximately $29 billion. Over the past decade, the occurrence of medical injuries has been shown to be a significant societal problem jeopardizing patients who undergo medical treatment. The Institute of Medicine, in a landmark book *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 the cost of preventable medical injuries is approximately $29 billion. Although complex, health care 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 health care professionals and other workers. The types of adverse events that may contribute to excessive cost, preventable injury, and, death which occur during the course of providing medical treatment include diagnostic errors, treatment errors, and preventive errors. Other types

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3 WILLIAM C. RICHARDSON ET AL., Executive Summary in *To Err is Human: Building a Safer Health System* 1, 2 (Linda T. Kohn, et al., eds., Institute of Medicine, Committee on Quality of Health Care in America 2000).
of errors, such as equipment failures and failures to communicate, also occur.\textsuperscript{6} 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.\textsuperscript{7}

Surgical procedures are common causes of medical injury.\textsuperscript{8} The list of potential harms –risks – is long, and includes bleeding, infection, operative site or other organ injury, disability and death in all cases. 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 insure informed consent, prevent the wrong operation or retention of foreign bodies, the mandate for scrupulous intraoperative documentation, and, safe anesthesia are required for all facilities that perform operations and other invasive procedures. The transfusion of blood and blood products can also be associated with injury ranging from mild allergic reactions to cardiovascular collapse and death. The discipline of transfusion medicine is also subject to rigorous safeguards in laboratory testing, accurate patient identification and proper administration. Diagnostic and therapeutic radiologic procedures are fraught with the potential for injury; delayed diagnosis can arise from a missed finding or a delay in

\textit{Diagnostic:} error or delay in diagnosis; failure to employ indicated tests; use of outmoded tests or therapy; failure to act on results of monitoring or testing. \textit{Treatment:} error in the performance of an operation, procedure, or test; error in administering the treatment; error in the dose or method of using a drug; avoidable delay in treatment or in responding to an abnormal test; unnecessary or inappropriate care. \textit{Preventive:} failure to provide prophylactic treatment, inadequate monitoring or follow-up of treatment. \textit{Other:} including failure of communication, equipment failure.)


\textsuperscript{7} JAMES REASON, \textit{Chapter 1 The Nature of Error, in HUMAN ERROR} 1, 17 (Cambridge University Press 1990)

\textsuperscript{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.
receipt of information by the responsible treating physician; life-threatening side-effects of various contrast agents, to inaccurate dosage calculations in the provision of diagnostic and therapeutic ionizing radiation. Lastly, every medication prescribed has side effects from mild to lethal, predictable to idiosyncratic, and each passes through a variable series of individuals from physician to nurse to pharmacist to nurse to patient. 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 purposes of making informed decisions regarding future care. Better approaches to patient disclosure include providing a careful account – or type of remedial work - by the responsible health care 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 by 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.

I. The Complexities of Modern Medicine
A. Risks of Injury in Contemporary Medical Care

The aphorism “first, do no harm” is well known to all physicians and surgeons. Yet every surgeon accepts the uncomfortable fact that he or she will make errors leading to complications and death. There is no such thing as a “mask of infallibility”, as widespread media coverage has unmasked the medical profession as fallible, with sometimes catastrophic results. At each step in the complex process imposed upon the patient by disease, there is the possibility of error and injury caused by the treatment of that disease. One year old Jeanella Aranda had surgery for a liver tumor; damage to blood vessels during the surgery 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 and 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 one Rhode Island hospital, surgeons operated on the wrong

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9 Charles M. Smith, Origin And Uses Of Primum Non Nocere—Above All, Do No Harm! J. Clin. Pharmacol.;45:371-7. (2005) (reviewing the likely origin of the phrase and concluding prominent English physician Thomas Sydenham, not Hippocrates, was the author.)
10 CHARLES L. BOSK, CHAPTER TWO: ERROR, RANK, AND RESPONSIBILITY, in FORGIVE AND REMEMBER: MANAGING MEDICAL FAILURE 50 (University of Chicago Press 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.”)
side of the brain in three separate patients within the course of a year.\textsuperscript{13} Other cases of medical error leading to catastrophic injury are well documented.\textsuperscript{14}

Barely a decade ago, the Institute of Medicine (IOM) initiated a ‘tipping point’ in the safer delivery of healthcare to patients by publishing \textit{To Err is Human: Building a Safer Health System}; a landmark document which attempted to show the rates of medical injury and error, and point the way forward to improve patient safety.\textsuperscript{15} \textit{To Err is Human} got widespread attention from the public, the media, and legislators for its fundamental conclusion that as many as 98,000 people die in any given year from medical errors that occur in hospitals.\textsuperscript{16} Deaths due to errors in the delivery of medical care were more common than deaths from motor vehicle accidents, breast cancer, or AIDS.\textsuperscript{17}

The major accomplishment of \textit{To Err is Human} was to summarize and bring to the nation’s consciousness available data showing the magnitude of the problem of medical error, and articulate a way to decrease errors. Although data was not robust, some estimates of the rate of adverse events in patients could be found in the medical literature. First it was necessary to develop a common vocabulary. Errors were defined by the IOM as the failure of a planned action to be completed as intended or the use of a

\begin{itemize}
\item \textsuperscript{14} A Tale of Two Stories: Contrasting Views of Patient Safety Report from a Workshop on Assembling the Scientific Basis for Progress on Patient Safety National Health Care Safety Council of the National Patient Safety Foundation at the AMA www.npsf.org/rc/tts/npsf_w97.doc. (last accessed 02/20/10)(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.)
\item \textsuperscript{15} RICHARDSON ET AL., \textit{supra} note 3, at 26.
\item \textit{Id.}
\item \textit{Id.}
\end{itemize}
wrong plan to achieve an aim. Errors may involve one of two types of failure: first, 
*slips*, or errors of execution in which the correct action does not proceed as intended or 
second, *mistakes*, or errors of planning in which the original intended action is not 
correct. Errors can happen in all stages in the process of medical care, from diagnosis 
through treatment. Not all errors result in harm. Errors that do result in injury are also 
called preventable adverse events.

There are three generally acknowledged seminal studies in the analysis of medical 
injuries. The first was the largely unheralded Medical Insurance Feasibility Study done in 
the early 1970s by the California Medical Association and California Hospital 
Association. 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 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.

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18 Id. at 28.  
19 REASON, supra note 7 at 17.  
20 In To Err is Human, the authors and the Institute of Medicine chose to use the term adverse event rather 
than injury. The main reason for this distinction is the fact that from a systems analysis standpoint, a “near 
miss” - error without injury - is as significant as an error with patient injury. For purposes of the present 
analysis the concern is over what to say when patients are hurt; hence, the term injury will be used to 
highlight this important distinction.  
21 Don H Mills, Medical insurance feasibility study - A technical summary. 128 W. J. MED. 360, 362 
(1978).  
22 Id., at 364.  
23 Id.
The Harvard Medical Practice Study (HMPS) reviewed 30,195 New York hospital records from the year 1984 and documented a medical injury rate of 3.7%.\textsuperscript{24} 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.\textsuperscript{25} 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%).\textsuperscript{26} 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.\textsuperscript{27}

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, submitting for review non-psychiatric hospital discharge records; 5,000 in Utah and 10,000 in Colorado.\textsuperscript{28} 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%).\textsuperscript{29} More than four in five of the recorded injuries occurred in the hospital, with the rest occurring prior to admission in


\textsuperscript{25} Id., at 370.


\textsuperscript{27} Id.

\textsuperscript{28} Eric J. Thomas, David M. Studdert, Helen R. Burstin, E. John Orav, Timothy Zeena, Elliott J. Williams, K. Mason Howard, Paul C. Weiler, & Troyen A. Brennan, Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado. 38 MED. CARE 261, 262 (2000).

\textsuperscript{29} Id., at 265.
non-hospital settings. A lower percentage of deaths due to injuries (6.6%) were found when compared to the HMPS (13.6%).

The incidence of medical injuries appears to rise in parallel with increasing complexity of care. In a study of 1,047 patients admitted to two intensive care units and one surgical unit at a large teaching hospital, 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. 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 Medical Insurance Feasibility Study, the Harvard Medical Practice Study, and the Utah/Colorado studies. 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

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30 Id. at 268.
32 Id. at 310.
33 Id.
34 Id.
35 Id. at 311.
hospital stay. The most common causes of injury were individuals (37.8%), interactive causes (15.6%), or administrative decisions (9.8%).

In a study of 44,603 patients who underwent surgery between 1977 and 1990 at a large medical center, 2,428 patients (5.4 percent) suffered adverse events. 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.\(^{36}\) Gawande and colleagues studied Colorado and Utah data from a 1992 survey and found that injuries resulting in death, disability, or a prolonged hospital stay were no more likely to occur with surgical care than with nonsurgical care.\(^{37}\) Among surgical injuries, 54% were considered to be preventable.\(^{38}\) Fifteen common operations each accounted for 1% or more of surgical injuries.\(^{39}\)

*To Err is Human* focused widespread attention on the simple fact that patients were not always *safe*. There was a widespread problem of medical injury with and without error. To the public, documentation that doctors, nurses and others in the health care setting could make errors and injure patients was a revelation. However, *To Err is Human* made the novel suggestion that improving the safety of patients should identify and correct the faulty systems in which errors could happen; not focus on punitive approaches (for example malpractice litigation) when individual patients were injured by


\(^{38}\) *Id*. at 70.

\(^{39}\) *Id*. at 68-69. (noting abdominal aortic aneurysm repair, appendectomy, arthroscopy, cesarean section, cholecystectomy, colon resection, coronary artery bypass graft or heart valve replacement, hysterectomy, lower extremity bypass graft, oophorectomy/salpingectomy (without hysterectomy), open reduction with internal fixation of a fracture (ORIF), prostatectomy, spinal laminectomy or discectomy, total knee or hip replacement, and transurethral resection of the prostate or bladder tumor).
medical diagnosis and treatment. The main message of *To Err is Human* was later elegantly summarized:

“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. . .”

And yet, medical injuries appear unavoidable in the health care delivery system and occur throughout the spectrum of medical care. The recognition that patients are injured through error has led to the emphasis on patient safety initiatives. Surgical procedures are common causes of adverse events. The list of potential harms – or risks – is long, and includes in most cases bleeding, infection, operative site or other organ injury, 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 insure informed consent, scrupulous intraoperative documentation, safe anesthesia, and prevent the wrong operation or retention of foreign bodies during the right operation are mandated for all facilities that perform operations and other invasive procedures. Subsequently, in 2001, the IOM released a second medical error analysis, *Crossing the Quality Chasm* – interestingly choosing quality rather than patient safety for the title - making recommendations for enhancing patient safety in health care institutions.

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41 To conform to the terminology extant in the patient safety literature, most definitions are derived from the Institute of Medicine (IOM) study “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.

42 Committee On Quality Of Health Care In America Institute Of Medicine Crossing The Quality Chasm: A New Health System For The 21st Century National Academy Press Washington, D.C. (2001) (Proposing improvements in six dimensions towards which all health care constituencies should strive: Safe—avoiding injuries to patients from the care that is intended to help them. 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). Patient-centered—providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide
B Patient Safety: The Need for Protected Disclosure

1 Internal, Health System-based Approaches

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), the chemical industry (Bhopal), the National Aeronautics and Space Administration (Challenger, Columbia), and the airlines industry. The overarching goal of the patient safety approach is to prevent injuries caused during medical diagnosis and treatment, and 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 “just culture”, defined as a culture reconciling professional accountability with the need to create a safe environment to report medical errors. To achieve the goal of improving patient safety, accurate reporting of outcomes is crucial.

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all clinical decisions. Timely—reducing waits and sometimes harmful delays for both those who receive and those who give care. Efficient—avoiding waste, including waste of equipment, supplies, ideas, and energy. Equitable—providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

JAMES REASON, Chapter 7 Latent Errors and Systems Disasters, in HUMAN ERROR, supra note 7 at 189.

Id. at 191.

Id. at 192 see also National Aeronautics and Space Administration. Space shuttle Columbia and her crew. http://www.nasa.gov/columbia/home/index.html


Surgeons were first challenged to report procedural outcomes a century ago by Ernest A. Codman. He chastised public - or “charity” - hospitals for not looking at patient outcomes. Codman charged individual physicians as not wanting to standardize or report how their patients fared, because hospitals would not want the expense. Codman classified sub-optimal outcomes as due to one or more of several causes: errors due to 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, acknowledging the fact that not all sub-optimal outcomes could be attributed to error, “the calamities of surgery”. 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. . .” At the turn of the 20th 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 21st century, a systems approach – as advocated by the IOM in *To Err is Human* - to improving patient safety is based on three principles: human error is an inherent, unavoidable aspect of human work; faulty systems allow human error to lead to adverse events; and systems can be designed that prevent or detect human error before such adverse events occur. Support for a systems approach to patient safety is found in professional societies, specialty boards, medical centers, public and private health

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49 Id., at 53.
50 Id., at 59.
51 Id., at 17.
52 RHODES, supra note 6 at Surgical Care as System.
insurance purchasers, federal and state legislatures, and perhaps most importantly, patients. \(^{53}\) Low rates of adverse events now rank among the public's leading measures of health care quality. \(^{54}\) The results of a survey of over 2,000 adults indicate that people are more concerned about mistakes happening when they are in the hands of health care organizations than when they are flying in the hands of airlines. \(^{55}\) Large majorities of survey respondents say that information about medical errors (71%) would be one of the biggest helps in determining the quality of providers. \(^{56}\)

It is crucial for all relevant parties to acknowledge that most medical injuries are attributable to system flaws rather than individual incompetence or neglect. It is also essential to recognize that the current systems of surgical care are shaped by and will require changes in the larger patient care delivery system; any worthwhile effort to improve such systems is likely to require substantial collaboration among parties – collaboration that can only be accomplished by full, protected, blame-free reporting, \(^{57}\) as well as significant change in the larger system. To maintain or repair public faith in the United States health care system, patient safety must be made among the highest priorities of social policy setting, \(^{58}\) and transparency must be ensured. \(^{59}\)

Safe systems are designed by taking into consideration appropriate credentialing of physicians and surgeons, analysis of how OR personnel interact with each other in


\(^{55}\) Id.

\(^{56}\) Id.


teams and use machines and equipment. Output of such analyses included training and integration of new staff into existing teams, 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 providing a “blame–free” environment for organizational analysis and change to prevent future adverse events.\(^6^0\).

Hence, it seems clear that a systems-based approach is a valuable tool to help in the battle of medical injury reduction. To try and stem further erosion of public trust and loss of professional autonomy, physicians have taken the opportunity to improve the safety and quality of care, anticipating the expansion of internet resources in increasing public awareness of safety issues, as well as the potential consequences of this awareness.\(^6^1\) 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 who had previously provided care.\(^6^2\) Fiduciary concerns aside, improving patient safety thus becomes a matter of self-interest for the provider as well as a mechanism for improving patient safety.\(^6^3\)

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), achieving a 27% decrease in 30-day mortality after major procedures and a 45% decrease in

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\(^{60}\) Richard et al., supra note 3 at 62

\(^{61}\) Andrew R. Robinson, Kirsten B. Hohmann, Julie I. Rifkin, Daniel Topp, Christine M. Gilroy, Jeffrey A. Pickard, & Robert J. Anderson, Physician and Public Opinions of 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).


morbidity in Veterans Affairs Medical Centers throughout the country.\textsuperscript{64} One important aspect of the NSQIP is that data are maintained in a coded manner so only the individual participating health care organizations know which data set belongs to them. 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.\textsuperscript{65} Other notable findings were that for many common procedures, there was no significant association between procedure or specialty volume and 30-day mortality and that the savings from improved surgical care far exceeded the investment in the project.\textsuperscript{66} NSQIP has now expanded into the broader community under the auspices of the American College of Surgeons (ACS).\textsuperscript{67} It has also been used to validate the AHRQ Patient Safety Indicators.\textsuperscript{68}

Examples of successful safety improvement efforts within surgery in the private sector are also numerous, and include formalized team training at Beth Israel Deaconess,

\begin{thebibliography}{99}
\bibitem{64} Shukri F. Khuri, Jennifer Daley, William Henderson, Kwan Hur, John Demakis, J. Bradley Aust, Vernon Chong, Peter J. Fabri, James O. Gibbs, Frederick Grover, Karl Hammermeister, George Irvin, Gerald McDonald, Edward Passaro, Jr., Lloyd Phillips, Frank Scamman, Jeannette Spencer, John F. Stremple, & the participants in the National VA Surgical Quality Improvement Program. \textit{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 OF SURGERY 491, 507 (1998)
\bibitem{68} Patrick S. Romano, Hillary J. Mull, Peter E. Rivard, Shibei Zhao, William G. Henderson, Susan Loveland, Dennis Tsilimingras, Cindy L. Christiansen, & Amy K. Rosen, \textit{Validity of Selected AHRQ Patient Safety Indicators Based on VA National Surgical Quality Improvement Program Data}. 44 HSR: HEALTH SERVICES RESEARCH 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).
\end{thebibliography}
resulting in a 53% decrease in potential adverse outcomes in high-risk patients. 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%. Intermountain Health Systems in Utah has developed interdisciplinary care standards, 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, providers participate in outcomes research as a response to practice variations. Often these efforts reduced rather than increased liability exposure. In addition, the funding parties (including insurers) usually agreed to confidentiality in return for the benefit associated with voluntary physician involvement.

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71 Judy Hougaard, *Developing Evidence-Based Interdisciplinary Care Standards and Implications for Improving Patient Safety*. 73 INT’L J. MED. INFORMATICS 615, 624 (2004).
74 RHODES, supra note 6 at Successes and Obstacles to Success.
75 Id.
Other notable patient safety efforts include the Washington State Surgical Clinical Outcomes Program; the highly regarded Society for Thoracic Surgery national database, which is now a benchmark for risk-adjusted quality in cardiothoracic surgery; the New England Colorectal Cancer Quality Project; and the National Surgical Infection Collaborative. Mortality in trauma care and perception of preventability have increased in parallel with the appreciation of the importance of the system has also improved after efforts were made to understand and enhance systems of care.

Considerable obstacles to improving patient safety still exist. One institutional hindrance to making patients safer is the entrenched notion that 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

81 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; 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).
82 Id., at 1598.
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do not consider all complications, they are not consistently well attended, there is no
validation or categorization of complications, and they often do not involve health care
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
50% of the deaths and about 75% of the complications.

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, 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. 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 overt, whereas lapses
are 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. In one sense, surgeon performance can be a system factor, but in
another sense, their cognitive and technical abilities make up a large part of the system's

85 REASON, supra note 7 at 9.
86 RHODES, supra note 6 at Basic Principles of Human Performance.
87 Id.
88 Id.
safety barriers. Overemphasizing a surgeons' individual 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, 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 and performance on board recertification examinations, and specialty board certification is linked to improved outcomes. A direct link between CME participation and safer patient care is not as easy to confirm. Systematic reviews of differences in the impact various CME strategies have on actual practice change have raised serious concerns about the value of some current CME. 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. There is evidence to

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89 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).


suggest that despite some methodologic shortcomings, performance on cognitive examinations such as certification and re-certification examinations is related to performance in practice and that a physician's current certification status should be among the evidence-based measures used in the quality movement.

The purpose of clinical pathways and guidelines is to improve safety and quality—especially in high-risk procedures—by standardizing medical processes. The presumed benefits of standardization notwithstanding, critics of these tools argue that guidelines often do not apply to particular patients and can be difficult to use in patients with other, more urgent medical problems. Finally, guidelines—which can require intense efforts to craft—may become quickly outdated.

Peer review organizations were originally intended as a mechanism for professional self-evaluation but subsequently became subject to anticompetitive abuse and other undesired consequences. 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 committee.

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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. Quality improvement organizations (QIO) have largely supplanted peer review organizations however QIOs have yet to prove effective.99

Another way to evaluate physician quality is through physician clinical performance assessment (PCPA); reluctance to embrace PCPA initiatives on the grounds that they will be used as evidence against physicians in malpractice litigation reflects perception rather than reality of the law.100 The bar 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. 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. They place limited emphasis on close calls and tend to lack systematic follow-up. 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.101


100 Aaron S. Kesselheim, Timothy G. Ferris, David M. Studdert. Will physician-level measures of clinical performance be used in medical malpractice litigation? 295 J. Am. Med. Ass’n 1831, 1833 (2006) (noting, however, that PCPA actions could still be used against physicians in other circumstances (e.g. proceedings by state licensure boards, hospital review committees, and other adjudicatory bodies).

101 Fed. R. Evid. 803(6).
3 External Oversight

Although as argued above, those best able - from a policy standpoint - to enhance patient safety decreasing adverse events, deaths and major injury are those within individual health care 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.\textsuperscript{102} There is concern even in the surgical community that voluntary reporting is inconsistent as viewed by state licensing boards or even local credentials committees.\textsuperscript{103} Psychology may also underlie these behaviors, including fear about discussions in an open forum, feelings of denial, and infallibility.\textsuperscript{104} Further, education is usually stated as an important goal of the M&M conference, a goal which may work against full analysis of an adverse event.\textsuperscript{105}

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 including inter alia, Agency for Healthcare Research and Quality (AHRQ, of the Department of Health and Human Services), Centers for Disease Control and Prevention (CDC), Centers for Medicare and Medicaid Services (CMS), the Joint Commission (TJC), Institute for Healthcare Improvement (IHI), American College of Surgeons (ACS), American Medical Association (AMA, American Hospital Association (AHA), American Society of Anesthesiologists (ASA), and the Association of periOperative

\textsuperscript{102} Walter P. Bowers, Editor in Chief. \textit{Why Medical Malpractice?} 200 NEW ENG. J. MED., 93, 93 (1929). (noting “in 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.”)

\textsuperscript{103} Hutter et al., \textit{supra} note 84 at 621.

\textsuperscript{104} \textit{Id.} at 622.

\textsuperscript{105} \textit{Id.}
Registered Nurses (AORN). The rationale is that as medical error reporting improves 
error detection rates increase while (hopefully) the severity of errors decreases. There is 
demand that error detection rates be high because unreported, uncorrected, repeated 
errors might lead to injuries \textit{ex ante}.

Commentators within the discipline of surgery as well as the community at large 
have noted it vital that physicians not use protected disclosure as an excuse for avoiding 
responsibility for complications.\footnote{Wachter et al., supra note 38 at see also Keith D. Lillemoe, \textit{To Err is Human, but Should We Expect More from a Surgeon} 237 Annals of Surgery 470, 472 (2003)} External agencies have helped alleviate concerns 
regarding the “self-policing” nature and lack of oversight of most individual and 
institutional mechanisms of enhancing patient safety. 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 health care organizations.\footnote{The most recent version of the Joint Commission Sentinel Events Policy (the Policy) can be found at: http://www.jointcommission.org/NR/rdonlyres/F84F9DC6-A5DA-490F-A91F-A9FCE26347C4/0/SE_chapter_july07.pdf. see also The Joint Commission. Sentinel Events: Approaches to Error Reduction and Prevention. 24 J. Quality Improvement 175 (1998).} The 
Policy requires\footnote{The Joint Commission, Sentinel Events. http://www.jointcommission.org/SentinelEvents/se_glossary.htm (last visited 12/27/09) (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.”).} that health care organizations report certain adverse, or sentinel, events 
to TJC.\footnote{The Joint Commission, supra note 108 at 9 (Noting that although there are claims by representatives of TJC that adherence to the Policy is "voluntary", accreditation and the ability to provide services to at least Medicare and Medicaid patients, hinges upon adherence to the Policy). see also, Bryan A. Liang, \textit{Comment: Other People’s Money: A Reply to the Joint Commission}, 33 J. HEALTH L. 657 , 659 (2000).} The health care 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.110

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 regarding exposure during litigation and the use of information beyond its intended patient safety purpose, such as TJC sanctions against health care organizations.111 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. If the 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.112 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. Ultimately, TJC may revoke the provider's accreditation, which, with special statutory “deeming authority” for CMS, has major implications for reimbursement.113

110 The Joint Commission, supra note 88 at 7.
111 Id., at 9.
112 Id., at 8.
113 The Joint Commission’s Hospital Accreditation Recognized by CMS: Deeming Authority Continued for The Joint Commission http://www.jointcommission.org/NewsRoom/NewsReleases/nr_11_30_09.htm. (last visited Jan. 12,2010) (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 may choose to be “deemed” as meeting Medicare and Medicaid certification requirements. CMS found that The Joint Commission’s standards for hospitals meet or exceed those established by the Medicare and Medicaid program. The Joint
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. Further, the policy does not necessarily endorse a non-threatening, blame-free cooperative, mechanism necessary to reduce adverse events. Since the inception of TJC’s unanticipated outcomes disclosure policy in 2001, the Elements of Performance have become more exacting. Therefore, although recognition of the systems nature of error may represent progress in theory, the shame and blame mechanisms used by the Joint Commission for enforcement represents at least one step backwards. In combination with other medical efforts, progress toward error reduction and patient safety promotion may be significantly retarded.

Other non-governmental organizations have also weighed in; the Leapfrog Group defined volume surrogates for quality and listed hospitals based on the likelihood of best

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115 The Joint Commission: The 2009 Comprehensive Accreditation Manual for Hospitals (CAMH) Program – Hospital; Chapter - Rights and Responsibilities of the Individual; Standard - RI.01.02.01 : The hospital respects the patient's right to participate in decisions about his or her care, treatment, and services; http://edition.jcrinc.com/Frame.aspx (last visited Dec. 29, 2009) (Elements of Performance (inter alia): # 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. see also # 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.)

116 Ed Lovern, *JCAHO's New Tell-All; Standards Require that Patients Know About Below-Par Care*, MODERN HEALTHCARE, Jan. 2001, at 2 available at 2001 WL 9418041 (documenting 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).
outcomes. The notion that a reduction in liability concerns may facilitate disclosure and discussion of mistakes is suggested by international comparisons of health care systems. In one study, patients in New Zealand, which has no-fault medical malpractice, had a low claiming rate especially in the aged, individuals of Maori and Pacific ethnicity, socioeconomic disadvantage, and injury resulting in either temporary disability or death.

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. Even before the enactment of the Patient Safety Act, the view that open discussion of medical errors was appropriate appeared to be winning converts. A transparent discussion of errors, complications, and deaths was reported not to lead to an increased risk of lawsuit in the trauma setting. The improvements in patient safety achieved by anesthesiologists 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 pay

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117 The Leapfrog group fact sheet. http://www.leapfroggroup.org/about_us/leapfrog-factsheet (describing four hospital quality and safety practices as the focus of Leapfrog’s hospital ratings and include: computer physician order entry; evidence-based hospital referral; intensive care unit (ICU) staffing by physicians experienced in critical care medicine; and the Leapfrog Safe Practices Score.)


120 JAMES REASON, Preface, in HUMAN ERROR, supra note 7 at vii.

121 Ronald M. Stewart, Michael G. Corneille, Joe Johnston, Kathy Geoghegan, John G. Myers, Daniel L. Dent, Marilyn McFarland, Joshua Allen, Basil A. Pruitt, Jr, & Stephen M. Cohn. Transparent and Open Discussion of Errors Does Not Increase Malpractice Risk in Trauma Patients. 243 ANNALS OF SURGERY 645, 647 (2006) (reporting that in an open M&M conference, of 412 cases, only seven claims were filed and of these, six were surprises – having not been presented).
less for malpractice insurance today, adjusted for inflation, than they did more than 20 years ago.\textsuperscript{122}

In summary, three converging trends have pointed to patient safety as a source of reform for health care institutions: First, quality measurement methods are evolving quantitatively as a way to assess patients’ perceptions of care, patients’ health status, and compliance with guidelines for appropriate care. Second, there are mature methods for quality improvement, applying industry analytic techniques and the fundamentals of human performance and failure to health care as a system. Lastly, we have an evolving understanding of professional commitment to the principles of patient self-determination, beneficence, and distributive justice.\textsuperscript{123}

4. Mandatory Disclosure of Adverse Events to Patients

Legal protection of reported data is critical if medical error reporting is to be truly effective in improving patient safety. Effective reporting requires encouragement of health professionals to report medical errors and other threats to patient safety and a prevailing national norm of legal protection of all reported patient safety data. One important component that has not yet gained wide acceptance is malpractice reform; however other safety initiatives have grown in importance, including reporting obligations to state and national entities. Pennsylvania has some of the most progressive statutory provisions in this regard in the so-called “M-CARE” Act.\textsuperscript{124}

The present professional liability system is particularly controversial with respect to whether it facilitates or hinders improvements in patient safety. A fiduciary duty has

\textsuperscript{122} Brian A. Liang, Clinical Assessment of Malpractice Case Scenarios in an Anesthesiology Department. 11 J. CLINICAL ANESTH. 267, 270 (1999)

\textsuperscript{123} Troyen A. Brennan, Physicians’ Responsibility to Improve the Quality of Care. 77 ACAD. MED. 973, 976 (2002) see also Anthony D. Whittemore. The Competent Surgeon 250 Ann. Surgery 1, 3 (2009).

\textsuperscript{124} 40 PA. STAT. ANN., § 1303.308 (2004).
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recently been suggested for the disclosure of medical injury.\textsuperscript{125} Further, a number of states have enacted patient safety statutes which also require analysis and reporting of error.\textsuperscript{126}

\textbf{C \hspace{2mm} Medical Malpractice as Deterrence: A Failed Approach to Patient Safety}

The patient safety movement involves health care professionals in a position to apply principles of systems analysis, human performance, and protected reporting of errors to make patients safer. Implicit in the analysis is a genuine desire to reduce injuries: \textit{primum non nocere}. Injuries are studied not only for effects on involved individuals, but a critical objective is to establish systems to prevent similar injuries to others. The only viable option to the patient safety approach is litigation for a presumed deterrence effect. In contrast to patient safety approaches, which are barely a decade old, negligence tort law claims of medical malpractice have been brought against physicians to for nearly a century; in 1910 New York City, 1.1\% of tort cases were for medical malpractice.\textsuperscript{127} In 1929, a physician was sued for malpractice once every four days.\textsuperscript{128} In 1934 surgeons were cautioned “Secure consent before you operate.”\textsuperscript{129}

\textsuperscript{125} Thomas Hafemeister & Selina Spinos. \textit{Lean on Me: A Physician’s Fiduciary Duty to Disclose an Emergent Medical Risk to the Patient}, 86 \textit{WASH. U. L. REV.} 1167 (2009).

\textsuperscript{126} Although detailed discussion of state legislative approaches to adverse event disclosure is beyond the scope of this paper, \textit{see} CAL. \textit{HEALTH \& SAFETY § 1279.3 (West 2007) Information regarding reports of substantiated adverse events and outcome of inspections and investigations; FLA. STAT. ANN. § 429.23 (West 2009) Internal risk management and quality assurance program; adverse incidents and reporting requirements; 40 PA. CONS. STAT. ANN. § 1303.308 (West 2006) Reporting and notification.}

\textsuperscript{127} LAWRENCE M. FRIEDMAN. Chapter Two: The Growth of the Law in Part IV The Twentieth Century. \textit{A HISTORY OF AMERICAN LAW}. 521 (Touchstone, Simon \& Schuster 2007).

\textsuperscript{128} Bowers, supra note 102 at 93 (writing “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”).

\textsuperscript{129} Halbert G. Stetson & John E. Moran, \textit{Malpractice Suits: Their Cause and Prevention}, 210 \textit{NEW ENG. J. MED.} 1381, 1383 (1934) (noting “approximately 20,000 suits have been brought against physicians in the United States in the past five years.”)
Lawyers are generally responsible only to their clients. Plaintiff’s 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, how a case would likely stand up to a jury, and the fact that the firm must be ready to work 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 1,133 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 for a rate of 1.53 percent. A total of 98 claims were filed against 151 health care providers. Of the 98 claims, only 47 were confirmed as due to treatment given in the 1984 time period. In addition to the eight claims with a negligent adverse event related to treatment in 1984, 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

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130 AMERICAN BAR ASSOCIATION, Preamble: A Lawyer's Responsibilities ANNOTATED MODEL RULES OF PROFESSIONAL CONDUCT, (American Bar Association 6th ed. 2007) ([1] 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).
132 Id., at 53.
135 WEILER ET AL., supra note 133 at 70.
negligence criteria.\textsuperscript{136} Twenty-six claims - more than half - provided no evidence of medical injury or negligence.\textsuperscript{137} Another estimate of the litigation gap can be made by results of the statewide medical chart reviews which estimated 27,179 negligent injuries and 3,571 patient claims for 1984 treatment – one claim for every 7.6 estimated negligent injuries.\textsuperscript{138} 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 one in 7.6, but one in 50.\textsuperscript{139}

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; 18 malpractice claims were filed from a sample of 14,700 hospital discharges.\textsuperscript{140} 14 of 18 were made in the absence of negligence, and ten in the absence of an adverse event.\textsuperscript{141} The overall probability of a claim after a negligent adverse event causing significant or major disability was 3.8%.\textsuperscript{142} 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 75 years of age or over.\textsuperscript{143}

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 70 or older whose monetary damages would be comparatively low.\textsuperscript{144} Such

\textsuperscript{136} Id., at 71.
\textsuperscript{137} Localio et al., supra note 134 at 248 (Table 1).
\textsuperscript{138} WEILER ET AL., supra note 133 at 70.
\textsuperscript{139} Id., at 73
\textsuperscript{140} David M. Studdert, Eric J. Thomas, Helen R. Burstin, Brett I.W. Zbar, E. John Orav, & Troyen A. Brennan, Negligent Care and Malpractice Claiming Behavior in Utah and Colorado 38 MEDICAL CARE 250, 250 (2000)
\textsuperscript{141} Id., at 253.
\textsuperscript{142} Id., at 255.
\textsuperscript{143} Id., at 257.
\textsuperscript{144} Localio et al., supra note 134 at 248.
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 systems 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.

Regarding injured patients’ responses to disclosure, a survey of sixty-five experts predicted a 95 percent chance that claims would increase, including a 60 percent chance that full disclosure of severe injuries would double the annual number of claims nationwide and a 33 percent chance that volume would increase by threefold or more. Among patients, deterrent impact was perceived to be greater: disclosure would deter an average of 57 percent of plaintiffs whose injuries were not due to negligence and prompt 17 percent 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. The data suggest that the poor, the uninsured, and the aged suffer a disproportionate impact under the theory of malpractice litigation as deterrence for patient adverse events. 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. While the absolute number of claims is considerably larger than the absolute number of valid

145 AMERICAN BAR ASSOCIATION, supra note 130.
147 Id., at 219.
148 WEILER ET AL., supra note 133 at 74
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claims, the likelihood a physician will be sued is greater if negligent treatment were believed to have occurred than if not. Further, given the care with which clients are selected by plaintiff’s attorneys, the success of malpractice claims is modest. What of the success of medical malpractice litigation?

Studdert has labeled malpractice law as “punitive, individual and adversarial” seeking to place blame and transform injury into money. 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; an individual surgeon is a more satisfactory target for the anger and grief of a patient or family than a nameless, faceless health care organization. This is certainly not to say that surgeons should avoid responsibility; rather, the point is that focusing on the errors of individual surgeon without addressing flaws in the underlying system does little to improve health care, and increases the likelihood that errors will go under-reported.

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’

149 WEILER ET AL., supra note 133 at 74.
150 Thomas H Cohen, Tort Bench and Jury Trials in State Courts, 2005 Bureau of Justice Statistics Bulletin November 2009 http://www.ojp.usdoj.gov/bjs/abstract/tbjtsc05.htm (last visited Mar. 12, 2010) (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.)
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. 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, 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 adds very little value to health care and is counterproductive from a cost standpoint. Many believe that major reform of the professional liability system is a prerequisite for achieving any significant improvements in quality. 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.

II Apology Law: Common Law and Statute

Traditionally there is a case law on the disclosure by physicians of admissions of liability as to various injuries sustained by patients. Although verdicts for both physician and patient are found throughout the Common Law, for the most part, plaintiffs prevail. Voluntary apologies began with a study at the Lexington Veteran’s Affairs

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156 Giles v. Brookwood Health Services, Inc., 5 So.3d 533 (Ala., 2008); Woods v. Zeluff, 158 P.3d 552 (Utah App., 2007); Quibodeaux v. Medical Center of Southwest Louisiana 707 So.2d 1380 (La. App. 3d
Hospital, which had a high number of malpractice claims and financial exposure. The early disclosure of medical error—with or without injury—led to decreased claims and pay-outs. This experience was subsequently reproduced in a study at the University of Michigan. Later studies were equivocal, and there is still debate about whether such apologies increase, decrease, or have no effect on the level of malpractice risk.

Despite this less than convincing data, many states have now enacted so-called "Apology laws," which are supposed 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 are statutes that change the traditional rule on admissibility of evidence by declaring that apologies are inadmissible in civil actions arising from alleged medical errors. Apology laws protect apologies from being entered into evidence, but can be separated into those that do or do not protect accompanying acknowledgments of fault that accompany the apology. A Colorado 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.” 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.

The obvious need for liability reform notwithstanding, there are issues involved in enhancing safety and quality that are too complex to be addressed solely by changes in the liability system. Major safety and quality problems exist in nations where professional liability is not an issue; however, the higher rates of adverse events in these
countries should not be taken as evidence of the benefits of the current U.S. liability system. Physicians tend to act defensively even in a no-fault liability system. To minimize such defensiveness, greater emphasis must be placed on measurement for improvement than on measurement for judgment.\textsuperscript{157}

\section*{A Why Apologizing Won’t Work}

His mother said:
—O, Stephen will apologise.

Dante said:
—O, if not, the eagles will come and pull out his eyes.\textsuperscript{158}

\section*{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 of that a patient has suffered. There is a substantial medico-legal literature on the use of apology, and the majority view is that apologies should be made by physicians to patients who have experienced medical injury.\textsuperscript{159} Medico-legal analysts and bioethicists have treated the term “apology” rather cursorily perhaps without a clear understanding of what the offer of an apology entails linguistically, if not morally. To obligate clinicians to engage in such endeavors is therefore naïve and possibly counter-productive to the goal of patient safety.

Apology, in a standard dictionary is defined as “a written or spoken expression of one's regret, remorse, or sorrow for having insulted, failed, injured, or wronged

\textsuperscript{157} RHODES, supra note 6 at Basic Principles of Human Performance.


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." Such definitions leave no doubt as to the fact that apologies, as illocutionary acts, include a statement of fault. The consensus as to the requirement of admission of fault is also confirmed by empirical studies on the uses of apology in legal settlements. Robbenolt has subdivided apologies into “partial” apologies and “full” apologies.

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:

- [h]as 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

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161 Bruce W Darby and Barry R Schlenker, Children's reactions to apologies. 43 J. Personality and Social Psychology, 742, 753 (1982).
163 Jennifer K. Robbenolt, Apologies and Legal Settlement: An Empirical Examination. 102 MICH. L. REV. 460, 484 (2003-2004) (defining "partial apology" as a statement that expresses sympathy, but does not admit responsibility. These are contrasted with "full apologies," in which the offender both expresses sympathy and accepts responsibility).
164 ERVING GOFFMAN. Chapter 4 Remedial Interchanges, in RELATIONS IN PUBLIC: MICROSTUDIES OF THE PUBLIC ORDER. 109 (Basic Books Inc, (1971) (describing the function of remedial work as ‘to change the meaning otherwise 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).
avowal henceforth to pursue that course; performance of penance and the volunteering of restitution."

The form of an apology is also varied; by saying "I apologize," one makes an explicit performative utterance. Utterances may be considered to be apologies without the benefit of an explicit statement. Apology utterances have been further classified as illocutionary acts, which succeed if the patient recognizes the expression as one of apology.

As such, apologies are different than other statements expressing responsibility, liability, sympathy, commiseration, condolence, compassion or a general sense of benevolence which 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.

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165 Id., at 113.
166 BACH, supra note 161 at 148.
167 BACH, supra note 161 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 inexplicitly).
168 JOHN LANGSHAW AUSTIN. Lecture VIII in HOW TO DO THINGS WITH WORDS. 94 ff. (J. O. Urmson and Marina Sbisà eds. 2nd ed. Harvard University Press 1962) (1975) (distinguishing three distinct levels of action beyond the act of utterance itself: He distinguishes 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) and dubs these locutionary, illocutionary, and perlocutionary acts, respectively.)
169 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, Wolfgang Linden, & Martine E. Habra. Influence of Apologies and Trait Hostility on Recovery from Anger. 29 J. BEHAVIORAL 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
In order for an 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 ("affirms a belief in the offended rule"), and therefore conveys that the speaker will be able to avoid the offense in future interactions. The admission of responsibility further performs the function of "splitting the self in preparation for the expression of regret or remorse that will serve as an indication of the separation of the good, innocent self from the guilty self."

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, increase emotions of remorse or regret attributed to the speaker, and enhance 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 states that an apology is at issue. Apology strategies which 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 (s)he actually say that what (s)he is doing is apologizing. Other choices, 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 (s)he is responsible for or that he regrets/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”, without an expression of remorse, does not convey the required information about the emotional state of the speaker.

Remorse and regret are the primary information intended to be 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

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176 FRASER, supra note 170 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 ... ").
177 FRASER, supra note 170 at 264.
178 Scher & Darley, supra note 169 at 130.
179 FRASER, supra note 170 at 264.
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. In saying " I will make amends" the speaker certainly implies but does not make explicit that (s)he has some responsibility and feels regret. It is an offer to try to correct the situation, to try to partially restore the patient to their 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 health care system to make such an offer 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.

3 Malpractice Insurance Coverage and the Physician as Independent Contractor

Among the practical issues which 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

180 GOFFMAN, supra note 164 at 117.
181 FRASER, supra note 170 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")
182 FRASER, supra note 170 at 264.
183 Scher & Darley, supra note 169 at 130.
health care 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, will pay for the claims. However, liability insurance may impose upon the insured a *general duty of cooperation* with the insurance company to defend claims.\(^{184}\) Some liability insurance policies also specifically prohibit the insured from voluntarily assuming liability.\(^{185}\) 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:\(^{186}\) 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?\(^{187}\)

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.)\(^{188}\) If instead of apologizing the insured simply recounts the facts as known, he insured is offering information that he would likely have to admit in depositions, or at trial.\(^{189}\)

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\(^{185}\) *Id.*, at 1025 (citing also Jeffrey W. Stempel, *Interpretation Of Insurance Contracts §31.9* (1994)).

\(^{186}\) *Id.*, at 1025.

\(^{187}\) *Id.*

\(^{188}\) *Id.* (citing also 8 John A. Appleman & Jean Appleman, *Insurance Law And Practice § 4771* (1981)).

\(^{189}\) *Id.*, 1025.
The harder case for the injured party 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. One distinction that has been drawn by courts is that statements by the insured that (truthfully) admit fault may not void coverage (a good thing as statements of fault will likely result in verdicts for the plaintiff) while statements that assume (financial) liability will void coverage.

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. However, on balance such statements are more likely to be admitted into evidence against physicians than not:

\[\ldots\text{we must, \ldots resolve every conflict in their testimonies in favor of plaintiff, consider every inference which can reasonably be drawn and every presumption which can fairly be deemed to arise in support of plaintiff, and accept as true all evidence adduced direct and indirect which tends to sustain plaintiff's case.}\]

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 in the standard of care, breach and causation in some cases. Well-intentioned, compassionate doctors have had their statements used

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190 Annotation, Validity, Construction, and Effect of "No-Consent-to-Settlement" Exclusion Clauses in Automobile Insurance Policies, 18 A.L.R. 4th 249, II. Exclusion clause governing claims against insured § 4(a) and § 4(b) (1981). Citing cases where courts have variously upheld and rejected such clauses.

191 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.").

192 Wei, supra note 11 at 110.

against them in a later malpractice suit. Most cases include statements, invariably recalled by the plaintiff, family or friends that lack compassion when taken out of the context of the whole conversation. In *Colbert v. Georgetown*, a District of Columbia Court case, 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. In *Snyder v. Pantaleo*, statements by the physician defendant to another were used as expert testimony as to breach of standard of care. 122 A.2d 21 (1956).

In a California wrongful death suit, *Sheffield v. Runner*, the defendant stated that in a patient with bacterial pneumonia, ‘I should have put her in the hospital.’ Foreshadowing inter alia Oklahoma case law, the California District Court of Appeals approvingly cited *Lashley v. Koerber* affirming that a physician’s statements could not only prove liability but be used as expert testimony as to breach of standard of care.

According to the testimony of 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

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194 Colbert v. Georgetown Univ., 623 A.2d 1244, 1253 (D.C.1993) (reversed *en banc* on other grounds (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 that he had performed “the wrong operation”; and that he “had forgotten” lumpectomy was inappropriate for multicentric cancer.) *see also* Abbey v. Jackson, 483 A.2d 330, 333-334 (D.C.1984) (holding that plaintiffs may elicit from the defendants or their agents the expert opinion necessary to establish a prima facie case of malpractice.)

195 Snyder v. Pantaleo, 122 A.2d 21, 23 (Conn. 1956) (holding that defendant radiologist's statement to the deceased's family physician was expert testimony of the standard of care and its breach.)

196 Sheffield v. Runner, 328 P.2d. 828, 829 (Cal App, 1958) (finding that the case was sufficient to reverse a nonsuit judgment by the trial court and submit to the jury.)


198 Lashley v. Koerber, 156 P.2d 441, 445 (Sup. Ct. Cal. 1945) (finding that a jury could reasonably conclude that the alleged admission of the defendant physician to plaintiff constituted breach of the standard of care).
judgment constituting 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, 324 P.2d 661, 667 (1958) 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 directed verdicts after a jury has

199 Robertson v. LaCroix, 534 P.2d 17, 22 (Okla. App. 1975) (holding that physician's statement that he "just made a mistake and got over too far" during surgery was prima facie evidence of the standard of care and its breach);
200 Woronka v. Sewall, 69 N.E.2d 581, 582 (Mass 1946). (holding that “[the defendant’s] mere use of the word ‘negligence’ supplies the essential elements to justify a necessary finding of liability on his part.” and that “much more is contained in the admissions than the mere use of that word.”)
No Role for Apology: Remedial Work and the Problem of Medical Injury

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 physician’s out of court statements, including apologies, are insufficient to establish the standard of care or its breach. 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. Further, whether or not statements are admissible is less important from a strategy standpoint in that an apology explicitly providing details of where a defendant physician believes they or others in the health care setting went wrong is certain (in the hands of a good plaintiff’s attorney) to have breached the standard of care when reviewed by an expert witness for the plaintiff. In general, courts seem to be 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

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203 Wooten v. Curry 362 S.W.2d 820, 822 (Tenn.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.)
204 Woods v. Zeluff, 158 P.3d. 552, (UT 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 warrants a new trial.)
following: “And I said, ‘Well, how did this all happen?’ He said, ‘I’m sorry, I
accidentally cut the nerve to your vocal cord.’ ” 205 In Senesac v. Associates in Obstetrics
& Gynecology, plaintiff testified that shortly after the operation the defendant “admitted
that she had made a mistake.” 206 The Supreme Court of Vermont affirmed a defendant’s
motion for summary judgment after 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.” 207 In Giles v. Brookwood Health Services, Inc, the defendant was sued for removing
a normal right rather than a diseased left ovary. 208 Defendant Adcock admitted that
plaintiff’s husband Giles “. . . was absolutely right, that it was the left side that should
have been removed. ‘I am so sorry’ . . .” 209 He stated that he was thinking of our talks in
the office and he took for granted that it was the right . . .” when he saw all of the scar
tissue, that the right was the correct ovary to take out, and your wife pointed to the right
side just before the surgery. 210 “I advised Dr. Adcock . . . to check your records before
beginning surgery, because the male anesthesiologist that was in the room indicated that
you were scheduled to remove the right. I asked Dr. Adcock, how could that be right that
the right ovary was removed? He stated that he just took it for granted that the right ovary

205 Jeffries v. Murdock, 701 P.2d. 451, 453 (1985). (holding that the significance of the defendant’s alleged
statement was negated by testimony of defense expert witnesses and by plaintiff’s failure to present any
evidence to the contrary.)
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.)
207 Phinney v. Vinson, 605 A.2d 849, 849 (VT Sup Ct. 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.)
208 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.)
209 Id.
210 Id.
was the correct one.”

Dr. Adcock advised me that he forgot to look at the charts or his notes before starting the surgery. He stated that he remembered after I mentioned the left ovary, he stated again, ‘Mr. Giles, I am so sorry ... we can always go back after maybe four to six weeks to get the correct one, I did see some growth on the right ovary that we took out.

When physicians describe adverse events as "mistakes" or "accidental" some courts have held that such out-of-court statements are not enough to establish a prima facie case in the absence of expert testimony. In Maxwell v. Women's Clinic, plaintiff’s husband testified: ‘And 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.’

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, paraphrasing; argued were 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....’

In a federal diversity case, Sutton v. Calhoun, family members of the plaintiff alleged that after the operation the defendant [who denied the statement] came to them and said he had “made a mistake,” that he should not have cut the common bile duct.

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211 Id.
212 Id.
213 Maxwell v. Women's Clinic, P.A. 625 P2d 407, 408 (Idaho Supreme Court 1981) (holding that plaintiff’s statement and act of nonbilling for the surgery together would not be sufficient to create the required inference about failing to meet the community standard.)
214 Locke v. Pachtman 521 N.W.2d 786, 789 (Sup. Ct. 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.)
215 Sutton v. Calhoun, 593 F.2d 127, 128 (Okla. Civ App. 1979) (holding that it was proper for the court to refuse to give an instruction to the jury that if the “mistake” statement was made it was an admission of negligence.)
Lastly, in an older case, still good law, *Quickstad v. Tavenner* after a needle was retained in the chest cavity during thoracentesis, the plaintiff alleged statements, all denied by defendant, that ‘he broke the needle’; he ‘should have used a stronger needle’; he ‘shouldn’t have done it’ and would ‘never try it again’.\(^{216}\) In some instances, written documents or statements that are provided by the physician either spontaneously or in response to a patient’s request after an “apology” or other verbal act is made have been held inadmissible.\(^{217}\)

In some of the cited cases discussed above, statements attributed to defendant physicians were denied but admitted into evidence anyway. In some circumstances the statements were admitted as proofs of negligence, and in some cases, not. Apology laws will not make case law more predictable by barring admission of apologies into evidence. 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 that logic is to ignore the much deeper problem that the kind of apologies that these laws seek to protect are ones that are given in the context of adverse events and medical errors. Apology laws are not necessary to enable doctors to deliver statements of empathy and understanding in the everyday situation; physicians frequently and without hesitation can say to their patients that they are sorry that their patients are experiencing pain or suffering. These are not scenarios to which the apology laws are concerned. Apology laws are supposed to help doctors speak up when medical errors occur—to push doctors to engage in apologies as part of disclosure. In this way, apology laws do not

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\(^{216}\) *Quickstad v. Tavenner* 264 N.W. 436, 436 (Sup. Ct. Minn. 1936) (holding that defendant’s statements were not enough to support a prima facie case for the plaintiff).

\(^{217}\) *Smith v. Karen S. Reisig, M.D., Inc.*, 686 P.2d 285 (1984) (holding that defendant doctor's statement in the medical record that injury to plaintiff's bladder was "inadvertent" was not an admission of negligence).
tackle the more fundamental issue that physicians struggle with apologies as part of disclosure of medical errors.

C How, Exactly, Does “Sorry” Work?\textsuperscript{218}

One of the most strident voices for requiring physicians to say “I’m Sorry” is that of the “Sorry Works!” coalition. “Sorry Works!” has proposed that after patients experience adverse events (or other “bad outcomes”), root cause analyses would need to be performed - presumably by a panel of members of the health care 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{219} “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.

A more troubling aspect of the “Sorry Works!” agenda would be the requirement of determining whether standard of care was met. The Coalition notes such analysis may take weeks to months and may involve the assistance of “outside experts”. A root cause analysis which shows that the standard of care was not met—through medical error or negligence,\textsuperscript{220} require providers to admit fault, apologize to the patient and/or family (which as previously discussed is tantamount to admitting fault), 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 (as determined, presumably, by expert


\textsuperscript{219} The Joint Commission, supra note 108.

\textsuperscript{220} Breach of standard of care is by definition negligence, a legal term which can only be determined by finders of fact in a court of law.
witnesses such as actuaries.) The attorney(s) 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 health care organization essentially 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 the likelihood of such screening panels in unlikely to provide meaningful assistance in the analysis and disposition of claims, concluding that: “neither theory nor experience strongly supports proponents’ optimistic view of screening panels.” Further, a significant number of states which had adopted screening panel provisions subsequently repealed or invalidated them. Although somewhat dated when compared to the current malpractice climate, Danzon analyzed insurance company data on claims closed throughout the 70’s in response to a previous malpractice crisis which occurred in 1975. 1970 and 1975-1978. She found that pretrial screening panels had no significant effect on malpractice claims frequency or severity.

221 Wojcieszak et al., supra note 218 at 345.
223 Id., at 57.
225 Patricia M. Danzon. The Frequency and Severity of Medical Malpractice Claims: New Evidence. 49 Law and Contemporary Problems 57, 78 (1986) (concluding that the effect of screening panels on claim
Concerns regarding 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, panels are likely to “entail the costs and delay that panels are intended to prevent.”

**D Statutory Approaches: The “Apology” Laws**

Federal Rule of Evidence 408, which has been widely adopted into state law, could be said to be a type of protected statement. 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 excluded. A survey of states enacting apology laws identified 34 states and the District of Columbia as having some protected disclosure of certain statements made by putative offenders to victims. Of the 35 identified statutes, 25 explicitly mention the word “apology.” Only one state, Montana, defines apology and includes in the

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227 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.

228 For a detailed list of states which were identified as having disclosure statutes, see Appendix 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.

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; evidence of a desire to keep apologies separate from other statements, as admissions of fault.\footnote{Scher & Darley, supra note 169 at 129; Fraser, supra note 170 at 262; Coulmas, supra note 172 at 76; see also Lee Taft, Apology Subverted: The Commodification of Apology, 109 YALE L. J. 1135, 1139-43 (2000).}

Eight states do not explicitly mention health care providers or patients,\footnote{California, Florida, Hawai‘i, Indiana, Massachusetts, Missouri, Tennessee, and Texas.} 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 states allow health care providers or health care professionals, as well as employees or agents of health care providers or health care professionals.\footnote{Arizona, Colorado, Connecticut, Delaware, District of Columbia, Georgia, Idaho, Maine, Nebraska, North Dakota, Ohio, Oklahoma, South Carolina, Virginia, West Virginia and Wyoming.} Oregon requires the person by or on whose behalf statements are made to be a licensed professional and against whom civil action is taken. New Hampshire is completely silent, which presumably means any individual is able to make a protected statement. North Carolina and Louisiana restrict the making of protected statements only to health care 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 of the consequences of the adverse event.\footnote{233} Utah awaits the bringing of a claim, and limits protective statements made by or on behalf of defendants who are health care providers.

There is variability in persons to whom protected statements may be made. In all cases the alleged individual is included, as are those persons defined as relatives and/or family members.\footnote{234} A subgroup of states has also included a variety of other representatives.\footnote{235} South Carolina requires that, in order to be protected, the statements must be made during a designated meeting to discuss the unanticipated outcome.

The circumstances under which statements are rendered admissible or inadmissible has also been addressed. Most states have protected, as inadmissible, the content of statements only as 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.\footnote{236} 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 who have made expressions of

\footnote{233}{\phantomsection\addcontentsline{toc}{footnote}{}Illinois had shortened the time frame to 72 hours but this statute was, as noted in Table 1, declared unconstitutional.}

\footnote{234}{\phantomsection\addcontentsline{toc}{footnote}{}States use, variously, the term victim, patient, plaintiff or person.}

\footnote{235}{\phantomsection\addcontentsline{toc}{footnote}{}Various states includes “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”}

\footnote{236}{\phantomsection\addcontentsline{toc}{footnote}{}Fed. R. Evid. 804. Hearsay Exceptions: Declarant Unavailable (b)(3) \textit{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.}
regret or apology; Vermont has similar provisions. Virginia protects the making of such statements only if death has occurred.

Fourteen states allow, variously, 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 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...

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239 Ken Braxton & Kip Poe, How Should Hospital Policy Address Apologies to Patients? 9 HOSPITALS AND HEALTH SYSTEMS Rx 22, 22 (2007)(admonishing “Hospitals must ensure that their risk management and legal staff fully understand their applicable state law regarding “I am Sorry” guidelines...); MICHAEL S. WOODS, HEALING WORDS: THE POWER OF APOLOGY 14 (Joint Commission Resources 2nd ed. 2007) (stating the five "R"s of an effective apology include recognition, regret, responsibility, remedy, and remaining engaged); Kathy Wire, Apology Just First Step In Event Management. 30 MEDICAL 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).
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 health care apologies would create at least three types of problems for effective communication between physicians and patients or their families. Trying to craft a health care 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 24 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 an proposed apology text invites revision and possible change of intended meaning. Lastly, apologies will essentially fit the contours of any statutory protection for health care apologies will result: “Simply put, once there is a safe harbor, all boats will moor there.”

III Rational Alternatives to an Apology

240 Robbenolt, supra note 163 at 506.
241 Lucinda E. Jesson & Peter B. Knapp, My Lawyer Told Me To Say I'm Sorry: Lawyers, Doctors, and Medical Apologies. 35 WM. MITCHELL L REV 1410, 1445 (2009)(noting that the creation of an evidentiary exclusion for medical apologies inevitably means the creation of new work for lawyers.)
242 Id., at 1447.
243 Id.
244 THE JOINT COMMISSION, Chapter 3: Disclosing Medical Errors in DISCLOSING MEDICAL ERRORS: A GUIDE TO AN EFFECTIVE EXPLANATION AND APOLOGY 53 (Joint Commission on Accreditation of Healthcare Organizations Resources 2007).
245 Jesson & Knapp, supra note 241 at 1449.
246 Id., at 1451.
The disciplined, systematic approach of empathy ("I'm sorry this happened) coupled with competent patient service immediately after an injury, an investigation (root cause analysis), and then the 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 health care institutions disclose an error. The physician may have not have made a mistake, a mistake was made but without causation in the injury or death; or a mistake was made, causation was shown, but a systems error was responsible.

A Change the Correct Rule

The systems approach of patient safety to reducing error is diametrically opposed to the deterrence approach of medical malpractice liability. Leveling fault at an individual physician or other health care worker for the occurrence of a complex systems error will not prevent the same or similar errors from happening again.247 Progress will be slowed since “[e]rror identification requires a comfortable and candid relationship among members of a health care team, built on trust among members that errors may be openly discussed without fear of sanction in all but the most egregious cases.”248 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.249

Rather than focus on legislation which “protects” apologies from admission into evidence, a better strategy might be to strengthen protections in other rules of evidence,

247 Richardon et al., supra note 3 at 4.
249 Richardon et al., supra note 3 at 87.
such as FRE 803(6).\textsuperscript{250} 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.\textsuperscript{251} 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.\textsuperscript{252} Once adverse events are identified and analyzed, health care systems can be redesigned so as to eliminate or minimize them. The highly successful Aviation Safety Reporting System (ASRS) is good example of the type of reporting system needed in health care.\textsuperscript{253} However, for such reports to be comprehensive and “kept in the course of a regularly conducted business activity”\textsuperscript{254} the protections regarding discovery and admissibility should be further strengthened.

A successful reporting system such as the ASRS is typically nonpunitive, confidential, anonymous, independent, timely, systems oriented, and responsive to issues

\textsuperscript{250} Fed. R. Evid. 803. Hearsay Exceptions; Availability of Declarant Immaterial (6) \textit{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, \textit{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.

\textsuperscript{251} John R. Clarke, \textit{Making Surgery Safer}. 200 J. AM. C. SURGEONS 229, 233 (2005) (abridging recommendation 7 of the Agency for Healthcare Research and Quality (AHRQ)).

\textsuperscript{252} Lucinda Glinn, \textit{Navigating Provider Protections for Quality of Care Reports—From Peer Review Statutes to Common Law Privileges} 9 HOSPITALS AND HEALTH SYSTEMS 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).

\textsuperscript{253} RHODES, \textit{supra} note 6 at Nature and Characteristics of Systems, \textit{see also REASON, supra} note 7 at vii).

\textsuperscript{254} Fed. R. Evid. 803(6), \textit{supra} note 250.
The absence of a punitive focus reduces health care 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 health care 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 three times greater than the actual risk, and there is no good correlation between hospitals' claims ratings and their injury rates. 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

259 RHODES, supra note 6 at Challenges to the Traditional Surgical Paradigm.
regulations. However, unless strict confidentiality 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.

B. Strengthen Protections for Reporting of Adverse Events

Acknowledging the concerns related to self-policing in the health care industry, health care professionals are best positioned to make patients safer – certainly so with respect to plaintiff’s attorneys and legislators. 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. The federal government has long understood 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 which 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).

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260 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).
261 Agency for Healthcare Research and Quality: Reauthorization Fact Sheet http://www.ahrq.gov/about/ahrqfact.htm (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.) (last visited 12/01/09).
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.\(^\text{262}\) The act required the creation of patient safety organizations to collect, aggregate, and analyze confidential information reported by health care providers. PSQIA also calls for establishing a network of patient safety databases as an interactive, evidence-based management resource. However, there are short-comings 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.”\(^\text{263}\) Further, any information shared with patients or families, whether a limited factual disclosure or an apology, is not protected.

\(^{262}\) Public Law 109–41—July 29, 2005 Patient Safety And Quality Improvement Act Of 2005 http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_cong_public_laws&docid=f:publ041.109.pdf (last visited Jan. 30, 2010) (summarizing the Law as: 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. Summary can be found at: http://www.thomas.gov/cgi-bin/bdquery/z?d109:SN00544:@@@D&summ2=3& last accessed 01/30/10).

In the health care setting, safety can be defined as freedom from accidental injury.\textsuperscript{264} Apologies, to the extent they inhibit full disclosure of the causes of adverse events also serve to inhibit and render less effective attempts to enhance patient safety. This definition recognizes that avoidance of accidental injury is an overarching goal from the patient’s perspective. In the past decade, the definition of patient safety has been expanded to acknowledge patient safety as both emerging discipline and a process.\textsuperscript{265} A number of states have begun to protect patient safety analyses from discovery or as evidence in most civil proceedings.\textsuperscript{266} 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.\textsuperscript{267} 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.\textsuperscript{268} In Virginia, no privilege to a health care provider, emergency medical services agency, community services board, or behavioral

\textsuperscript{264} Richardson et al., supra note 3 at 18.

\textsuperscript{265} Linda Emanuel, Don Berwick, James Conway, John Combes, Martin Hatlie, Lucian Leape, James Reason, Paul Schyve, Charles Vincent, Merrilyn Walton, What exactly is patient safety? INFORMED 2010-2011 PENNSYLVANIA PATIENT SAFETY UPDATE http://pa.cme.edu/index.aspx (last accessed July 5th 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.”)


\textsuperscript{267} OR. REV. STAT. ANN. § 442.846 (2003).

\textsuperscript{268} VT. STAT. ANN. tit. 18, § 1917 (2005).
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.269

C Disclosure of the Adverse Event: Account, Not Apology

As errors - 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 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.270

At this point, it should be clear that encouraging surgeons to apologize for adverse events is counterproductive to the goal of improving patient safety. Surgeons should, however, be involved in a process of disclosure to insure 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 is the offering of external, mitigating circumstances and is a form of remedial work which seeks to reduce the responsibility of the transgressor for the

transgression.\footnote{Marvin B. Scott & Stanford M. Lyman, \textit{Accounts}, 22 AM. SOC. REV. 46, 46 (1968) (defining accounts as statements made to explain untoward behavior and bridge the gap between actions and expectations); \textit{Erving Goffman, Relations in Public: Microstudies of the Public Order} (Basic Books Inc. 1971); C. R. Snyder, Raymond L. Higgins, & Rita J. Stucky, \textit{Chapter 10: The Value of Excuse Making in Excuses: Masquerades in Search of Grace} 300 (John Wiley & Sons 1983).} 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, a frank discussion in which the health care 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.\footnote{H. L. A. Hart Chapter VIII The Ascription of Responsibility and Rights in Logic and Language (First Series): Essays by Professor Gilbert Ryle, Professor J. N. Findlay; Paul Edwards; Margaret MacDonald; G. A. Paul; Dr. F. Waisman 147-60 (John Wisdom & Antony Flew eds. Basil Blackwell Publishers 1952) (noting that philosophical difficulties arise when ignoring the concept of human action as ascriptive and defeasible while searching for its necessary and sufficient conditions. The ascription and assumption of responsibility of assertions with simple utterances such as ‘I’m sorry’, ‘I apologize’, or I did it’, are, primarily speech acts by which one confesses or admits liability.)} Austin has further separated such accounts, or in his vernacular, excuses, into several types of speech acts.\footnote{\textit{Id.}, at 124.} One may discuss having performed an action, but also justify, or give reasons for the action.\footnote{\textit{Id.}, at 124.} 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. 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. Austin argues against easy solutions:

“If 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 into place into some single, interlocking, consistent, conceptual scheme. Not only is there no reason to assume this, but all historical probability is against it . . .”

The same is arguably true for the wide variety of terms which 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” and stands alone as a strategy more harmful to patient safety and more likely to condemn health care 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. The development of an account is not to be taken lightly, and falls generally into one of two broad categories, both of which are underutilized in modern discourse;

275 Id.
276 Id. (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 271 at 109.
277 AUSTIN, supra note 273 at 151.
278 AUSTIN, supra note 262 at 151 n. 1.
279 Scott & Lyman, supra note 271, at 46 (noting accounts are important speech acts which can be employed whenever adverse events occur and are, inevitably, subject to “evaluative inquiry”).
excuses and justifications. Accounts in particular, are useful in the disclosure of an adverse event. 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 or frozen - are likely to be useful in giving an account of an adverse event.

IV Conclusions

Since 2004, there has been a steady decline in the number of reported wrong-site surgeries in Pennsylvania. Fewer patients subjected to a wrong operation are but one tangible result of the emphasis placed on patient safety. The decrease is multifactorial; implementation of a universal protocol “pause for safety”, intra-institutional confidential reporting of the adverse event, mandatory reporting to a state patient safety authority, and root cause analysis to prevent similar events in the future. Threat of litigation does not drive this process; rather the intent of health care organizations to “do the right thing” coupled with the

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280 Scott & Lyman, supra note 271 at 47. (describing excuse as “a socially approved vocabulary for mitigating or relieving responsibility when conduct is questioned.” Four modal forms are described: appeal to accident, defeasibility, biologic drive, and scapegoating) see also HART supra note 261 at 160. (providing further discussions of defeasibility “the capacity of being voided”.)
281 Id.
282 Id., at 56. (distinguishing the three 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).
283 Id.
knowledge of administrative action affecting licensing or accreditation makes such an approach effective.

Apologies, statements of regret, remorse and responsibility do little to improve the process, and open up the involved individuals and organizations to liability and loss. 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. Such disclosure is a part of the process of making patients safer; but in a complex, imperfect system such as that of modern healthcare, there is no role for apology.
<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</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>health care provider or an employee of a health care provider</td>
<td>made to that person or to the family of that person</td>
<td>Not explicit as to patients or health care; A statement of fault, however, which is part of, or in addition to, any of the above shall not be inadmissible.</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>D. C. CODE § 16-2841 (2007) 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</td>
<td>Nothing herein shall preclude the court from permitting the introduction of an admission.</td>
</tr>
<tr>
<td>Source</td>
<td>Language</td>
<td>Description</td>
<td>Plaintiff</td>
<td>Defendant</td>
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<tr>
<td>FLA. STAT. ANN. § 90.4026 (West 2001) Statements expressing sympathy; admission of liability</td>
<td>English</td>
<td>The portion of statements, writings, or benevolent gestures expressing sympathy or a general sense of benevolence</td>
<td>individual who claims damages by or through that victim</td>
<td>made to that person or to the family of that person</td>
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<td>A statement of fault, however, which is part of, or in addition to, any of the above shall be admissible</td>
<td></td>
</tr>
<tr>
<td>GA. CODE ANN. § 24-3-37.1 (West 2006) Statements or activities constituting offers of assistance or expressions of regret, mistake, etc.; not admission of liability</td>
<td>English</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>the patient, a relative of the patient, or a representative of the patient</td>
<td>The General Assembly issued findings regarding this statute.</td>
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<td>Statements are inadmissible as evidence and shall not constitute an admission of liability or an admission against interest</td>
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<td>HAW. REV. STAT. § 626-1 (2007) Admissibility of expressions of sympathy and condolence</td>
<td>English</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>
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<td>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.</td>
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<tr>
<td>IDAHO CODE ANN. § 9-207. (2006) Admissibility of expressions of apology, condolence and sympathy</td>
<td>English</td>
<td>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</td>
<td>a patient or family member or friend of a patient</td>
<td>inadmissible as evidence for any reason including, but not limited to, as an admission of liability or as evidence of an admission against interest</td>
</tr>
<tr>
<td>735 ILL. COMP. STAT. ANN. § 5/8-1901 (West 2005) Admission of liability--</td>
<td>English</td>
<td>Any expression of grief, apology, or explanation provided by a health care provider</td>
<td>a patient, the patient's family, or the patient's legal representative about an</td>
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<td>This section was found unconstitutional due to inseverability with other</td>
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| 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. |

IND. CODE ANN. § 34-43.5-1-3 (West 2006) Communication of sympathy defined; IND. CODE ANN. § 34-43.5-1-4 (West 2006) Admissions into evidence; § IND. CODE ANN. § 34-43.5-1-5 (West 2006) Statements of fault |

A court may not admit into evidence a communication of sympathy ("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.) |

agent thereof, a physician, or other licensed health care professional.) |

inadequate or unanticipated treatment or care outcome that is provided within 72 hours |

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. |

A court may admit a statement of fault into evidence, including a statement of fault that is part of a communication of sympathy, if otherwise admissible under the Indiana Rules of Evidence. |

that relates to causing or
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<tr>
<th>Appendix 1 Steven E. Raper, M.D.: No Role for Apology: Remedial Work and the Problem of Medical Injury</th>
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<tbody>
<tr>
<td><strong>IOWA CODE ANN. § 622.31 (West 2007) Evidence of regret or sorrow</strong></td>
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<td>that portion of a statement, affirmation, gesture, or conduct expressing sorrow, sympathy, commiseration, condolence, compassion, or a general sense of benevolence</td>
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<td><strong>LA. REV. STAT. ANN. § 3715.5 (2005) Confidentiality of communication from health care provider</strong></td>
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<tr>
<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>
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<td><strong>ME. REV. STAT. ANN. tit. 24, § 2907 (2009) Communications of sympathy or benevolence</strong></td>
</tr>
<tr>
<td>any statement, affirmation, gesture or conduct expressing apology, sympathy, commiseration, condolence, compassion or a general sense of benevolence</td>
</tr>
<tr>
<td><strong>MD. CODE ANN., CTS. &amp; JUD. PROC. § 10-920 (2005)</strong></td>
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<td>an expression of regret or apology, . . . including an expression of regret or apology, . . .</td>
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<td>Health care providers; expression of regret or apology</td>
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<td><strong>MASS. GEN. LAWS ch. 233 § 23D (West 2000)</strong> Admissibility of benevolent statements, writings or gestures relating to accident victims</td>
</tr>
<tr>
<td><strong>MO. REV. STAT. § 538.229 (West 2005) Certain statements, writings, and benevolent gestures inadmissible, when--definitions</strong></td>
</tr>
<tr>
<td><strong>MONT. CODE ANN. § 26-1-814 (2005) Statement of apology, sympathy, or benevolence--not admissible as evidence of admission of liability for medical malpractice</strong></td>
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<td><strong>NEB. REV. STAT. § 27-1201 (2007) Unanticipated outcome of medical care; civil action; health care</strong></td>
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Appendix 1 Steven E. Raper, M.D.: No Role for Apology: Remedial Work and the Problem of Medical Injury

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<td>condolence, compassion, or a general sense of benevolence</td>
<td>A statement, writing, or action that expresses sympathy, compassion, commiseration, or a general sense of benevolence</td>
<td>A statement, writing, or action that expresses sympathy, compassion, commiseration, or a general sense of benevolence</td>
<td>A statement, affirmation, gesture, or conduct . . . that expresses apology, sympathy, commiseration, condolence, compassion, or benevolence</td>
<td>any and all statements, affirmations, gestures, or conduct expressing apology, sympathy, commiseration, condolence, compassion, or a general sense of benevolence</td>
<td>any and all statements, affirmations, gestures, or conduct expressing apology, sympathy, commiseration, condolence, compassion, or a general sense of benevolence</td>
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<tr>
<td>admissible. inadmissible as evidence of an admission of liability or as evidence of an admission against interest.</td>
<td>that individual or to the individual’s family</td>
<td>This section does not apply to a statement of fault, negligence, or culpable conduct that is part of or made in addition to a statement, writing, or action inadmissible as evidence of an admission of liability in a medical injury action</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>not admissible as evidence of liability or as an admission against interest in a civil action, arbitration proceeding, or administrative hearing regarding the health care provider</td>
<td>inadmissible as evidence of an admission of liability or as evidence of an admission against interest</td>
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## Statements, conduct, etc. expressing apology, sympathy, etc.--Admissibility--Definitions

<p>| Oregon Revised Statutes Annotated § 677.082 (West 2003) | 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. |
| South Carolina Code Annotated § 19-1-190 (2006) South Carolina Unanticipated Medical Outcome Reconciliation Act; legislative purpose; definitions; inadmissibility of certain statements; waiver of inadmissibility; impact of South Carolina Rules of Evidence. | 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 unanticipated 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 |
| <strong>TENN. RULES OF EVIDENCE; Article IV. Relevance; Rule 409.1. Expressions Of Sympathy Or Benevolence</strong> | 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 | the inadmissibility of the statements | 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. |
| <strong>TEX. CIV. PRAC. &amp; REM. CODE ANN. § 18.061 (Vernon 1999) Communications of Sympathy</strong> | 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; | 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. |
| <strong>UTAH CODE ANN. § 78B-3-422 (West 2006) Evidence of disclosures—Civil proceedings—Unanticipated outcomes—Medical care</strong> | 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) | Does not alter any other law or rule that applies to the admissibility of evidence in a medical malpractice action |
| <strong>VT. STAT. ANN. tit. 12 § 1912 (West 2005) Expression of regret or apology by health care provider inadmissible</strong> | An oral expression of regret or apology, including any oral good faith explanation of how a medical error occurred | made by or on behalf of a health care provider or health care facility, that is provided within 30 days of when the | does not constitute a legal admission of liability for any purpose and shall be inadmissible in any civil or |</p>
<table>
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<th>Code</th>
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<tr>
<td>Va. Code Ann. § 8.01-52.1 (West 2009) Admissibility of expressions of sympathy</td>
<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 from a provider or facility knew or should have known of the consequences of the error may not be examined by deposition or otherwise with respect to the expression of regret, apology, or explanation.</td>
</tr>
<tr>
<td>WASH. Rev. Code Ann. § 5.64.010 (West 2006) 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.</td>
<td>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 administrative proceeding against the health care provider or health care facility, including any arbitration or mediation proceeding. 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>
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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.

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