Annals of Health Law

Volume 14
Issue 1 *Winter 2005*

Article 4

2005

Apology and Medical Mistake: Opportunity or Foil?

Lee Taft

Apology and Medical Mistake: Opportunity or Foil?

Lee Taft[*]

I. INTRODUCTION

Everyone makes mistakes. Being fallible is a part of being human, an anthropological fact that links all humans regardless of race, ethnicity, or culture.[1] As children we learn that there are procedures to follow in the wake of error, pathways that invite us to look at the harm we have caused, amend for the injuries we have inflicted, and, in so risking, create opportunities for forgiveness and reconciliation. As we age, it becomes more difficult to acknowledge harms caused because, in part, we have gained the maturity and insight to recognize what it means to be *a*, and sometimes, *the* cause of another's suffering. Yet, it is not only the experience of contributing to another's suffering that prompts us to distance ourselves from admitting wrongdoing: we are also afraid of the consequences that truth-telling sometimes demands. This is why authentic adult expressions of remorse are rare. When the discourse of mistake and accountability is translated into the modern medical environment, where the consequence of mistake can be patient death or disability with attendant legal liability, the stakes rise dramatically. This is why physicians often choose silence when struggling between truth and fear.

In 1999, the Institute of Medicine (IOM) published a now well-known study called *To Err is Human*.[2] According to this study, patient deaths from

[*] Lee Taft, J.D., M. Div., is an ethicist who provides solutions for businesses, organizations, and individuals facing crisis in the wake of error by focusing on litigation strategies, client objectives, and the ethical opportunities crisis offers. Mr. Taft is grateful to Professor Ellen Smith Pryor for her intellectual support and guidance without which this essay would have languished. He would also like to acknowledge the scholars who continue to explore the interdisciplinary dimensions of apology; their work continues to be critical to the evolution of the author's thinking on this fascinating and important topic. Finally, the author would like to thank the *Annals of Health Law* editors, especially Valerie Witmer, for insightful comments and editorial guidance. Mr. Taft can be contacted at leetaft@earthlink.net.

1. Of course, rituals and discourse regarding amends are culturally dependent. This essay addresses the process in the western world, more particularly, the United States.

2. INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (Linda T. Kohn et al. eds., Nat'l Acad. Press 1999), *available at* http://www.iom.edu/Object.file/master/4/117/0.pdf (last visited Nov. 5, 2004) [hereinafter IOM].

medical errors were occurring at the shocking rate of between 44,000 and 98,000 deaths per year in the United States.[3] While these numbers have been contested, there is no doubt that large numbers of patients die from medical mistakes each year. Patient mortality from medical mistakes accounts for more deaths each year than from motor vehicle crashes, breast cancer, or AIDS.[4]

The economic costs tied to preventable medical errors are also enormous. According to the IOM report, the costs associated with such errors hover between $17 billion and $29 billion.[5] Half of these costs are attributable to ameliorative health care, and the balance to lost income, loss of household production, and disability costs.[6]

The IOM report proved to be a catalyst for change within the health care industry. In 2001, the Joint Commission for the Accreditation of Hospitals (JCAHO) published new patient safety standards, including a regulation requiring disclosure of unanticipated outcomes.[7] The new standard, as published in the 2004 Hospital Accreditation Standards, reads: "[p]atients and, when appropriate, their families are informed about the outcomes of care, treatment, and services, including unanticipated outcomes."[8] When questions arose regarding the breadth of the requirement, "JCAHO . . . clarified that accredited organizations must tell patients when harms occur to them in the course of treatment."[9] Today, disclosure of harmful outcomes is understood not only as a regulatory requirement, but also as an ethical obligation.[10]

Currently, the subject of disclosure is a hot topic leading hospitals and health care institutions to create committees, or charge those already in existence, with the task of drafting policies and procedures to address the disclosure of adverse events. An emerging issue within the conversation around disclosure is the use of apology in communicating unanticipated outcomes. Consultants are increasingly in demand for seminars on how to

3. *Id.* at 26.

4. *Id. See also* Lawrence Gostin, *A Public Health Approach to Reducing Error*, 283 JAMA 1742, 1742 (2000).

5. IOM, *supra* note 2, at 27.

6. *Id.*; Leslie Werstein Hann, *Safety Measures,* BEST'S REVIEW, Aug. 2000, at 38.

7. JOINT COMM'N ON THE ACCREDITATION OF HEALTHCARE ORGS., HOSPITAL ACCREDITATION STANDARDS (2001), Standard RI.1.2.2 [hereinafter JCAHO I]. This standard was renumbered so that in 2004 it is identified as Standard RI.2.90.

8. JOINT COMM'N ON THE ACCREDITATION OF HEALTHCARE ORGS., HOSPITAL ACCREDITATION STANDARDS (2004), Standard RI.2.90 [hereinafter JCAHO II].

9. Rae M. Lamb et al., *Hospital Disclosure Practices: Results of a National Survey*, 22 HEALTH AFFAIRS 73, 74 (2003).

10. AM. SOC'Y FOR HEALTHCARE RISK MGMT., *Disclosure: What Works Now & What Can Work Even Better*, MONOGRAPH, Feb. 2004, at 4 [hereinafter ASHRM I].

deliver the apology and some medical schools, such as Vanderbilt University School of Medicine, now require medical students and residents to take courses designed to address the communication of error through apology.[11] Although currently in vogue, the consideration of apology in the face of medical error is not new.

In 1986, American physician and writer David Hilfiker highlighted the tension between mistake and confession in a candid and poignant essay entitled *Mistakes*.[12] In his essay, he describes errors he made while working in a small town in Minnesota—mistakes that made the difference between life and death for some of his patients.[13] Hilfiker recognizes the inevitability and ubiquity of mistakes as an inescapable part of the human experience and sees a pedagogical and redemptive value in acknowledging error: "[s]hown our mistakes and forgiven them, we can grow, perhaps in some small way become better people."[14] Hilfiker sees that acknowledgment of mistakes actually invites connection between human beings, the admission creating "a process, a way we connect with one another and with our deepest selves."[15] Hilfiker describes the interdependency that arises between humans when the person who errs confesses and invites the person harmed to forgive, a deeply moral process between the offender and the offended.[16] There is mutuality in the multidirectional nature of the process: expression of remorse moving from the party who injures, thus inviting forgiveness, and, often, forgiveness granted and extended by the party harmed. It is a process that inspires humility in the recognition that today it may be me who errs and you who forgive. Yet tomorrow, it may be your turn to confess and mine to forgive. After all, we all err.

However, Hilfiker excepts doctors from this process because he believes the healing dimension heartfelt confession provides the broader population is not available to physicians.[17] One reason for this physician exception is Hilfiker's perspective that mistakes in the medical arena are different from those in the broader culture because "[a] doctor's miscalculation or oversight can prolong an illness, or cause a permanent disability, or kill a

11. Rachel Zimmerman, *Medical Contrition: Doctors' New Tool to Fight Lawsuits: Saying 'I'm Sorry,'* WALL ST. J., May 18, 2004, at A1.

12. *See* David Hilfiker, *Mistakes*, *in* ON DOCTORING 325-36 (R. Reynolds & J. Stone eds., 3d ed. 2001).

13. *Id.*

14. *Id.* at 328.

15. *Id.*

16. *Id.*

17. *Id.*

patient."[18] Another factor which Hilfiker believes impedes real confession is an expectation of perfection, arising from unrealistic views generated not only within the medical community itself, but also from the broader, outside society, especially patients and their lawyers.[19] The consequence is what Hilfiker describes as an "intolerable dilemma," a situation in which physicians "see the horror of [their] mistakes yet . . . cannot deal with their enormous emotional impact."[20] He concludes that while some "emotionally mature" physicians may disclose facts of what happened, rarely are such disclosures accompanied by "real confession,"[21] or by what I have described as authentic apology.[22]

For more than twenty years, I represented patients and families who had suffered as a result of medical error and sustained adverse outcomes as a result of preventable error or what is understood in legal terms as "medical negligence."[23] In the course of my practice, I interviewed three types of doctors: physicians offering guidance in case selection, those offering "expert" testimony, and, of course, the treating physicians. I often wondered if the doctors who had caused the injury suffered as we all do in the face of our mistakes. I wondered if they hungered to apologize, just as my clients hungered to hear the apology. Sometimes, I asked that question directly to the doctor during deposition. The doctor's lawyer invariably objected, refusing to allow the doctor to answer.

When one of my physician friends was confronted by a mistake and called to talk with me about the advice being provided by lawyers and risk managers, I learned that the urge to express sorrow in the face of error was as strong in a medical environment as in any other. Yet, the moral inclination was systemically interrupted. My friend was instructed never to admit mistake, acknowledge error, or apologize in a way that his words could be construed as an admission of wrongdoing. The heartfelt desire to amend the wrong was ignored and the doctor's own suffering was not considered. Instead, the physician was left in the untenable situation Hilfiker described, caught in an "intolerable dilemma" where the physician was completely aware of the error and its effects, yet shackled and silenced

18. Hilfiker, *supra* note 12, at 328.

19. *Id.*

20. *Id.* at 335.

21. *Id.*

22. Lee Taft, *Apology Subverted: The Commodification of Apology*, 109 YALE L.J. 1135, 1139-42 (2000).

23. This is different from a mere mistake in judgment; this is the legal standard required to impose civil responsibility, a standard that in lay terms means that in order to prevail, the injured patient (or the deceased patient's family) must establish that the physician failed to render that degree of care the patient could reasonably expect from other physicians within the accused physician's area of expertise.

by a system and its advisors.[24]

I write to counter the kind of advice and systemic perceptions that lock a physician within this "intolerable dilemma."[25] The purpose of this essay is to explore the healing possibilities of apology in the face of medical mistake. My thesis is that the authentic expression of remorse should be given voice, not only because morally and ethically it is the right thing to do, but also because it is potentially spiritually healing for both the patient and the physician. I will demonstrate that when cast into a legal arena, the authentic expression of remorse carries additional practical benefits that outweigh the real and presumed risks that lead lawyers, risk managers, and insurers to give advice like that provided to my friend. Hopefully, proof of the moral and practical dimensions of authentic apology will inspire physicians and others in the health care industry to think more critically in the face of advice that interrupts their moral inclinations and garner sufficient courage to "bring medical mistakes out of the closet."[26]

The recent requirement by JCAHO that patients be advised of all unanticipated outcomes, whether positive or negative, presents an opportunity for precisely the kind of moral conversations this essay seeks to address. Yet, an examination of the tenor of the conversations surrounding disclosures suggests that the opportunity before the industry may be lost because of misunderstandings about what constitutes a real apology. I begin my analysis in Part II by identifying the philosophical shifts regarding physician-patient communication that support systemic change. In Part III, I describe what I mean by authentic apology and outline its place within the moral dialectic between harm and reconciliation. In Part IV, I examine how different models for the disclosure of unanticipated outcomes suggest that error should be communicated and demonstrate the potential for harm when apology is appropriated as a communication strategy rather than understood as an integral part of a larger moral conversation. In Part V, I analyze the legal implications of disclosure and outline legislative trends intended to disconnect disclosure from legal consequences and conclude that it is fear that interrupts the physician's moral inclination to fully disclose. To counter this fear, I offer evidence of the practical benefits of authentic apology in quantitative terms in Part VI.

II. PHILOSOPHICAL SHIFTS IN PHYSICIAN-PATIENT COMMUNICATION

The 1999 Institute of Medicine (IOM) report, while shocking statistically, energized the conversation already taking place within the

24. Hilfiker, *supra* note 12, at 335.
25. *See id.* at 336.
26. *Id.*

medical community regarding patient welfare, patient safety, and patient rights. There were immediate responses to the IOM report, including the 2001 Joint Commission on the Accreditation of Hospital Organizations (JCAHO) requirement that all unanticipated outcomes be communicated to patients or their families.[27] This type of disclosure was not frequently addressed before the JCAHO regulation made the disclosure of unanticipated outcomes an industry standard.[28] Now, the requirement for the disclosure of unanticipated outcomes is unequivocally established as both an ethical and regulatory expectation for both physicians and nurses.[29] The expectation for such disclosure is addressed in the opinions of such standard bearers as the American Medical Association, the American College of Physicians, and the American Nurses Association.[30] These regulatory and ethical movements reflect something deeper than a recent trend in patient care; they reveal a philosophical shift in the very nature of communication between patient and care provider.

The traditional relationship between patient and doctor was hierarchal. Knowledge, information, and the power of decision rested primarily with the physician. In this kind of system, "communication[s] with patients [were] taken for granted, the assumption being that health care providers would decide what was appropriate for patients and families to know."[31] It was a culture in which the health care provider "assumed the right to decide what was good for the patient, both in terms of action (which treatment to accept) and in terms of the effect of the information (what information to withhold) . . . ."[32] This is the system within which Hilfiker was working in the 1980s, a culture that contributed to a tragic mistake he details in his essay.

One of Hilfiker's patients was Barb Daily.[33] She and her husband, Russ, became friends of Hilfiker's after he delivered their first child.[34] When Barb returned because she believed that she was pregnant with her second child, Hilfiker examined her.[35] Although she presented with many symptoms of an early pregnancy, her urine test was negative.[36] The test

27. JCAHO I, *supra* note 7, at Standard RI.1.2.2.

28. AM. SOC'Y OF HEALTHCARE RISK MGMT., *Disclosure of Unanticipated Events: The Next Step in Better Communication With Patients*, MONOGRAPH, May 2003, at 10 [hereinafter ASHRM II].

29. *See* Lamb et al., *supra* note 9, at 73.

30. *Id.* at 82.

31. *See* ASHRM I, *supra* note 10, at 4.

32. *Id.*

33. Hilfiker, *supra* note 12, at 325.

34. *Id.*

35. *Id.*

36. *Id.*

remained negative over the summer and Hilfiker finally concluded that Barb had experienced a "missed abortion" and recommended a dilation and curettage (D & C).[37] On the day of the procedure, Hilfiker examined Barb again and, in spite of her uterus feeling bigger than it had two days earlier, he still performed the procedure.[38] During the operation, he realized that it was not the expected bits of decomposing tissue he was removing, but rather "parts of a body that was recently alive!"[39]

In the frantic calls he made post-surgically, no one was able to explain how a woman in Barb's condition could have had four consecutive negative pregnancy tests.[40] Hilfiker was left with the hideous task of describing what he did and why he did it.[41] When Russ asked if an ultrasound examination would have prevented the mistake, Hilfiker acknowledged that it would have.[42] However, in his essay, Hilfiker laments that he could not "explain why [he] didn't recommend it."[43]

Hilfiker had considered the test.[44] He knew that by ordering it he would know for sure whether or not Barb was pregnant.[45] He decided against it partly because the test was not immediately available in the rural town where Hilfiker practiced.[46] However, the primary reason he decided not to offer it as a treatment option was the expense of the procedure.[47] He said, "I know the Dailys well enough to know they have a modest income,"[48] a comment which suggested that Hilfiker thought the cost of the test prohibitive for the Dailys.

It is not clear from his essay whether Hilfiker ever realized that his most serious mistake was not in performing the surgery, but was, rather, his self-determination that the Dailys could not afford a test that would have saved their child's life. While this decision spared the Dailys from the complexities of choice, it overlooked their agency and resourcefulness. As a result, he denied his patients the opportunity to participate in a decision critical to their child's care. However, Hilfiker is not to be criticized for this. He was operating within a philosophical framework that encouraged

37. *Id.* at 326-27.
38. *Id.*
39. Hilfiker, *supra* note 12, at 327.
40. *Id.* at 327-28.
41. *Id.* at 328.
42. *Id.*
43. *See id.*
44. *Id.* at 325-26.
45. Hilfiker, *supra* note 12, at 325-26.
46. *Id.* at 326.
47. *Id.*
48. *Id.*

and supported such a patriarchal approach. This is a framework that over the past decade has been evolving away from doctor-based decision-making to a more patient-centered approach. A study of recent commentaries on communications to patients regarding unanticipated outcomes illustrates this trend.

Unlike the Dailys, patients today are no longer seen as passive recipients of a doctor's decision of what is good for them. Patients are now seen as independent agents, "full partners in their health care."[49] The American Society for Healthcare Risk Management (ASHRM) describes the agency now seen in patients in terms even stronger than that of partner when they declare that "the patient is now recognized as the *arbiter* of how information that pertains to them should be conveyed and used."[50] In order to fulfill this role, patients must be fully informed of all relevant facts about their care.[51] This necessitates "[o]pen and ongoing communication with patients about their care . . . ."[52] The required communication covers outcomes of all care, including an unanticipated outcome defined as "a result that differs significantly from what was anticipated to be the result of a treatment or procedure."[53] An unanticipated outcome can be positive, negative, or neutral and "may or may not be associated with . . . error."[54] Given this article's focus on apology, my analysis will focus on adverse unanticipated outcomes associated with error, and the role apology plays in communicating error to patients.[55]

III. APOLOGY WITHIN A MORAL DIALECTIC

In 1999, when I first addressed apology and its role in the legal arena, I wrote against the backdrop of President William Clinton's apology in the Monica Lewinsky scandal. The expressions of contrition were so frequent then that one pundit described the atmosphere pervading the culture as "apology mania."[56] Five years later, the "mania" continues as we again witness extraordinary expressions of remorse by our President and Secretary of Defense in the wake of the abuse of Iraqi prisoners in our care. Apologies also are rampant in the medical arena as evidenced in a recent

49. *See* MINN. HOSP. ASS'N, *Communicating Outcomes to Patients* 2 (2002).

50. ASHRM I, *supra* note 10, at 4 (emphasis added).

51. *Id.* at 5; MINN. HOSP. ASS'N, *supra* note 49, at 2.

52. MINN. HOSP. ASS'N, *supra* note 49, at 2.

53. *See* JCAHO II, *supra* note 8, at Standard RI.2.90. *See also* MINN. HOSP. ASS'N, *supra* note 49, at 2.

54. MINN. HOSP. ASS'N, *supra* note 49, at 2.

55. *Id.* at 3.

56. Barbara Amiel, *Saying Sorry is Fine, But Only to a Point*, MACLEAN'S, May 25, 1998, at 11.

Wall Street Journal article lauding apologies in the face of medical mistakes and highlighting their beneficial effect in reducing liability.[57] In that article, a surgeon who teaches seminars for doctors and malpractice insurers on the importance of apology, states that "nothing is more effective in reducing liability than an authentically offered apology."[58] Yet, what is missing from this article, as well as from the national conversation about apology, is a thoughtful analysis of what defines authentic apology.

Nicholas Tavuchis, a sociologist who has written a detailed text on the subject of apology and reconciliation, believes that "[w]hatever else is said or conveyed, an apology must express sorrow."[59] Yet, sorrow in this context means something more than an expression of sympathy or regret. "In the context of apologetic discourse, the expression of sorrow is equated with feelings of remorse, shame, and repentance."[60] In fact, an authentic apology is the voice of repentance, another nuanced and complex term.

There is no agreed upon definition of civic repentance in our culture. Perhaps the word that most closely approximates its meaning is rehabilitation, where one is restored to good health or a useful life.[61] In religious language, repentance "unites two linguistic and theological traditions."[62] It combines the Greek "*metanoia*" with the Hebrew "*shub*."[63] *Metanoia* suggests a fundamental change of mind just as metamorphosis suggests a fundamental change in form.[64] *Shub* is a Hebrew root word meaning "to turn" or "to return," as in turning away from wrong conduct and returning to right pathways.[65] Broken into component parts, the elements of true repentance are remorse, apology, restitution, and a restructuring of life.

In the face of medical error, the physician must first take time to identify

57. *See* Zimmerman, *supra* note 11, at A1.

58. *Id.*

59. NICHOLAS TAVUCHIS, MEA CULPA 36 (Stanford Univ. Press, 1991).

60. Taft, *supra* note 22, at 1139.

61. REPENTANCE: A COMPARATIVE PERSPECTIVE 7 (Amitai Etzioni & David E. Carney eds., 1997); THE AMERICAN HERITAGE COLLEGE DICTIONARY 1172 (Houghton Mifflin Co. 1993).

62. Malcolm David Eckel, *A Buddhist Approach to Repentance, in* REPENTANCE: A COMPARATIVE PERSPECTIVE 129 (Amitai Etzioni & David E. Carney eds., 1997) (citing THEOLOGICAL DICTIONARY OF THE NEW TESTAMENT, 978 (Gerhard Kittel ed., 1967)).

63. *Id. See also* THEOLOGICAL DICTIONARY OF THE NEW TESTAMENT, *supra* note 62, at 978, 984.

64. Eckel, *supra* note 62, at 129; THEOLOGICAL DICTIONARY OF THE NEW TESTAMENT, *supra* note 62, at 978.

65. BROWN-DRIVER-BRIGGS HEBREW AND ENGLISH LEXICON 996 (Francis Brown et al. eds., 1996); NEW INTERNATIONAL DICTIONARY OF OLD TESTAMENT THEOLOGY & EXEGESIS 55 (Willem A. VanGemeren ed., 1997); THEOLOGICAL DICTIONARY OF THE NEW TESTAMENT, *supra* note 62, at 984.

what went wrong and why, a process that must take place before communicating with the patient or the patient's family. This is a time not only for internal reflection but also a time for communication with the medical team, mentors, and colleagues. This is a difficult process, especially when one recalls the burden of professionalism that Hilfiker described, how one's professional reputation itself seems to be at stake.[66] To fully appreciate this difficulty, we can recall Hilfiker's agony when he realized that he was removing parts of a body that had been recently alive, not the expected decomposing tissue of a missed abortion.[67] The humility required for him to place the call and tell another physician of the mistake he made is unimaginable. While this is an incredibly difficult starting place, it is a critical step in apologetic discourse. It equips the physician to communicate with clarity, and, if a norm or standard was violated, it allows space for the doctor to experience the remorse that can gird and support the courage required to take the next step—the communication of the error through authentic apology.

According to Tavuchis, for an apology to be authentic, it must follow a precise formula whereby the party offering the apology: (1) acknowledges through speech the legitimacy of the violated rule; (2) admits fault for its violation; and (3) expresses genuine remorse and regret for the harm caused by the violation.[68] While some suggest that at this stage there should also be an explicit offer of restitution and/or promise to reform,[69] Tavuchis believes that these additional elements are implicit in the apology's authentic expression.[70] For him, the expression of regret coupled with the admission of fault itself implies a willingness to change, a promise of forbearance, and an implicit agreement to accept all the consequences—social, legal, or otherwise—that flow from having committed the wrongful act.[71] This is the apology that seemed almost unimaginable to Hilfiker: "a real confession" where the doctor comes to the injured patient and

66. Hilfiker, *supra* note 12, at 328-29.

67. *Id.* at 327.

68. *See* TAVUCHIS, *supra* note 59, at 3.

69. Aviva Orenstein, *Apology Excepted: Incorporating a Feminist Analysis into Evidence Policy Where You Would Least Expect It,* 28 SW. U. L. REV. 221, 239 (1999); 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, 138 (1997); Hiroshi Wagatsuma & Arthur Rosett, *The Implications of Apology: Law and Culture in Japan and the United States,* 20 LAW & SOC'Y REV. 461, 469-70 (1986).

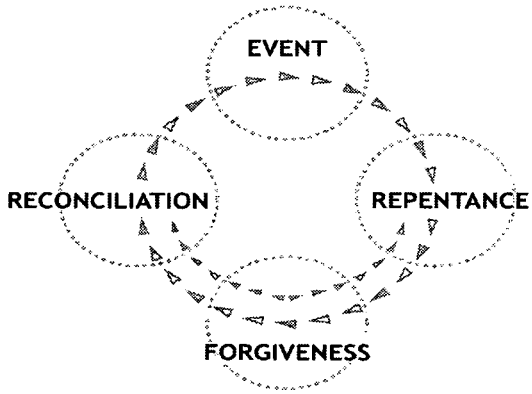
70. TAVUCHIS, *supra* note 59, at 23.

71. Taft, *supra* note 22, at 1140. In the context of the disclosure of harmful, unanticipated outcomes, an explicit offer of restitution/reparation is critical. See discussion *infra* Part VI.

forthrightly says, "This is the mistake I made; I'm sorry."[72]

The "real confession" illustrates that apologetic discourse is a moral activity because it recognizes the existence of a norm and that the breaking of the norm has caused harm. Moreover, apologetic discourse demands great courage from the party who has erred because he must not only acknowledge wrongdoing, but also subject himself to the consequences that flow from the admission, including the risk of litigation. When the courage of the act is thought of in this light, it becomes clear that an "authentic apology is itself a moral action regardless of its efficacy."[73] There is integrity in acknowledging wrongdoing and voluntarily subjecting oneself to the consequences, regardless of the injured party's response.[74]

The process of forgiveness provides another significant explanation of the morality of apology and reveals another dimension of its healing capabilities. Hilfiker speaks of this potential when he notes that "the only way to face our guilt is through 'confession, restitution, and absolution.'"[75] He identifies, in shorthand form, the process of forgiveness.[76] This process begins with the occurrence of an event that triggers repentance, which in its authentic expression invites forgiveness, which is the door to reconciliation. Illustration of the process looks like this:[77]



72. Hilfiker, *supra* note 12, at 335-36.

73. Taft, *supra* note 22, at 1142.

74. *Id.*

75. Hilfiker, *supra* note 12, at 335.

76. *Id.*

77. This diagram demonstrates that initially the movement toward reconciliation begins with the event and moves toward and through the physician in the process of repentance. Authentically performed and communicated, repentance can inspire forgiveness, which is itself multidirectional. To be granted only by the injured party, forgiveness moves in one direction back to the party causing harm and in the other direction, it opens the door to reconciliation. With reconciliation complete, the original event while not erased is re-framed. The circles around each step in this process are intended to communicate that a process occurs within each critical moment in this cycle of healing. The overall arrangement is intended to communicate the relational nature of the dialectic.

As the voice of repentance, an authentic apology becomes the "middle term in a moral syllogism," itself a moral action inviting forgiveness as a moral option for the injured party.[78] Authentic apology then is the centerpiece in a moral dialectic between remorse and forgiveness.[79] There is a promise within this dialectic, one that states that authentic repentance swings wide the door of forgiveness. This is a fact recognized in the emerging science of forgiveness, where psychologists have discovered that one of the most significant factors influencing the granting of forgiveness is repentance by the party who has erred.[80] Apology does not exist in isolation; rather, it is an intensely relational process.[81] It begins as a singular experience with feelings of remorse yet in its expression, it becomes unquestionably dyadic. It "cannot be understood alone any more than could a promise be understood without reference to a promisor and promisee."[82] In Hilfiker's terms, it is a confession that invites absolution.[83]

This insight establishes that authentic apology has the capacity to inspire a unique kind of healing that contains the potential to heal both doctor and patient. In moral terms, this healing occurs because authentic apology restores right relationship between the party injured and the party who caused the injury.[84] Undisclosed error interrupts the essential ingredient of trust between doctor and patient and disrupts the doctor's sense of integrity.[85] Although the error itself relates to physical harm, the lack of apology disrupts the moral dimension of the doctor's relationship with the patient, the broader medical community, and himself. In its authentic expression, apologetic discourse restores moral balance and an equality of regard.[86] Thus, it is multidirectional in its potential healing capabilities.

But is authentic apology really possible in the modern medical world, or

78. TAVUCHIS, *supra* note 59, at 20.

79. Taft, *supra* note 22, at 1143.

80. *E.g.*, Roy F. Baumeister et al., *The Victim's Role, Grudge Theory, and Two Dimensions of Forgiveness, in* DIMENSIONS OF FORGIVENESS 82, 93 (Everett L. Worthington ed., 1998).

81. Taft, *supra* note 22, at 1142.

82. *Id.* at 1142-43.

83. Hilfiker, *supra* note 12, at 335.

84. *See* Taft, *supra* note 22, at 1137 n.9 and accompanying text. Another way to view this restoration is through the lens of equity theory. Jennifer Robbennolt notes that "[e]quity theory posits that a transgression by an offender against an injured party results in an inequity in their relationship; that is, the wrong creates a moral imbalance between the parties." Jennifer K. Robbennolt, *Apologies and Legal Settlement: An Empirical Examination*, 102 MICH. L. REV. 460, 477 (2003). Under this theory, apology offers one way to restore moral balance. *Id.*

85. *E.g.*, Thomas H. Gallagher et al., *Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors,* 289 JAMA 1001, 1001 (2003).

86. Taft, *supra* note 22, at 1137.

does Hilfiker have it right when he notes that "within the structure of modern medicine there is no place for such spiritual healing?"[87] It must be remembered that Hilfiker was writing before the Institute of Medicine's (IOM) report and the introduction of new regulatory and ethical considerations. So while sweeping systemic changes have not yet emerged, the IOM report and the variety of responses to it have cracked the structure that existed when Hilfiker was writing. These cracks may be understood today only as interstices, but, like it or not, the emerging regulations and ethical mandates inevitably mean that silence can no longer be assumed as a backdrop.

Yet there exist stumbling blocks, impediments that are both real and imagined. Many compelling questions arise: how is apology being communicated within the context of disclosure policies? Do the expressions of remorse that are being encouraged capture the heart of the authentic apology? And what about the legal implications of the kind of authentic apology outlined here? Would authentic apology not simply add fuel to the malpractice fire? This essay seeks to answer these questions. In Part IV, I will first illustrate how disclosures are being communicated through two model disclosure policies. Next, I will show how apology is being communicated within these disclosure policies and how authentic apology and expressions of sympathy are being conflated. I will then demonstrate how this conflation causes confusion in understanding the true nature of apology and how this confusion ultimately leads to communications that hurt rather than heal. In Part V, I will examine the legal risks associated with the kind of apology I have described and, in Part VI, offer an analysis of the quantitative benefits of authentic apology in contrast to associated risks. This analysis will support my thesis that authentic apology should be given voice, not only because of its capacity to heal, but also because of the practical advantages realized in its expression.

IV. DISCLOSURE: COMMUNICATING UNANTICIPATED OUTCOMES

A. Disclosure Models

The majority of institutions are struggling to implement policies and procedures to address the requirement for disclosure. While there is general agreement that the patient should be informed of an unanticipated outcome, there is much variability in terms of what words should be used in communicating the event.[88] This is especially true when it comes to

87. Hilfiker, *supra* note 12, at 335.

88. *See* MINN. HOSP. ASS'N, *supra* note 49, at 2. *See also* ASHRM I, *supra* note 10, at

empathic expressions between physicians and patients.[89] A recent brochure published by the Minnesota Hospital and Healthcare Partnership (MHHP) outlines "a model communication policy" that MHHP believes is the "gold standard communication policy for communicating with patients and families."[90] The model highlights the modern philosophy of patient-centered medical care and recognizes the patient's right and need to know about unanticipated outcomes, medical accidents, or near medical accidents.[91] The model outlines the specific steps that should be taken before the actual disclosure is made to the patient and begins with such preparatory matters as consulting with risk management, considering the timing of the disclosure, and identifying the persons who should be present during the disclosure itself (e.g., a second member of the health care team or a patient's representative).[92] The brochure then outlines the content of the disclosure itself.[93]

According to the model policy, the first thing to be communicated—*before* any factual information is provided about the event itself—is that "the hospital and its staff regret and apologize that a medical accident has occurred."[94] It is only after this expression that more expected matters are addressed, such as what happened, the implications of the event, ameliorative actions taken and to be taken, and plans to compensate the patient.[95] The model does not specifically define what it means by regret or apology. However, an issue of *Monograph* published this year by the American Society for Health Care Risk Management (ASHRM) does.[96]

The ASHRM model entitled "*Disclosure: What Works Now & What Can Work Even Better*" describes four distinct skills required to ensure an effective communication: Preparation, Initiation of Conversation, Conclusion of Conversation, and Documentation.[97] The "Initiation of

4-5.

89. *See* MINN. HOSP. ASS'N, *supra* note 49, at 2. *See also* ASHRM I, *supra* note 10, at 4-5.

90. MINN. HOSP. ASS'N, *supra* note 49, at 2.

91. *Id.* The MHHP document defines an unanticipated outcome as "[a] result that differs significantly from what was anticipated to be the result of a treatment or procedure." *Id.* Medical accident is defined as "[a]n unintended event in the system of care with actual or potential negative consequences to the patient. Medical accidents can result from defect, failure and error within the system of care." *Id.* A "near medical accident" is "[a]n event that would have constituted a medical accident but was intercepted at the patient care services before it actually reached the patient." *Id.*

92. *Id.* at 3.

93. MINN. HOSP. ASS'N, *supra* note 49, at 3-4.

94. *Id.* at 3.

95. *Id.*

96. ASHRM I, *supra* note 10, at 8.

97. *See id.* at 6-11.

Conversation" section identifies what the *Monograph* calls the "heart of the discussion," which means the core elements of what disclosure is to cover and without which "it is not possible to say that adequate disclosure has occurred."[98] These core elements are: what happened, where things are now, next steps, and the requirement that the party disclosing "sincerely acknowledge the patient/family's suffering."[99]

The authors of the ASHRM model note that even though "[e]mpathy continues to be controversial among risk managers, lawyers and claims adjustors . . . [a] well-crafted expression of empathy can both provide the acknowledgment of suffering and the opportunity for both parties to heal."[100] The authors suggest that this "well-crafted acknowledgment" start with "I'm sorry" or "I feel badly" or "I'm sad that . . ." since "it is what follows that initial phrase that determines the efficacy and interpretation of the apology."[101] In a situation where there has been medical error, they suggest that the physician apologize by saying, "I am so sad that this has happened. You must be terribly upset, and so am I." [102] In the case of an unanticipated outcome, they suggest that the apology that would be healing to both the patient and the physician be communicated like this: "This is sad and not what any of us expected. I wish it weren't this way and I know you do, too."[103]

I have tried to imagine how Hilfiker's patients, Barb and Russ Daily, would have responded to these kinds of "apologies." Recall that the "heart of the disclosure conversation" that ASHRM recommends begins with a simple description of what happened, followed by the result of the event, the next steps, and then the expression of empathy.[104] Under these guidelines, Hilfiker's statement to the Dailys would proceed as follows:

> I want you to know what happened in the surgery. As it turned out, you were carrying a viable fetus and, as a result of the procedure, the fetus died. You will experience the passage of fetal tissue in the next few days, and then, physically, you will feel much better. No one has ever heard of a patient being pregnant in the face of four negative urine tests. We are trying to cetermine why this happened so that this never occurs again. I am so sad this has happened. You must be terribly upset, and so am I.

98. *Id.* at 7.
99. *Id.* at 7-8.
100. *Id.* at 8.
101. *Id.*
102. ASHRM I, *supra* note 10, at 8.
103. *Id.*
104. *See Id.* at 7-8.

If you were the Dailys, would this "well-crafted expression of sympathy" provide the opportunity for the healing that the ASHRM *Monograph* suggests? Does it matter that this disclosure contains no admission of wrongdoing and stops short of a real confession? How would you feel when you learned the reason the ultrasound was not offered? Can healing occur in the absence of the authentic apology I have described? Can Hilfiker realize his desire for absolution in the absence of confession?

B. Distinguishing Empathic Disclosure from Authentic Apology

There is, of course, a difference between a disclosure that includes an expression of sympathy, well-crafted or not, and the authentic apology described in this essay. The difference is both linguistic and teleological. Linguistically, the empathic disclosure is more akin to an apologia than it is to authentic apology. In the modern business environment, apologia is understood as a communication device employed by those experiencing crisis in the face of actual or perceived wrongdoing.[105] While the rare apologia may contain an authentic apology, it is primarily a strategic communication designed not only to convey information, but also, and perhaps more importantly, to neutralize the potential negative ramifications that might otherwise result from the information given.[106] Understood through a business communications model, apologia is more than a simple justification of one's position. In business parlance, it is a justification coupled with a defensive strategy.[107]

Under this expanded understanding, the empathic disclosure is closer to an apologia than it is to authentic apology. Understanding disclosure this way shows that while both are communications, there is an important difference between empathic disclosure and authentic apology. Like apologia, an empathic disclosure is both explanatory and strategic in that it seeks to relate critical factual information to the patient in a way designed to neutralize negative ramifications. The authentic apology is also a communication but, in its openness to truth, it avoids strategic and defensive purposes. This explanation shows that the difference is deeper than one of semantics; the difference is teleological as well. The purpose of the disclosure of unanticipated outcomes is to provide patients with essential information to guide their healthcare decisions.[108] The requirements of the Joint Commission on the Accreditation of Hospital

105. Keith Michael Hearit, *Apologies and Public Relations Crises at Chrysler, Toshiba, and Volvo*, 20 PUB. RELATIONS REV. 113, 114 (1994).

106. *Id.* at 115.

107. *See id.* at 114.

108. *See supra* notes 49-54 and accompanying text.

Organizations (JCAHO) standard are straightforward: "[p]atients and, when appropriate, their families are informed about the outcomes of care, treatment, and services, including unanticipated outcomes."[109] The reason for this standard, the ultimate end to be served by these disclosures, is to create a mechanism to ensure that patients are knowledgeable and equipped to participate "in current and future decisions affecting the patient's care, treatment, and services."[110] This is more than a response to the 1999 IOM report; it is a reflection of the previously described philosophical shift toward patient-centered and directed care. This is the clear purpose and the telos of both the standard requiring disclosure and the ethical considerations that are associated with it.[111]

Apology is much more than a conveyor of information.[112] It is the centerpiece in a moral dialectic between error and forgiveness.[113] Its purpose is to give voice to repentance through the expression of sorrow and the admission of wrongdoing. These two elements are essential, so that the absence of either renders the apology incomplete and interrupts its moral dimension. In its authentic expression, apology is an invitation to the party harmed to extend forgiveness and, thus, provide the opportunity for reconciliation. Its ultimate end is healing for both the party who has inflicted harm as well as for the one who suffers.[114] It is healing for the party who has erred because the one who risks apology demonstrates moral courage by speaking a truth that carries potentially grave consequences.[115] Yet paradoxically, it is the taking of the risk that also restores one's integrity with the party harmed, with one's self, and with the community.[116] The receipt of apology sparks healing in the party harmed, not only because it restores moral balance by demonstrating the regard and care in which the party harmed is held by the party causing injury, but also because apology invites the party harmed to extend forgiveness, itself a courageous and

109. *See* JCAHO II, *supra* note 8, at Standard RI.2.90.

110. *See id.* at Elements of Performance for RI.2.90.

111. *See supra* notes 49-54 and accompanying text.

112. As I noted in an earlier essay, apology is a performative utterance. *See* Taft, *supra* note 22, at 1139-40. The classic formulation of a performative utterance is that of J.L. Austin. Austin challenges the philosophical assumption that to state something is simply to state something. Austin does this by showing that there are times when in saying something we actually do something as when one says "I do" in a marriage ceremony. J.L. AUSTIN, HOW TO DO THINGS WITH WORDS, 5 (J.O. Urmson & Monica Sbisa eds., 1975). Austin's view, one which I share, is that "I apologize" is another paradigmatic performative utterance. *Id.* at 79, 146.

113. *See* discussion *supra* p. 66.

114. *See supra* pp. 62-66 (discussing apology and its implications).

115. *See supra* pp. 62-66 (discussing apology and its implications).

116. *See supra* pp. 62-66 (discussing apology and its implications).

moral act.[117]

The failure to recognize these linguistic and teleological differences between empathic disclosure and apology causes confusion and missteps regarding the design and implementation of policies and procedures regarding the disclosure of unanticipated outcome within the medical arena. This occurs when the telos of disclosure is mixed with that of authentic apology even in thoughtful and well-intentioned policies like those suggested by MHHP and ASRHM.[118] Combining disclosure with well-crafted expressions of empathy seems perfectly logical when viewed as a communication strategy, but the conflation of expressions of empathy with those of true repentance blurs the telos of the communication. This moral misstep ultimately exacerbates the very injury that prompted the disclosure.

The new injury may not be at once apparent. The empathic disclosure may even initially appear efficacious. Yet, when the patient has an opportunity to reflect and realizes that there was no real accountability, no real confession, he will feel betrayed, and the temporary alleviation of pain will evaporate into a deepened sense of abandonment and mistrust. This is the effect of what psychiatrist Aaron Lazare calls a "botched apology."[119] This is an apology that not only fails to communicate effectively the offender's repentance, remorse and regret, but also creates further harm that can strain relationships and fuel bitter vengeance.[120] A recent example that the *Dallas Morning News* described as having a "depressingly familiar ring to it" is illuminating.[121]

---

117. *See supra* pp. 62-66 (discussing apology and its implications).

118. *See* MINN. HOSP. ASS'N, *supra* note 49, at 2. *See also* ASHRM I, *supra* note 10, at 4-5.

119. Aaron Lazare, *Go Ahead and Say You're Sorry*, PSYCH. TODAY, Jan.-Feb. 1995, at 40.

120. What Lazare calls the botched apology Jennifer Robbennolt describes as the partial apology. Robbennolt, *supra* note 84, at 469. This is the apology that expresses sympathy but does not admit responsibility. *Id.* From her research comparing the partial apology to the full apology and their respective effects on settlement, Robbennolt concluded that in the case of serious injury, the full apology positively impacted settlement while the partial apology "increased the likelihood that the respondent would be unsure how to respond to the settlement offer." *Id.* at 486, 491. In the case where there is strong evidence of culpability coupled with a partial apology, the partial apology was found to be particularly detrimental. *Id.* at 497. "When the offender failed to take responsibility in the apology (i.e., offered a partial apology) for an incident that resulted in severe injury, the degree of responsibility attributed to the offender was greater and the offer was seen as less likely to make up for the injury." *Id.* at 497-98 and accompanying footnotes. This perception also extended to the element of repentance regarding a restructuring of one's life. Robbennolt found that the offender who offered the partial apology "was seen as less likely to be careful in the future than those offering either a full or no apology." *Id.* at 498. And where responsibility is clear, Robbennolt concluded that no apology is better than the empathic or botched apology. Robbenolt, *supra* note 84, at 498.

121. *Lutheran Sex Scandal: $37 Million Verdict Makes a Good Point*, DALLAS MORNING

In April 2004, an east Texas jury awarded $37 million to the plaintiff in a sexual abuse lawsuit.[122] The plaintiffs in that case demonstrated that the abuser "had a record of inappropriate behavior with boys and an interest in pornography," yet the church ordained him anyway.[123] Worse, neither the bishop nor his top assistant told the congregation of the abuser's record.[124] After the verdict, another bishop, who had replaced the first, offered this apology to the victims: "[w]e do express our regrets. We pledge to make sure people like Gerry Thomas [the abuser] never serve a church again."[125] What made this a "botched apology?" The bishop never acknowledged the church's wrongdoing, nor did he accept responsibility for the church's failure and its part in the horror it made possible. Lazare finds this gloss psychologically predictable and destined to fail because it is not offered to make amends for an injury inflicted, but rather to manipulate the injured party's feelings in favor of the party who caused the harm.[126] Yet, the inclination to avoid the pain of a true confession is also foreseeable since the admission of wrongdoing collides with values most professionals embrace, traits such as competency and honesty.[127] As Hilfiker noted, perfectionism takes its toll.[128]

The empathic disclosure that admits no wrongdoing is like a "botched apology." It informs, it expresses regret, but it does not heal. Ultimately, a disclosure without authentic apology lacks the central element required to restore moral balance. Without an admission of wrongdoing, it does not and should not, inspire forgiveness. It is the confession within authentic apology that invites healing and it is this healing that physicians who err seek.

If "[v]irtually every practitioner knows the sickening reali[z]ation of making a bad mistake" and if most desire to confess, then why do they remain silent?[129] And why do those who advise them continue to encourage empathic expressions but insist that these communications be constructed so that they contain no admission of wrongdoing? Of course, the primary reason advanced is the fear of litigation.[130] Those studying the

---

NEWS, Apr. 26, 2004, at A16.

122. *Id.*

123. *Id.*

124. *Id.*

125. *Lutheran Bishop Apologizes to Victims*, DALLAS MORNING NEWS, Apr. 24, 2004, at A3.

126. Lazare, *supra* note 119, at 78.

127. *Id.*

128. Hilfiker, *supra* note 12, at 336.

129. Albert W. Wu, *Medical Error: The Second Victim*, 320 BRIT. MED. J. 726, 726 (2000).

130. *See e.g.*, Lamb et al., *supra* note 9, at 76.

implementation of disclosure policies have concluded that fear of malpractice litigation is "the most prominent foil to aspirations of openness." Regardless of whether or not that fear is justified, are we prepared to say that the fear of litigation, real or perceived, is itself sufficient justification to excuse physicians from admitting error? There are many who argue that it is.[132] Those who view the dilemma this way and see physicians caught "between the powers and liabilities of apologies"[133] also see the law as the culprit and look to legislatures for solutions.

V. LEGAL IMPLICATIONS OF DISCLOSURE

In legal language, an admission is a statement against one's own interest, and the general rule is that an admission may be considered by judge and jury.[134] The rationale for the general rule is that an admission carries evidentiary value because, in the normal course of human behavior, one would not make a statement against one's own interest unless the statement were true. An authentic apology constitutes an admission and, in the event of litigation, may be considered by the trier of fact.[135] When authentic apology is considered within the context of litigation, there is a decided shift away from moral concerns "to strategic maneuvers and legal consequences."[136]

This shift is encouraged by those advising physicians, especially their lawyers, insurers and risk managers. In a recent essay, the chair of a litigation team specializing in health care addressed the issue of disclosure.[137] Noting the importance of communication with the patient and the opportunity for strategic advantage, he reminds care providers that "[w]e need to see that providing the *right* amount and type of information in

131. *Id.* at 81.

132. Jonathan R. Cohen, *Advising Clients to Apologize*, 72 S. CAL. L. REV. 1009, 1028-30 (1999). *See* Orenstein, *supra* note 69, at 259-60.

133. Deborah Tannen, *About Last Week . . . Apologies: What it Means to Say 'Sorry,'* WASH. POST, Aug. 23, 1998, at C1.

134. *See, e.g.*, 28 U.S.C. § 801(d) (2004) (providing that a statement made by a party to the litigation is admissible as an exception to the hearsay rule, a rule that would normally exclude statements made out of court).

135. The existence of the traditional view of the evidentiary rule is what propelled the California legislature to modify it. In the commnentary to that rule, the bill's sponsor, Judge Quentin Koop, noted "apologies and similar expressions are admissible as purported exceptions to the hearsay rule in a trial by court or jury." CAL. EVID. CODE § 1160 (2004 Electronic Update Comment). *See also, e.g.*, Cohen, *supra* note 132, at 1010.

136. Deborah L. Levi, Note, *The Role of Apology in Mediation*, 72 N.Y.U. L. Rev. 1165, 1188 (1997).

137. James W. Saxton & Maggie M. Finklestein, *Enhanced Communication to Reduce Liability*, PHYSICIAN'S NEWS DIG., *available at* http://www.physiciansnews.com/business/1103saxton.html (2003).

the *right* way and by the *right* people can benefit the patient from a health perspective and the health care provider from a liability perspective."[138] According to the author, the "right" way to disclose an unanticipated result is for the physician to "have a timely discussion with the patient and/or family in an empathetic manner, providing an apology, *yet certainly without admitting liability.*"[139]

This advice was echoed last year at an annual conference for obstetricians and gynecologists when the director of risk management at the University of Colorado Health Science Center advised doctors to "apologize for what happened."[140] When some members of the audience argued against this advice because of the possibility that "apologizing implies that you did something wrong," the director explained that "it's how you go about it that matters."[141] ASHRM warns that "[e]ach organization, working with its attorneys and insurers, must decide if the potential for a benevolent gesture being construed as an admission of culpability outweighs the value of acknowledgment of patient/family suffering."[142]

Advice like this from leaders in the health care industry shows that there is indeed a shift from moral concerns to those focused on "strategic maneuvers and legal consequences"[143] for many of those drafting policies to address the emerging duty to disclose unanticipated results. Yet this movement is not limited to the health care industry; it is now accelerating and is being reflected in an emerging area of law.

I introduce a legislative trend here because there are similarities between laws that are being enacted to protect apologies and policies surrounding the disclosure of medical error. These statutes, like some policies guiding the execution of empathic disclosures, begin with good intentions yet ultimately interrupt the moral dimension of apology. In the process, these statutes erase the healing capability of apology. This is a development that should alarm anyone interested in the moral dimension of apologetic discourse and its healing possibilities.

The trend began in 1986 when the Massachusetts legislature created a "safe harbor" provision for would-be apologizers.[144] This statute provides:

138. *Id.* at 3.

139. *Id.* at 4 (emphasis added).

140. Heidi Splete, *Recognize Risk Management Strategies to Avoid Losing Lawsuits*, 33 FAM. PRAC. NEWS 44 (2003).

141. *Id.*

142. ASHRM I, *supra* note 10, at 8.

143. Levi, *supra* note 136, at 1188.

144. MASS. GEN. LAWS ANN. CH. 233 § 23D (2000).

> Statements, writings, or benevolent gestures expressing sympathy or a general sense of benevolence relating to the pain, suffering or death of a person involved in an accident and made to such person or to the family of such person shall be inadmissible as evidence of an admission of liability in a civil action.[145]

The statute was created after a Massachusetts legislator's daughter was killed while riding her bicycle.[146] The driver of the automobile that struck her never apologized.[147] Her father, angry at the lack of contrition, was told that the driver dared not risk apologizing because of the potential legal consequences attached to an admission.[148] Rather than being incensed at the driver's lack of moral courage, the senator and his successor erected a legislative screen intended to promote apology.[149] There was no consideration given to the moral implications of this "protected apology" within the broader context of apologetic discourse by either of these men or the Massachusetts legislature.[150]

This Massachusetts statute was the only one of its kind until 1999 when a Texas lawyer, visiting Massachusetts, heard about the Massachusetts law.[151] When he returned to Texas, he encouraged a Texas legislator to create a law following the Massachusetts example.[152] The Texas law, dubbed by the *Austin American Statesman* as the "I'm sorry" bill, is similar to the Massachusetts law except in one important respect.[153] In Texas, the statute does not protect "a statement . . . concerning negligence or culpable conduct . . . ."[154] This means that in Texas the expression of regret, like the empathic disclosures described above, are protected, while an admission of wrongdoing, as is required by authentic apology, is not. Like the Massachusetts legislators, the lawmakers in Texas enacted this law without regard to its moral implications.[155] And, unfortunately, the Texas statute has proven to be the model for other states, including California.[156]

According to its sponsor, Judge Quentin Kopp, the California statute was

145. *Id.*
146. Taft, *supra* note 22, at 1151.
147. *Id.*
148. *Id.*
149. *Id.*
150. *See id.* at 1151 n.82.
151. *Id.* at 1153 n.93.
152. Taft, *supra* note 22, at 1153 n.93.
153. *Id.* at 1152.
154. TEX. CIV. PRAC. & REM. CODE ANN. § 18.061 (Supp. 2004-05).
155. *See* Taft, *supra* note 22, at 1153 n.93.
156. *E.g.*, CAL. EVID. CODE § 1160 (Supp. 2004); FL. STAT. ANN. Ch. 90.4026 (Supp. 2004); WASH. REV. CODE § 5.66.010(1) (2004).

designed to address the many ("although unquantifiable") lawsuits that are filed as a result of anger.[157] Kopp attributed this anger to the "failure of another party to express regret or sympathy."[158] In support of the statute, he noted that an "apology is underrated and underused as a tool in legal settings . . . too often overlooked . . . as a lubricant to advance settlement talks . . . ."[159] Kopp cited anecdotal evidence that "30 percent of plaintiffs claim no suit would have occurred if a medical doctor in a medical malpractice context had apologized."[160] He concluded his commentary with specific examples that "may be helpful to the [Assembly] Committee [on Judiciary] in understanding the parameters of the bill's proposed new evidence rule."[161] His examples help us see the human toll when there is a shift away from moral concerns toward utilitarian and strategic goals.

In his first example, "an automobile accident occurs and one driver says to the other: 'I'm sorry you were hurt,' -or- 'I'm sorry that your car was damaged.' Under the bill, these statements would not be admissible in court."[162] In the second example,

> [t]he same accident occurs, and one driver says to the other: 'I'm sorry you were hurt, the accident was all my fault.' –or– 'I'm sorry you were hurt, I was using my cell phone and just didn't see you coming.' Under the bill, only the portions of the statement containing the apology would be inadmissible; any other expression acknowledging or implying fault would continue to be admissible, consistent with present evidentiary standards.[163]

It is clear from this commentary that Kopp does not appreciate the distinctions between expressions of sympathy and authentic apology, either in theoretical or practical terms. Had he considered the practical implementation of the kind of apology he supported, Kopp would have seen that what was theoretically thought to help caused harm in praxis. He simply failed to translate his example into the real life experience of this theoretical victim (or into the life experience of a patient who is harmed by medical error). To test the theory, the actual result of the hypothetical must be considered. Was it a fender bender? Was there a loss of life? If you had lost your leg or your sight or your spouse or your child because someone was using his or her cell phone, would it assuage your anger if he or she

157. CAL. EVID. CODE § 1160 (2004 Electronic Update Comment).
158. *See id.*
159. *Id.*
160. *Id.*
161. *Id.*
162. *Id.*
163. CAL. EVID. CODE § 1160 (2004 Electronic Update Comment).

said only, "I'm sorry you were hurt" or "I'm sorry you lost your husband" or "I'm sorry your child can no longer see?" Would that "apology" help you heal even if you could admit the portion of the statement as evidence of fault?[164]

When Hilfiker excepted doctors from the healing dimension of apology he did so because of his perspective that mistakes in the medical arena are different from those made by others because "[a] doctor's miscalculation or oversight can prolong an illness or cause a permanent disability, or kill a patient."[165] His statement shows that it is not the mistake itself that makes authentic apology so complex in the medical arena, but rather the severity of the outcome that results from the mistake that makes it so hard for a doctor to admit wrongdoing. If I run a red light and hit an unattended grocery cart left in the intersection, will it be so difficult for me to admit my error to the owner of the cart that I remain silent? What if I run that same light and, rather than a cart, I strike and kill a human being? How will the difference in result effect what it is I communicate? Thinking this way illustrates that it is not the mistake itself that makes authentic apology so difficult, but rather the gravity of its outcome.[166]

When there is a small event, insignificant in terms of harm caused, statutes like those in Texas and California and disclosures like those suggested by the American Society for Healthcare Risk Management (ASHRM), which encourage expressions of sympathy, may be efficacious, at least for the kind of people who, while not seriously harmed, expect the courtesy the "protected apology" and the empathic disclosure encourage.[167] Yet when an unanticipated outcome causes serious injury, the permanent kinds of injury Hilfiker describes, empathic disclosures must be seen as "protected apologies" like those the California statute promotes. These

164. In contemplating this series of questions, recall the findings of Lazare and Robbennolt. *See supra* notes 84, 119 and accompanying text.

165. Hilfiker, *supra* note 12, at 328. As I note in the balance of this paragraph and the following note, it is not only the severity of the outcome that makes apology different for doctors. Another factor, and one I think of more significance, is the constancy of the risk of causing harm, the hourly experience that a misstep can lead to a harmful, unanticipated result.

166. This is to say that the feeling of remorse tied to *actual* harm caused is different from a feeling tied to the *possibility* that harm could have resulted from one's behavior. The JCAHO standard requires the disclosure of all unanticipated outcomes, yet it is the harmful outcome that is much more difficult to disclose. Legal philosopher Jeffrie Murphy makes this point clear when he notes that it is not the violation of an authoritative prohibition alone that fuels the intense experience of guilt; rather "[w]e typically feel our most intense guilts, not because of abstract and formal violations of authoritative rules, but because we see vividly the harm we have inflicted on others by such violations." Jeffrie G. Murphy, *Shame Creeps Through Guilt and Feels Like Retribution*, 18 LAW & PHIL. 327, 332 (1999).

167. Robbennolt, *supra* note 84, at 498.

gestures—empathic disclosures and protected apologies—encourage half measures similar to the "botched apology." And, like the "botched apology," these kinds of gestures must ultimately be seen as expressions that cause more harm than good, or worse. As Lazare notes, "botched apologies" can fuel bitter vengeance rather than assuage the anger the gesture was strategically designed to alleviate.[168]

I oppose these kinds of protected apologies, at least in the context of serious and meaningful injury. Their sponsors fail to see the wisdom of the evidentiary rule. The rule makes the expression of apology much more difficult because it takes great courage to accept responsibility in the face of great loss. For some, the rule may totally interrupt the moral inclination to confess. Yet it is precisely because the rule demands so much that it must ultimately be seen as a safeguard of the moral integrity of authentic apology.

There is no ethical or regulatory requirement that authentic apology be included in disclosure. Ethical and regulatory standards of disclosure require only that the patient is told that harm has occurred and is given sufficient information to make an informed decision regarding his or her health care.[169] There is no external legal or regulatory requirement that compels a doctor to confess wrong conduct or risk being placed in legal jeopardy. Authentic apology is reserved for the morally courageous who seek for themselves and their patients the deep healing authentic apology inspires. When authentic apology is shrouded with legal protection or communicated through strategic and defensive mechanisms, and moral concerns give way to worry about legal consequences, the moral dimension of apology is potentially totally subverted. This is what happened last year in Colorado.[170]

A Colorado statute shows what happens when perceived utility eclipses considerations of morality.[171] The Colorado legislature was interested in granting blanket immunity regarding the expression of apology to one class of people: health care providers and their employees.[172] This statute, shocking both in its breadth and in its one-sidedness, declares that:

> [A]ll statements, affirmations, gestures, or conduct expressing apology, fault, sympathy, commiseration, condolence, compassion, or a general sense of benevolence which are made by a health care provider or an

168. *See* Lazare, *supra* note 119, at 40. *See also infra* pp. 53-55 (discussing the implications of anger in malpractice cases).

169. *See supra* pp. 59-60, 67-70.

170. COLO. REV. STAT. ANN. § 13-25-135 (2003).

171. *Id.*

172. *Id.*

> employee of a health care provider to the alleged victim, a relative of the alleged victim, or a representative of the alleged victim and which relate to the discomfort, pain, suffering, injury, or death, or the alleged victim as the result of the unanticipated outcome of medical care shall be inadmissible as evidence of an admission of liability or as evidence of an admission against interest.[173]

This is precisely the kind of statute some legal scholars have proposed. Those who see value in this kind of law argue that it disrupts "the law of the sandbox," a law with a voice saying, "Ha, ha, you said it, now you're stuck with your own admission."[174] The argument is disingenuous in that even though the proponents of this kind of statute understand that its one-sided protection is potentially unfair, they encourage its enactment.[175] They do so despite the fact that a statute like this exacerbates the very injury the "apology" is designed to heal.

I will leave for another essay a critique of the Colorado legislators' choice to protect only one category of people from the consequences of their admissions. There, I will examine the logic that leads a legislative body to determine that a health care provider is more deserving of protection from the consequences of an admission than is a truck driver or a lawyer or a bishop. Here I will focus on the moral implication of this statute and show how the moral dimension of authentic apology is corrupted by its application. This becomes clear when a theoretical idea is transcribed into a practical context, just as the California statute was when placed in reality's harsh light.

Consider a case where a two-year-old child with glaucoma is undergoing a routine procedure to check his eye pressure under anesthesia. The anesthesia is being administered by a resident under the supervision of a board-certified anesthesiologist. After the initial induction, the supervisor leaves the operating suite to grab a quick cup of coffee. The resident inadvertently administers curare[176] because the vials on her cart were not color-coded or otherwise clearly marked. The resident fails to notice the child's distress, which continues until the opthamologist conducting the examination realizes the child is in complete cardiac arrest. Although eventually resuscitated, the child suffers permanent brain injury. If you were the supervising anesthesiologist, what would you say to the child's parents?

---

173. *Id.*

174. Orenstein, *supra* note 69, at 249.

175. *E.g.*, *id.* at 255.

176. Curare is an extract used to relax muscles. MERRIAN WEBSTER'S COLLEGIATE DICTIONARY 283 (10th ed. 1996).

Under the Colorado statute, the physician would be free of all concerns that are normally present in disclosing to the patient and the patient's family an unanticipated, adverse outcome. One could tell the parents precisely what happened and offer an apology minus, of course, the dimension of authenticity that requires the person apologizing to risk potential consequences that would normally flow from the admission. The statute allows one to say with full immunity:

> I am so sorry for what occurred, I was supposed to be supervising the administration of the drugs, but left to grab a cup of coffee. I intended to be gone only a minute but received a call on my cell phone. By the time I returned, your child was already in arrest, but I participated in his resuscitation. The error is my fault and would not have happened had I stayed in the operating room. In leaving, I violated hospital policies and procedures. This was wrong and I am so sorry. I promise to see that you are fairly compensated.

If the promise is fulfilled, then the moral dilemma I raise here is avoided. This is because the physician or health care provider is acting with integrity and abandons the temptation to accept the subversion the statute allows. In fulfilling the promise made, there is moral integrity and the restoration I have described is complete. In keeping the promise, accepting the consequences of the error and waiving the immunity the statute allows, the apology proffered becomes authentic and promotes the healing that flows to both patient and physician. But what if the promise is not fulfilled? What if the doctor recants either of her own volition or because of institutional pressures?

Those who recognize this potential acknowledge that the effect of the statute—its protection of the entire discourse from the jury's consideration—may be problematic for the plaintiff. After all, it would be "maddening" to hear the doctor "deny in [open] court what [she] admitted in an apology."[177] Yet, the proponents of these blanket protections argue that "the plaintiff on balance is better off."[178] How are the parents of this brain-damaged child "better off?" Would you be better off if you had to prove in court what your doctor had already admitted? Would those protected words help you heal? And what if you were the anesthesiologist in this example? How would you feel knowing that what you said had only the appearance of authenticity, that there was no possibility of the admission leading to consequence? How would this distort your moral compass? Would this expression help *you* heal? Is this the kind of

177. Orenstein, *supra* note 69, at 255.
178. *Id.*

confession Hilfiker imagined?

We can do better than this. The subversion the Colorado statute promotes is not what either patients or physicians desire. I spoke recently at an ethical forum before a large group of health care providers at Children's Medical Center in Dallas. These dedicated professionals taught me in a candid setting what journals have long reported: "[p]hysicians want to apologize to patients when harmful medical errors occur" but their moral inclination is constantly challenged and often trumped by the real and perceived fear of the consequences that result from confession.[179]

Encouraging cultural shifts away from "moral concerns to strategic maneuvers and legal consequences" results in human cost in terms of the lost opportunity for healing.[180] These kinds of movements can be seen subtly in "well-crafted expressions of sympathy" as well as in blatant and offensive expressions like the Colorado statute.[181] It begins when a communication designed to promote healing becomes distorted by strategic and legal maneuvers that cause more harm than good, piling suffering on top of suffering. This movement must be interrupted, but to do so will take a pioneering spirit and great courage from those in the health care industry.

VI. OVERCOMING FEAR: OPPORTUNITIES

In spite of statistical data showing that only a fraction of those who suffer injury file suit,[182] fear of litigation continues to be the primary

179. Carol M. Ostrom, *Malpractice Bill Would Require Disclosure of Medical Errors*, SEATTLE TIMES, Jan. 28, 2004, at B2.

180. Levi, *supra* note 136, at 1188.

181. COLO. REV. STAT. ANN. § 13-25-135.

182. *See* Wendy Levinson, *Physician-Patient Communication: A Key to Malpractice Prevention*, 272 JAMA 1619, 1620 (1994). Statistical data is not particularly reliable in quantifying the number of claims made because the numbers presented vary depending on who is doing the reporting and how the numbers are interpreted. In 1994, it was reported that there were eight times as many instances of negligence as claims for compensation and only a one in fifty chance of a doctor being sued. Charles Vincent et al., *Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action*, 343 LANCET 1609, 1609 (June 25, 1994). This year it is reported that the American Medical Association found that one in six physicians face a medical claim each year. Adam Scharn, *Sick System: Adam Scharn Makes a Case for Malpractice Lawsuit Reform*, BATTALLION, Aug. 25, 2004, *available at* http:www.thebattallion.com/news/2004/08/25/Opinion/Sick-System-704655.shtml (last visited Nov. 19, 2004). The Insurance Information Institute reports that claims are growing at the rate of 3% per year. INSURANCE INFORMATION INSTITUTE, *Medical Malpractice*, November 2004, *available at* http://iiidev.iii.org/media/hottopics/insurance/medicalmal/?printerfriendly=yes (last visited Nov. 19, 2004). Conversely, the National Association of Insurance Commissioners found that the number of malpractice claims actually dropped between 1995 and 2000. DEMOCRATIC POLICY COMMITTEE, *Myths and Facts About Medical Malpractice*, *available at* http://democtrats.senate.gov/~dpc/pubs/108-1-023.html (last visited Nov. 19, 2004). Others say it is not even medical malpractice claims

impediment to the performance of authentic apology.[183] This fear leads to defensive and strategic disclosure practices and legislative initiatives such as those examined in this essay. It is this fear that overrides well-documented studies that repeatedly state that authentic apology is what both patients and physicians want.[184] It is this fear that continues to be "the most commonly cited institutional barrier to developing and implementing disclosure policies."[185]

Medical journals and publications are replete with examples that should undercut this fear. One illustration is the well-documented success of the Veteran's Administration hospital (VA) in Lexington, Kentucky.[186] After experiencing costly, back-to-back malpractice cases, the hospital enacted a proactive disclosure policy.[187] This policy required investigation of all cases that could result in litigation.[188] During the course of one such investigation, the risk management committee discovered an error that was unknown to the patient.[189] This proved to be a decisive moment in defining that institution's integrity; the committee not only disclosed the error to the patient, but also accepted responsibility for the adverse outcome.[190]

In a recent article, Dr. Steve S. Kraman, the medical director of the Lexington VA, and Ginny Hamm, the Lexington VA's in-house lawyer, outline the key components in the Lexington VA's disclosure policy: (1) risk management identifies "an instance of accident, possible negligence, or malpractice;" (2) the patient is notified that "there was a problem with the

---

that pose the most significant legal and financial risk to hospitals: "it is more likely for a hospital to face a multi-million dollar fraud settlement with the government than face a similarly large settlement in a medical malpractice case." Susan Huntington, *Fraud Probe Raises New Malpractice Risks*, 105 ERLANGER 13, 14 (Jan. 8, 2001). In investigating the rapid rise of malpractice insurance premiums, the United States Government Accounting Office recently concluded that any analysis of the issue is necessarily incomplete because of "a lack of comprehensive data at the national and state levels on insurers' medical malpractice claims and the associated losses." UNITED STATES GENERAL ACCOUNTING OFFICE, MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTHCARE 9, GAO-03-836 (Aug. 2003).

183. *E.g.*, Gallagher et al., *supra* note 85, at 1006.

184. *Id.*

185. Lamb et al., *supra* note 9, at 76.

186. *See, e.g.*, Maureen Glabman, *The Top Ten Hospital Malpractice Claims—And How to Minimize Them*, 57 TRUSTEE 12, 15 (2004); *Owning Up to Errors Saves Money*, 30 NURSING 53, 53 (2000) [hereinafter *Owning Up to Errors*]; Steven S. Kraman & Ginny Hamm, *Risk Management: Extreme Honesty May Be the Best Policy*, 131 ANNALS OF INTERNAL MED. 963, 964 (1999).

187. Kraman & Hamm, *supra* note 186, at 964.

188. *Id.*

189. *Id.*

190. *See* Kraman & Hamm, *supra* note 186, at 964; Albert W. Wu, *Handling Hospital Errors: Is Disclosure the Best Defense?*, 131 ANNALS OF INTERNAL MED. 970, 971 (1999).

care" received and is invited to come to the hospital; (3) a face-to-face meeting is conducted; and (4) the hospital offers continuing assistance to the patient in obtaining compensation.[191]

The details of the error are not outlined in the preliminary call to the patient, but the patient is given enough information "to indicate the seriousness of the matter (including, if necessary, a statement that a medical mistake was made and that an attorney may accompany the patient or family if desired)."[192] The heart of the disclosure occurs at the actual meeting when the hospital, through its chief of staff, expresses regret, details corrective action taken to prevent other similar occurrences, and extends an offer of restitution.[193] The VA considers restitution in broad terms which cover corrective medical procedures, assistance in filing for governmental benefits (such as disability), and monetary compensation.[194] The patient is guided in filing all requisite forms for preserving their claim and is advised to hire an attorney.[195] "The committee is then equally forthcoming with the plaintiff's attorney . . . ."[196]

This approach has reaped significant economic rewards. In 1999, the median malpractice settlement in the private sector was $497,412 while Lexington's was only $98,150.[197] In a concentrated study that focused only on the years 1990-1996, "the Lexington facility had 88 malpractice claims" and paid an average of $15,622 per claim.[198] Additionally, only eight claims were filed in court, seven of which were dismissed before trial,[199] and the VA won the only case that proceeded to trial.[200] Before the initiation of the policy, the Lexington VA was among the nation's VA hospitals that paid the most in claims.[201] Now it is "among those that pay the least."[202]

The experience of the Lexington VA cuts against the kind of advice limiting disclosure to empathic communications with patients where there is no admission of wrongdoing. The VA disclosure practice fulfills the

191. Kraman & Hamm, *supra* note 186, at 966-67.
192. *Id.* at 967.
193. *Id.*
194. *Id.*
195. *Id.*
196. *Id.*
197. Steve S. Kraman, *Lexington VA Hospital Provides a Model of Patient Disclosure*, 3d Annenberg Conference on Patient Safety (May 17, 2001), *available at* http://www.npsf.org/congress_archive/2001/summary_thursday.html.
198. Kraman & Hamm, *supra* note 186, at 964.
199. *Id.*
200. *See id.*
201. *Owning Up to Errors*, *supra* note 186, at 53.
202. *Id.*

elements of repentance to which authentic apology gives voice: it acknowledges wrongdoing through recognition of negligent treatment, expresses remorse and offers to make restitution. The final element of repentance, which requires restructuring of a life, is also borne out by the VA's experience: the rigorous honesty of its policy encourages systemic change. Discussing errors openly creates educational opportunities that help others avoid similar mistakes in the future.[203] The VA example establishes that risking authentic apology is efficacious not only from a moral perspective, but also from a practical analysis. Yet even this policy misses a critical opportunity. By having someone other than the physician who made the error communicate the disclosure, the opportunity for spiritual healing for both patient and physician is lost.[204] Still, this policy is as close to an authentic disclosure as I have found.

Some caution that the VA experience should not be relied upon in a private setting.[205] After all, the VA serves a specific patient population of "mainly older men of limited means, a group that may have finite expectations and a low level of litigiousness."[206] Additionally, VA "physicians are [legally] protected from personal liability and are not named [as parties] in malpractice [cases]."[207] The success of the policy itself is counterintuitive: it is one that increases the number of malpractice suits yet decreases the amount paid out. This is a "rare solution that is both ethically correct and cost-effective."[208]

Yet, the VA is not the only example illustrating that truth-telling and accountability can be both morally and practically beneficial, as there is other evidence to support authentic disclosures like that of the VA. For example, it has recently been reported that the Dana Farber Cancer Institute, a private facility in Boston, has not seen an increase in litigation in spite of its proactive disclosure policies.[209] Additionally, doctors in hospitals in the University of Michigan Health System have been encouraged to apologize for mistakes since 2002 and, as a result, notices of intent to sue have fallen

203. For further discussion on the impact of openness in avoiding future errors, *see infra* note 217.

204. *See* JCAHO II, *supra* note 8, at Standard RI.2.90. It may also be out of step with the JCAHO requirement that the responsible care provider must inform the patient.

205. *See* Kraman & Hamm, *supra* note 186, at 966 (discussing the difference between claims in the public and private sector). *See also* Jonathan R. Cohen, *Apology and Organizations: Exploring An Example from Medical Malpractice*, 27 FORDHAM URB. L.J. 1447, 1455 (2000) (noting important differences between physicians in the private sector from those practicing in a federal governmental context).

206. Wu, *supra* note 190, at 971.

207. *Id.*

208. *Id.* at 972.

209. *See* Lamb et al., *supra* note 9, at 80.

from 262 in 2001 to approximately 130 per year.[210] Another anecdotal example is one recently reported by the American Society for Healthcare Risk Management (ASHRM). [211]

In its *Monograph* on disclosure, ASHRM reviews the results of research centered on an actual suit that resulted in a multi-million dollar plaintiff's verdict.[212] In that study, two mock trials were conducted before two mock juries.[213] In one of the mock trials, the jury was presented with the exact fact pattern as it had occurred in the original trial.[214] The second mock trial was identical, except a mock disclosure was added to the factual scenario presented.[215] The disclosure proved determinative in the verdicts.[216]

The first mock jury returned a verdict almost identical to that of the original jury trial. "By contrast, the jury where there was disclosure granted an award that was millions of dollars lower."[217] When the researchers debriefed the mock jurors, they learned that the failure to disclose the error "exacerbated the belief that the organization should be punished for more than compensable real damages."[218] Yet, when the jurors were advised of the disclosure, their inclination to punish evaporated so that the jurors "felt their duty was only to compensate for genuine losses."[219]

---

210. *Doctors: Just Say Sorry*, TRAVERSE CITY RECORD-EAGLE, Nov. 12, 2004, at 6A.
211. ASHRM I, *supra* note 10, at 6.
212. *Id.*
213. *Id.*
214. *Id.*
215. *Id.*
216. *Id.*
217. ASHRM I, *supra* note 10, at 6.
218. *Id.*
219. *See id. But see,* Brian H. Bornstein et al., *The Effects of Defendant Remorse on Mock Juror Decisions in a Malpractice Case,* 20 BEHAV. SCI. LAW 393 (2002). In this study, the authors identified what they described as four apology strategies: remorse, responsibility, forbearance, and reparation. *Id.* at 394. They then measured only the way in which the expression of remorse affected mock juror decisions. In their conclusions they mistakenly conflated the expression of remorse with apology concluding that "apologizing at the time the adverse event occurs leads to higher damage awards than not apologizing, especially when the injury is relatively severe." *Id.* at 407. They close with a caveat: "defendant physicians must unfortunately be very guarded about when and how they display remorse for a patient's negative outcome." *Id.* at 408. The conclusion and caveat seem precipitous, especially when it is recalled that the expression of remorse alone is tantamount to a botched apology. *See supra* pp. 70-72. Had the authors understood the expression of remorse alone as a "botched apology" then the results of the decision of the mock jurors would have been an expected hypothesis rather than the apparent surprise it was. The authors seem to recognize the limitation of their findings in their suggestion of the need for future research. Bornstein, *supra*, at 407. What is not clear, is whether they understand the specific reason that would explain the mock jurors decision. As the VA example makes clear, a fair offer of compensation must accompany the apology. *See supra* pp. 82-84; *cf.* Robbennolt, *supra* note 84, at 504 (recognizing the significance of the offer of compensation in conjunction with the full apology in promoting settlement).

The importance of disclosure to the jury's decision in the mock trials echoes the actual experience of Lexington's VA. When asked why the value of their claims was lower than other veteran hospitals, Dr. Kraman responded that "the reason our payout is lower is due to honesty."[220] Elaborating, he noted that what patients want first are facts, second an apology, and, finally, money, "which comes in a distant third."[221]

In this essay I have demonstrated the moral value of authentic apology and the way it inspires healing for both physician and patient. I have shown, too, how the moral dimension of apology can be subverted when strategic and legal concerns take precedence over moral and ethical movements. This is what happens when empathic disclosures are offered in lieu of authentic expressions of remorse and when misguided legislatures enact laws that "protect" apology and, in the process, legislate away the expression's central element. Some disclosures, like the "protected" apology, are actually "botched apologies" that harm instead of heal.

The examples in this section support the second prong of my thesis: in addition to its moral and healing dimension, full disclosure coupled with authentic apology also has quantitative benefits that outweigh the real and perceived risks in its communication.[222] Still, the resistance to full disclosure persists. How can it be that physicians and institutions recognize that apology carries with it both moral and practical benefits, yet continue to allow fear of litigation to be the overarching concern in constructing disclosure policies?[223] Perhaps one physician's candid comment

220. Carol Patton, *Physicians Wary of JCAHO Rules on Medical Errors*, PHYSICIANS FIN. NEWS, Sept. 15, 2001, *available at* http://www.doctorquality.com/www/news/news_091501.htm.

221. *Id.*

222. Another practical benefit of institutional support for authentic apology is the expectation that the movement toward a culture of honesty and openness will disrupt those cultures of silence that tend to hide systemic problems that may have contributed to the error. Recall that repentance requires, as one of its essential elements, the restructuring of life. *See supra* p. 13. In the context of medical error, this requires a willingness to learn from the mistake and effect changes in order to ensure that a similar mistake is not repeated. The benefit to hospitals that risk honesty and a willingness to change is particularly significant when the cost of individual error is considered as a cumulative expense within the institutional context. *See* Cohen, *supra* note 205, at 1464-68 (explaining that in the context of medical error, this requires a willingness to learn from the mistake and effect changes in order to ensure that a similar mistake is not repeated. The benefit to hospitals that risk honesty and a willingness to change is particularly significant when the cost of individual error is considered as a cumulative expense within the institutional context).

223. *See* Gallagher et al., *supra* note 85, at 1006. The authors of this study concluded that the current response to medical errors was inadequate in meeting the needs of patients and physicians. "Patients unanimously wanted information regarding an error's cause, consequences, and future prevention." *Id.* Yet, fear of litigation led to a discomfort for physicians to disclose and interrupted an inclination to apologize. *Id.*

illuminates what propels this paradox:

> Everything you read and everything that you're told says that you are supposed to tell what errors you make as soon as you can. Let them know what your thinking is, what you are going to do about it. And your chances of having an adverse litigation are less if you take that approach. Now the question is, how many of us believe that?[224]

The answer to this rhetorical question is not nearly enough. This is a systemic issue, one that threatens to undermine the opportunities created by the Institute of Medicine (IOM) report and the regulatory responses to it. While more than eighty percent of hospitals responding to a recent survey indicated that disclosure policies were in place or being developed, the most recent reports acknowledge that "there is still a long way to go before serious harm is consistently and thoroughly disclosed to patients."[225] The rhetorical question the doctor poses leaves me wondering if the insights I have offered to this point are enough to resolve the intolerable dilemma Hilfiker noted: when one sees the horror of his or her mistake yet is systemically constrained from initiating steps to alleviate the suffering caused by the mistake. Is the proof of my thesis enough to tip the scales of reason against perceptions fueled by fear?

I will make one last argument in my attempt to encourage a cultural shift that brings medical mistakes into the open through proactive disclosures that include authentic apology, one final attempt to tip the scales toward moral concerns and away from policies and practices that focus on strategic and legal consequences. In this argument, I rely primarily on my expertise as a trial lawyer, a role in which I was for many years board certified in both personal injury and civil trial practice. Throughout my legal career, I represented people who had suffered catastrophic loss, often as the result of medical mistake. If it is the fear of litigation that stands between truth and healing, if it is fear that interrupts Hilfiker's formula of confession leading to absolution, then that fear must be addressed head-on.

Recent studies have reported that "perceptions about [the] litigation risk may be worse than the reality."[226] Regardless of the truth of this claim, malpractice litigation is real and, if you are the one sued, litigation is a grueling, life-altering experience. It extracts great costs in both economic and non-monetary terms. The plaintiff's recovery is only one element of the economic costs, as money also pours out for lawyers, expert witnesses, and travel. The Lexington VA's lawyer reports that it costs $250,000 to

224. *Id.* at 1004.
225. Lamb et al., *supra* note 9, at 79.
226. *Id.* at 80.

defend a single malpractice case.[227] There is a financial cost to the physician regardless of whether or not malpractice insurance is in place. There are deductibles to pay and lost income due to the time litigation requires the physician to spend away from the practice of medicine. There are non-economic costs as well.

In the past fifteen years, there have been reports on the effects of mistake on physicians. Hilfiker's essay offers anecdotal evidence, while more recent reports are based on actual studies performed. All agree that the emotional impact of mistake on the health care professional is dramatic. Studies show that in the aftermath of error, "[p]rofessionals often feel shame, humiliation, agony, anguish, devastation, panic, guilt, remorse, sadness, anger, self-doubt, and self-blame."[228] In addition, doctors' need to satisfy professional and cultural expectations of perfectionism leads to breaches in integrity—cover-ups, record changing, and other forms of dishonesty.[229] In the present culture, mistakes fuel isolation, addiction, and suicide.[230] While "patients are the first and obvious victims of medical mistakes, doctors are wounded by the same errors: they are the second victims."[231]

It is widely believed among physicians that plaintiffs' lawyers constantly seek inventive ways to bring lawsuits and, in the hunt for cases, these lawyers fail to be sufficiently discriminating when accepting cases. I do not doubt that there are some plaintiffs' lawyers who operate precisely in this way. All negative stereotypes have some small measure of truth. Yet when translated into a business model, the impression of the way cases are selected does not make economic sense.

In any medical malpractice case, the plaintiff must prove by the greater weight of the credible evidence that the physician's care fell below the standard of practice. This is no easy burden. To satisfy this requires the testimony of physicians from within the defendant doctor's field of specialty. Finding such an expert is difficult, the fees charged by experts

227. Kraman & Hamm, *supra* note 186, at 966.

228. Martin L. Smith & Heidi P. Forster, *Morally Managing Medical Mistakes*, 9 CAMBRIDGE QTLY. HEALTHCARE ETHICS 38, 42 (2000).

229. *See* Berkeley Rice, *How Plaintiff' Lawyers Pick Their Targets*, 77 MED. ECON. 94 (2000), *available at* 2000 WL 100687116.

230. Gerald B. Hickson et al., *Factors that Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries*, 267 JAMA 1359, 1359 (1992); Gallagher et al., *supra* note 85, at 1005. As I was completing this essay, *The Dallas Morning News* reported the suicide of Dr. Philip Adam Ticktin. *See* Joe Simnacher, *Doctor Loved Pace of Working in ER*, DALLAS MORNING NEWS, May 12, 2004, at B7. According to the article, Dr. Ticktin "was upset about a recently settled medical malpractice lawsuit and a second lawsuit that was related to the first . . . ." *Id.*

231. Wu, *supra* note 129, at 726.

are enormous, and, like all costs associated with the malpractice case, experts' fees are typically paid by the plaintiff's lawyer as the case progresses. It is not uncommon for a plaintiff's lawyer to have costs advanced in a six-figure range, costs that do not include a fee that is contingent on the plaintiff's lawyer winning the case. The successful plaintiff's lawyer cannot afford to be careless in case selection. On the contrary, the careful plaintiff's lawyer is looking for the egregious case, one likely to incite a jury. Many malpractice lawyers share this perspective.Jeffrey Allen and Alice Burkin are "experts at suing doctors."[232] They underscore the difficulty of prevailing in a medical malpractice case when they offer this reminder: "[n]ever forget that you're asking [twelve] people to take money from one person and give it to another."[233] One of the key strategies they look for to convince this panel of twelve to take money from doctors and give it to their clients is an "incendiary device"—something that will get the jurors angry at the doctor.[234] This is because an angry jury awards more money, just as the mock jury did in the ASHRM study reported earlier.[235] Allen and Burkin's favorite "incendiary device" is the arrogant physician who "just can't... admit that [he or she has] screwed up, even when it's obvious."[236]

There is a systemic way to remove this incendiary device and disable its potential for explosive impact. That way is to create a disclosure policy like that modeled by the Lexington VA, but that also provides an opportunity for healing as I have outlined.[237] Under a best-case scenario, after this fault-admitting disclosure, the parties will, in most cases, resolve the matter expeditiously, as the Lexington experience has proved over and over during the past fifteen years.[238] Still, it is the worst-case scenario—where the case cannot be quickly resolved and proceeds to trial—that fuels the fear which interrupts the inclination to risk the opportunity authentic apology presents. Yet even when the case does not settle, the health care provider will be better off for risking what authenticity requires.

If the case proceeds to trial the admission can be used defensively in at least two different ways. In many states, trials can be bifurcated, that is, split so that issues of liability and damages are considered separately. In the face of an authentic apology, there is no reason to try the issue of fault

232. Rice, *supra* note 229.

233. *Id.*

234. *Id.*

235. ASHRM I, *supra* note 10, at 6.

236. Rice, *supra* note 229.

237. *See supra* pp. 84-85 (noting that the VA policy falls short in its failure to have the doctor who erred being the person communicating the apology).

238. Kraman & Hamm, *supra* note 186, at 964-65.

since it has already been admitted. Because of the admission created by the apology, the defense would accept liability and allow the case to proceed on damages alone. This keeps the jury focused on its central task—determining fair compensation for the injured party. In advising the jury that the doctor has admitted having made a mistake and has accepted responsibility, the skillful defense lawyer can communicate what the case is really about: money. This creates a complication for the plaintiff's lawyer: without the "incendiary device" the denial of clear liability creates, the issue of compensation takes center stage, so much so that the plaintiff must be cautious or risk that his demand for compensation be seen as greed instead.

In those states where bifurcation is not allowed, the jury should be advised from the beginning of the trial that this is not a case about fault-finding, but about the value to be assigned to the admitted mistake. Again, a skilled defense lawyer can create a tension in this trial between fair compensation and greed. For example, the trial can begin with a theme that informs the jury that its only job is to determine a fair value for the injuries the plaintiff sustained, since "Dr. Jones has apologized to Mr. Smith and has expressed his remorse. In accepting fault, we ask only for your help in determining fair compensation, the only issue we have not been able to agree upon."

Of course there is the possibility for this process to be subverted, for the authentic apology to become merely a "legal tool" or "lubricant" to facilitate a rapid disposition of the suit. It is this subversive use of apology that is advanced by many of the proponents of "protected" apologies.[239] Nevertheless, in most jurisdictions, the general rule prevails so that the opportunity for subversion is remote and unlikely.[240] After all, how many doctors in states other than Colorado would risk the consequences of a fault-admitting disclosure in an attempt to manipulate litigation?

My suggestion for authentic apology as an integral piece of disclosure practices when medical error is present is not one that I expect to be immediately embraced by members of the health care industry or their advisors. After all, if a national trend emerged along the lines suggested by the success of pioneers like the Lexington VA, some businesses that make

239. *See* CAL. EVID. CODE § 1160 (2004 Electronic Update Comment) (noting bill's sponsor argued in favor of the utility of apology without recognizing the moral implications of legislatively protecting apology). *See also* Orenstein, *supra* note 69, at 255 (arguing in favor of legislative protection in spite of realization that protection could be disruptive to injured party).

240. To date, Colorado is the only state to legislatively protect the authentic apology. COLO. REV. STAT. § 13-25-135. The other states that have enacted legislation protect only the expression of sympathy, not the admission central to an authentic apology. *See, e.g.*, CAL. EVID. CODE § 1160; FLA. STAT. ANN. § 90.4026 (2004); TEX. CIV. PRAC. & REM. CODE ANN. § 18.061; WASH. REV. CODE § 5.66.010(1).

money from both the fear of litigation and the litigation itself, such as insurers and their lawyers, could be at risk. While I maintain professional respect for most of the defense lawyers with whom I have worked, some have engaged in legal maneuvers and tactics that appeared to be motivated more by the chance to increase hourly billing than by advancing their clients' best interests. It must be remembered that if there is a quick and prompt settlement, defense firms stand to suffer economically. What is a $250,000 cost from the health care provider's perspective is $250,000 in income from the vantage point of their lawyers.

VII. CONCLUSION

This is a critical time for those in the health care industry. It is a time of opportunity. It is not hyperbole to say this moment is just as important to the health care industry as was the moment when a team of risk managers sitting in Lexington, Kentucky decided to disclose "an incident of negligence of which the patient or next of kin was apparently unaware."[241] Recall that the Kentucky team that made this decision was formed "to better prepare the risk management committee to defend malpractice claims . . . ."[242] It was in the face of an unexpected ethical dilemma that this group of people and the institution it represented chose a risky and courageous moral path. Just as that moment defined the integrity of a particular hospital, so too will this moment define the moral integrity of disclosure and its introduction into health care institutions across the nation.

How the health care industry chooses to respond will define the moral relationship between institutions, physicians, and the people they serve for the foreseeable future. If the choice is to disclose without an authentic apology, my hope is that the disclosures made will avoid the confusion and added suffering that result from well-crafted expressions of regret that do not admit wrongdoing. To spend enormous energy and resources with consultants and communication experts to craft self-serving disclosures that are intended not only to inform but also to manipulate seems contrary to the role of care-giver in a patient-centered environment. If there is an unwillingness to accept the consequences of a wrongful act, integrity requires that a disclosure not be conflated with apology through well-rehearsed and practiced communication strategies. That kind of disclosure takes further advantage of the imbalance of power in the physician-patient relationship. If moral courage fails and the decision is not to acknowledge fault, integrity ought to be demonstrated in another manner. The physician or health care provider should inform the patient of what happened and

241. Kraman & Hamm, *supra* note 186, at 964.
242. *Id.*

what will happen next, with courtesy and respect, but resist the urge to employ the self-serving and defensive communication strategies of the apologia.

For the courageous, the Lexington policy offers a good model, provided it is modified as I have suggested.[243] There should be an unequivocal admission of error communicated by the physician or health care provider responsible for the error, so the healing dimension of the authentic expression of remorse can be fully experienced by patient and provider alike. Should the patient refuse a fair offer of restitution, then let the trial proceed. One will see that the authentic disclosure has the capacity to help at trial as well. Defense lawyers and insurance carriers must also be courageous. They must help construct a fair restitution package and refuse to pay one dime to settle a frivolous suit.[244] Frivolous suits must be tried so that the kind of lawyer who takes a case with an eye on an easy settlement will become as anachronistic as an undisclosed medical error. A line needs to be drawn and this is the time to set it down.

There is also a role for the legislature in this process. Rather than enacting statutes that interrupt the integrity of apology, legislative bodies should create laws that support, rather than undercut, the moral courage required in fault-admitting statements. In the context of disclosure practices, this would be a law that conforms to the public policy supporting the peaceful resolution of disputes, a policy that promotes settlements rather than protracted litigation. In the face of the fault-admitting disclosure I describe here, a statute should be drawn that is reciprocal in the way it encourages both parties to be fair-minded so settlements are encouraged. This law would inspire health care providers to be reasonable in the restitution offered, yet restrain the human tendency to overstate the value of one's loss. Such a statute would read:

> In cases where a disclosure of an unanticipated outcome is made, in which disclosure the health care provider acknowledges fault with sufficient specificity so that the issue of negligence is removed from the trier of fact's consideration, the health care provider shall submit in writing an offer of restitution to the injured party or his or her representative [within some reasonable time period from the date when the injured party's losses can be measured]. The injured party will have [some reasonable time period from the date the offer of restitution is received] within which to accept or reject such offer of restitution. If the

243. *See supra* pp. 79-83.

244. *See* Kraman, *supra* note 197. This is in conformance with the Lexington experience. Dr. Kraman's advice is to offer fair settlements and "never settle nuisance claims." *Id.*

> offer of restitution is rejected, and if a verdict falls within 12% of the offer of restitution, then the injured party shall recover the amount tendered in the offer of restitution or the verdict, whichever is less. In addition, the injured party shall pay the reasonable litigation expenses incurred by the health care provider between the date of the offer of restitution and the conclusion of the trial.[245]

It will take years for a statute like this to be considered, and in that time many more errors will undoubtedly occur and thousands of patients and physicians will suffer as a result of medical mistakes. This essay is another step in the emerging research that undercuts the kind of advice that silences physicians in the face of their mistakes, advice that locks them within the "intolerable dilemma" Hilfiker described where one sees their mistakes yet feels powerless to address them.[246] There is a way out of this dilemma. It is not a path one takes alone, it is quintessentially relational. The path is as Hilfiker described: one of confession, restitution and absolution.[247] It is a path I hope Hilfiker has found.

245. The model I propose requires resolution of certain details. For example, the date at which the injured party's damages can be measured must be clarified. I would suggest that the damages be measured on the date the injured party has reached a point of maximum medical benefit, at which time the injured party's future has been more clearly revealed. Resolving such questions will add important detail and dimension to the proposed statute.

246. Hilfiker, *supra* note 12, at 335.

247. *Id.*