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A PHYSICIAN'S APOLOGY: AN ARGUMENT AGAINST
STATUTORY PROTECTION

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I. INTRODUCTION

We learn from the time we are children that if we hurt someone, even by accident, the right thing to do is apologize and see if we can help to make things better.¹ Apologizing and taking responsibility for our actions is built into the psyche of American culture.² However, there is one player in this culture, the physician who cares for us when we are sick or injured, who has historically refused to admit any mistake that he or she may make. The physician is guided by none other than Hippocrates himself, who taught that a physician should conceal “most things from the patient while . . . attending to him . . . revealing nothing of the patient's future or present condition.”³ This “medical paternalism” continued to dominate the profession well into the twentieth century, guided by the American Medical Association’s Code of Ethics directing all physicians “to avoid all things which have a tendency to discourage the patient and to depress his spirits.”⁴

It was not until 1957 when an American court first used the phrase “informed consent” to describe the duty of disclosure that a treating physician owes to his patient when deciding treatment options.⁵ It took the American Medical Association (AMA) another twenty-four years to amend its code to encourage a more honest and open communication between physician and patient, at least in the initial stages, when deciding on a course of treatment.⁶ In 1981 the AMA finally acknowledged that, when deciding on a treatment option, “[i]nformed consent is a basic policy in both ethics and law that physicians must honor, unless the patient is unconscious or otherwise incapable of consenting and harm from failure to treat is imminent.”⁷

¹ See Xuan-Thao Nguyen, *Apologies As Intellectual Property Remedies: Lessons from China*, 44 CONN. L. REV. 883, 888 (2012) (noting that children learn from their parents at a “young age to say the ubiquitous phrase when they take away toys from a friend without permission, hit a playmate, or hurt a friend’s feelings.”); Donna L. Pavlick, *Apology and Mediation: The Horse and Carriage of the Twenty-First Century*, 18 OHIO ST. J. ON DISP. RESOL. 829, 837–38 (2003) (observing that “children learn what constitutes an appropriate form of apology, its effects, and when one should expect to give or receive an apology”).

² See Nguyen, *supra* note 1, at 888–89 (noting the apologies of politicians, athletes, and the United States Congress for 246 years of institutional slavery and subsequent Jim Crow laws).

³ Sheldon F. Kurtz, *The Law of Informed Consent: From “Doctor is Right” to “Patient Has Rights,”* 50 SYRACUSE L. REV. 1243, 1243 (2000) (quoting 2 HIPPOCRATES, DECORUM 297 (W. Jones trans., Cambridge: Harvard Univ. Press 1967)).

⁴ *Id.* at 1244 (citation omitted).

⁵ *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 317 P.2d 170, 181 (Cal. Ct. App. 1957).

⁶ See AM. MED. ASS’N, CODE OF MED. ETHICS, OPINION 8.08–INFORMED CONSENT (1981) [hereinafter AMA OPINION 8.08], available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion808.page> (acknowledging that a “patient’s right of self-decision can be effectively exercised only if the patient possesses enough information to enable an informed choice.”).

⁷ *Id.*

Almost twenty years later came the push for transparency after treatment—after, in some cases, mistakes are made and a patient suffers harm.⁸ The Institute of Medicine (IOM) issued its report in 1999 that publicized the shockingly high number of deaths resulting every year because of mistakes made by physicians.⁹ In its report, the IOM called for a study of these mistakes to find ways to prevent them and the only way to accomplish that was to report them to someone.¹⁰ Of course, it would make sense for the physicians to report the mistakes to the victims themselves, and the AMA had already acknowledged, in the 1981 amendments to its Code of Medical Ethics, that “[s]ituations occasionally occur in which a patient suffers significant medical complications that may have resulted from the physician’s mistake or judgment” and that “[i]n these situations, the physician is ethically required to inform the patient of all the facts necessary to ensure understanding of what has occurred.”¹¹

Despite this push for transparency, however, change came slowly. Over the next few decades, the federal and state governments established reporting systems to track mistakes and corrections made, but few of these reporting requirements ensured that the patients who suffered harm were informed of the mistakes made.¹² The reasons for this are many, including physicians’ fears that honesty would lead to a loss of respect by their peers, lawsuits by their victims, and the loss of insurance coverage.¹³

Acknowledging the reality of these fears, state legislatures and courts have tried to encourage physicians to admit their mistakes by making apologies and even admissions of fault inadmissible in medical malpractice lawsuits.¹⁴ This paper examines these attempts, generically referred to “I’m

⁸ COMM. ON QUALITY & HEALTH CARE IN AM., INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 1 (Linda T. Kohn et al. eds., Nat’l Acad. Press 2000) [hereinafter TO ERR IS HUMAN], available at <https://www.iom.edu/-/media/Files/Report%20Files/1999/To-Err-is-Human/To%20Err%20is%20Human%201999%20%20report%20brief.pdf>

⁹ *Id.* (noting that “[a]t least 44,000 people, and perhaps as many as 98,000 people, die in hospitals each year as a result of medical errors that could have been prevented”).

¹⁰ *Id.* at 3.

¹¹ AM. MED. ASS’N, CODE OF MED. ETHICS, OPINION 8.12-PATIENT INFORMATION (1981) [hereinafter AMA OPINION 8.12], available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion812>.

¹² See *infra* notes 125–32 and accompanying text.

¹³ Richard C. Boothman et al., *A Better Approach to Medical Malpractice Claims? The University of Michigan Experience*, 2 J. HEALTH & LIFE SCI. L. 125, 128 (2009) (noting that physicians’ reluctance to speak to their patients about mistakes and complications unrelated to mistakes because of “myriad fears” including “a natural aversion to confronting angry people; concerns that disclosure might invite a claim that otherwise would not be asserted; anxiety that the discussion will compromise courtroom defenses later; and fear that the conversation may lead to loss of malpractice insurance or higher premiums.”).

¹⁴ See *infra* note 43 for a list of those statutes.

sorry” laws or “apology” statutes, in light of the concerns raised if physicians are honest. After a review of a physician’s ethical duty to disclose and the empirical evidence of how open and honest communication between patient and physician actually benefits both the patient and the treating physician, the paper questions whether apologies by health care providers need the protection afforded by these laws.

Section II reviews the history of the medical profession’s tendency toward silence and the reasons for that silence. Section III examines the state statutes passed to encourage the breaking of this silence. Section IV reviews the state rules of evidence that have traditionally been applied to determine whether or not statements of regret or fault are admissible and examines how these statements affect the outcome of medical malpractice claims. Then, Section V considers a physician’s ethical duty of full disclosure and the impact of honest communication between physician and patient. Section VI concludes, based on these considerations, that a physician should disclose mistakes and admit responsibility for those mistakes, and should do so without any special protection if they are sued to answer for those mistakes. Requiring physicians to do the same as what we expect of our children best serves a patient’s interests and properly reflects a physician’s ethical duty to disclose.

II. SILENCE, PLEASE

Physicians have traditionally kept their mistakes to themselves.¹⁵ With perfection as their goal, physicians have operated under the assumption that “mistakes are unacceptable” and, if they are made, they should not be admitted.¹⁶ However, assuming mistakes are unacceptable does not mean that physicians do not make them, as the IOM emphatically proved in 1999.¹⁷ In *To Err is Human*, the IOM reported that between 44,000 and 98,000 Americans die in hospitals each year due to medical mistakes.¹⁸ That num-

¹⁵ Lucinda E. Jesson & Peter B. Knapp, *My Lawyer Told Me to Say I’m Sorry: Lawyers, Doctors and Medical Apologies*, 35 WM. MITCHELL L. REV. 1410, 1428 (2009) (noting that “doctors and other health care professionals traditionally practiced in the context of a culture of silence”); Marlynn Wei, *Doctors, Apologies, and the Law: An Analysis and Critique of Apology Laws*, 40 J. HEALTH L. 107, 109 (2007) (noting the “pressing problem in medicine” of not only “the lack of apologies, but a more fundamental lack of disclosure”).

¹⁶ Jesson & Knapp, *supra* note 15, at 1417 (citation omitted).

¹⁷ See *TO ERR IS HUMAN*, *supra* note 8, at 1.

¹⁸ *TO ERR IS HUMAN*, *supra* note 8, at 1; see also Steven E. Raper, *No Role for Apology: Remedial Work and the Problem of Medical Injury*, 11 YALE J. HEALTH POL’Y, L. & ETHICS 267, 276 (2011) (noting that “error is an inherent, unavoidable aspect of human work.”).

ber does not even reflect the actual numbers of people injured who did not actually die or were treated in health care facilities other than hospitals.¹⁹

Even after the publication of this report, physicians tended not to admit mistakes to anyone.²⁰ They did not admit mistakes to other physicians who, they feared, would think less of them.²¹ Nor did they admit mistakes to their patients, perhaps for the same reasons, or perhaps because they feared their patients would sue them and use their admissions against them in court.²² Indeed, fearing liability, hospital administrators, insurance carriers, and defense lawyers routinely instruct physicians that they should not disclose mistakes to their patients.²³ As noted by one defense counsel, “Why give the enemy even one tiny gram of TNT if I could give them none?”²⁴

This fear is not without foundation. For example, in one case against Georgetown University, the District of Columbia Court of Appeals, sitting *en banc*, allowed a physician's admission that he had performed the “wrong operation” and that he had “forgotten” that the surgery he performed was not appropriate given the patient's condition to establish a *prima facie* case of negligence against him.²⁵ In other cases, courts have held that an admission may not, by itself, prove negligence, but it may be admitted as evidence of it.²⁶

In a Utah case, decided before the state had enacted its apology law, the Court of Appeals considered a request to keep an admission of fault out of court.²⁷ The physician requesting that protection had recommended that a patient have joint replacement surgery on a toe without trying more conservative treatments or referring the patient to a rheumatologist.²⁸ The surgery did not work and, after several subsequent surgeries, the patient be-

¹⁹ TO ERR IS HUMAN, *supra* note 8, at 2.

²⁰ TO ERR IS HUMAN, *supra* note 8, at 2; *see also* Pavlick, *supra* note 1, at 852.

²¹ TO ERR IS HUMAN, *supra* note 8, at 2; *see also* Pavlick, *supra* note 1, at 852.

²² *See* Boothman et al., *supra* note 13, at 128; Jeffrey S. Helmreich, *Does 'Sorry' Incriminate? Evidence, Harm and the Protection of Apology*, 21 CORNELL J.L. & PUB. POL'Y 567, 573 (2012) (citation omitted) (noting a survey of physicians who expressed the desire to apologize to their patients for harming them but the decision not to for fear that the apology would be used against them in court).

²³ Helmreich, *supra* note 22, at 573 (citation omitted).

²⁴ Helmreich, *supra* note 22, at 573 n.33 (citation omitted).

²⁵ *Colbert v. Georgetown Univ.*, 623 A.2d 1244, 1253 (D.C. 1993), *rev'd en banc*, 641 A.2d 469 (D.C. 1994); *see* Raper, *supra* note 18, at 297–02 (reviewing several cases in which a physician's admissions were admitted and used to establish a *prima facie* case of negligence against him).

²⁶ *See, e.g.*, *Phinney v. Vinson*, 605 A.2d 849, 850 (Vt. 1992) (holding that, while the defendant's admission of mistake may have been admissible, it did not “by itself” establish a *prima facie* case); *Woods v. Zeluff*, 158 P.3d 552, 556 (Utah Ct. App. 2007) (acknowledging that statements of fault may be admissible but would not alone be sufficient to prove negligence).

²⁷ *Woods*, 158 P.3d at 552.

²⁸ *Id.* at 553–54.

came permanently disabled.²⁹ After the surgery, the physician admitted to the patient that “‘I jumped the gun,’ ‘I’ve missed something,’ and ‘I don’t think we should have done this surgery.’”³⁰

The trial court decided the physician’s statements were inadmissible pursuant to the state’s rules of evidence “on the grounds that the testimony is minimally probative and is substantially outweighed by the dangers of unfair prejudice.”³¹ Consistent with the federal rules and other analogous state rules, the Utah appellate court noted that “relevant evidence is generally admissible.”³² Under the broad definition of relevance, defined as “evidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence,”³³ the trial court determined that the statements by the physician that he “missed something,” “jumped the gun,” and “shouldn’t have done this surgery” were relevant to the question of his negligence.³⁴ The trial court excluded the evidence despite its relevance, however, because its probative value was “substantially outweighed by the danger of unfair prejudice.”³⁵

On appeal, the court reversed the trial court’s decision to exclude the statements on the ground that, while the statements may be prejudicial, they were not “unfairly prejudicial.”³⁶ The importance of this decision lies in the fact that the appellate court allowed the physician’s statements to be considered by the jury, but it did not mean that the victim necessarily would win his case.³⁷ The court noted only that the plaintiff’s testimony regarding the physician’s alleged statements is “highly probative because it reveals a medical expert’s assessment of his own actions, an assessment that has bearing on the determination of negligence—specifically, on the question of breach of the standard of care.”³⁸ Balancing the probative value of the evidence with its potential prejudicial effect, the court noted that “the statements do not contain information that would likely create feelings of “bias, sympathy, hatred, contempt, retribution or horror” in the fact finder, or in-

²⁹ *Id.* at 554.

³⁰ *Id.*

³¹ *Id.* (quoting the trial court’s decision to exclude the statements).

³² *Woods*, 158 P.3d at 554 (citation omitted).

³³ *Id.* (quoting UTAH R. EVID. 401(2011)).

³⁴ *Id.*

³⁵ *Id.* (quoting UTAH R. EVID. 403 (2011)).

³⁶ *Id.*

³⁷ See *infra* notes 74–80 and accompanying text for a discussion of the impact of this evidence on the *Woods* case.

³⁸ *Woods*, 158 P.3d at 555.

formation that would otherwise shift the fact finder's attention away from the proper method for resolving the negligence issue.”³⁹ Seeing “only a remote possibility that the evidence at issue is of the sort that will lead the fact finder to render a decision on an emotional or otherwise improper basis,” the court therefore held that the evidence could come in.⁴⁰

After the *Woods* case was decided, the Utah legislature stepped in to guarantee that statements like the ones made in that case would not be admissible, regardless of the probative value or the prejudicial effect those statements might have in a future case.⁴¹ Pursuant to the Utah statute, “any unsworn statement, affirmation, gesture, or conduct made to the patient” by the defendant in a malpractice action against a health care provider “as evidence of an admission against interest or of liability if it expresses (i) apology, sympathy, commiseration, condolence, or compassion; or (ii) a general sense of benevolence; or (b) describes (i) the sequence of events relating to the unanticipated outcome of medical care; (ii) the significance of events; or (iii) both.” is “inadmissible as evidence of an admission against interest or of liability.”⁴² A majority of states have similar laws, which are reviewed in the following section.

III. THE “APOLOGY” LAWS

Two-thirds of the states and the District of Columbia have enacted statutes that define apologies of one sort or another as inadmissible in medical malpractice lawsuits to prove that the apologizing physician negligently provided medical care.⁴³ The first of these laws was passed in Massachu-

³⁹ *Id.* (citation omitted).

⁴⁰ *Id.*

⁴¹ UTAH CODE ANN. § 78B-3-422 (West 2008).

⁴² *Id.* Only one court has considered the reach of this statute. See *Lawrence v. Mountainstar Healthcare*, 320 P.3d 1037, 1051 (Utah Ct. App. 2014), *cert. denied*, 329 P.3d 36 (Utah 2014) (deciding that admissions of fault are admissible in light of the statute’s failure to explicitly protect them). See *infra* section III for a discussion of this case and others addressing the scope of apology laws.

⁴³ See ARIZ. REV. STAT. ANN. § 12-2605 (2015); COLO. REV. STAT. ANN. § 13-25-135 (West 2014); CONN. GEN. STAT. ANN. § 52-184d (West 2015); DEL. CODE ANN. tit. 10, § 4318 (West 2015); D.C. CODE § 16-2841 (2001); FLA. STAT. ANN. § 90.4026 (West 2014); HAW. REV. STAT. § 626-1 (West 2014); IDAHO CODE ANN. § 9-207 (West 2014); 735 ILL. COMP. STAT. ANN. 5/8-1901 (West 2014); IND. CODE ANN. § 34-43.5-1-4 (West 2014); IOWA CODE ANN. § 622.31 (West 2015); LA. REV. STAT. ANN. § 13:3715.5 (2014); ME. REV. STAT. ANN. tit. 24, § 2907 (2013); MD. CODE ANN., Courts and Judicial Proceedings § 10-920 (LexisNexis 2013); MASS. GEN. LAWS ANN. ch. 233, § 79L (West 2014); MICH. COMP. LAWS ANN. § 600.2155 (West 2014); MO. ANN. STAT. § 538.229 (West 2014); MONT. CODE ANN. § 26-1-814 (West 2013); NEB. REV. STAT. ANN. § 27-1201 (West 2014); N.H. REV. STAT. ANN. § 507-E:4 (2014); N.D. CENT. CODE ANN. § 31-04-12 (West 2013); OHIO REV. CODE ANN. § 2317.43 (West 2014); OKLA. STAT. ANN. tit. 63, § 1-1708.1H (West 2014); OR. REV. STAT. ANN. § 677.082 (West 2014); 35 PA. CONS. STAT. ANN. § 10228.3 (West 2014); S.C. CODE ANN. § 19-1-190

setts in 1986⁴⁴ in response to the traffic death of the daughter of a former state senator.⁴⁵ Wanting an apology from the driver but never getting one, the former senator discovered that the driver had wanted to apologize but was afraid that it would be used against him if he were sued.⁴⁶ Based on this revelation, the former senator prodded the Massachusetts legislature to enact a statute to protect apologies made by any tortfeasor by making them inadmissible in any civil action.⁴⁷

Since Massachusetts passed its law, a majority of states and the District of Columbia have enacted a “patchwork” of laws.⁴⁸ Although they are generically referred to as “apology” laws, the term “apology” is difficult to define.⁴⁹ In a recent decision considering the scope of Utah’s apology law, the Court of Appeals in that state observed that an apology may or may not include an admission of fault and defies any dictionary definition.⁵⁰ It may be as simple as saying “I am sorry” or as complex as including an “admission of responsibility, expression of remorse, promise of forbearance, and offer to repair.”⁵¹

Trying to avoid any confusion about what is protected and what is not, most of the statutes differentiate between expressions of apology or regret and admissions of fault or liability, with some statutes explicitly protecting both,⁵² but most protecting only statements of apology and explicitly ex-

(1976); S.D. CODIFIED LAWS § 19-12-14 (2014); TEX. CIV. PRAC. & REM. CODE ANN. § 18.061 (West 2014); UTAH CODE ANN. § 78B-3-422 (West 2014); VT. STAT. ANN. tit. 12, § 1912 (West 2014); VA. CODE ANN. § 8.01-581.20:1 (West Supp. 2014); WASH. REV. CODE ANN. § 5.64.010 (West 2015); W. VA. CODE ANN. § 55-7-11a (LexisNexis 2008); WYO. STAT. ANN. § 1-1-130 (West 2014); CAL. EVID. CODE § 1160 (2014); UTAH R. EVID. 409 (2014); TENN. R. EVID. 409.1 (2014). Georgia could be included in the tally as another state that enacted a protective statute but its statute was repealed. *See* GA. CODE ANN. § 24-3-37.1 (West 2014) (repealed 2013).

⁴⁴ MASS. GEN. LAWS ANN. ch. 233, § 23D (West 1986).

⁴⁵ Helmreich, *supra* note 22, at 575.

⁴⁶ Helmreich, *supra* note 22, at 575 (citing Lee Taft, *Apology Subverted: The Commodification of Apology*, 109 YALE L.J. 1135, 1151 (2000)).

⁴⁷ § 23D.

⁴⁸ Raper, *supra* note 18, at 308; *see also* Boothman et al., *supra* note 13, at 132 (noting that the “statutes range from broad and far-reaching to narrow.”).

⁴⁹ *See* Lawrence v. Mountainstar Healthcare, 320 P.3d 1037, 1049 (Utah Ct. App. 2014), *cert. denied*, 329 P.3d 36 (Utah 2014) (noting that trying to define “apology” is “one of those cases where the dictionary fails to dictate the meaning that the statutory term must bear in this context.”) (citations omitted).

⁵⁰ *Id.*

⁵¹ Helmreich, *supra* note 22, at 579 (citing 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. PSYCHOLINGUISTICS 127, 132 (1997)); *see* Jonathan R. Cohen, *Advising Clients to Apologize*, 72 S. CAL. L. REV. 1009, 1022 (1999).

⁵² *See* ARIZ. REV. STAT. ANN. § 12-2605 (2005) (West); COLO. REV. STAT. § 13-25-135 (2003); CONN. GEN. STAT. § 52-184d (2005); WASH. REV. CODE § 5.64.010 (2006).

cluding statements of fault.⁵³ Several state laws, however, fail to address whether admissions of fault are protected or not.⁵⁴ While some health care providers may take solace in the protections their state legislators have given them, many still hesitate to discuss mistakes openly with their patients because it remains unclear exactly what will be protected and what will not, even in jurisdictions that explicitly address admissions of fault.⁵⁵

Adding to the confusion is that the laws also differ by protecting different apologizers. Eight states' laws, like Massachusetts' pioneering law, protect apologies made by any tortfeasor, making apologies by any alleged wrongdoer inadmissible in any civil action as proof of negligence.⁵⁶ Iowa's statute, by contrast, protects apologies made by an enumerated list of pro-

⁵³ See DEL. CODE ANN. tit. 10, § 4318 (2006); D.C. CODE § 16-2841 (2007); FLA. STAT. § 90.4026 (2001); HAW. REV. STAT. § 626-1 (West 2007); IDAHO CODE ANN. § 9-207 (2006); IND. CODE ANN. § 34-43.5-1-4 (West 2006); LA. REV. STAT. ANN. § 13:3715.5 (2005); ME. REV. STAT. ANN. tit. 24, § 2907 (2005); MD. CODE ANN., CTS. & JUD. PROC. § 10-920 (West 2004); MICH. COMP. LAWS § 600.2155 (2011); MO. REV. STAT. § 538.229 (2005); NEB. REV. STAT. § 27-1201 (2007); N.H. REV. STAT. ANN. § 507-E:4 (2005); 35 PA. CONS. STAT. ANN. § 10228.3 (2013); TEX. CIV. PRAC. & REM. CODE ANN. § 18.061 (West 1999); VA. CODE ANN. § 8.01-581.20:1 (2007); CAL. EVID. CODE § 1160 (Deering 2000); TENN. R. EVID. 409.1 (2003).

⁵⁴ See, e.g., MASS. GEN. LAWS ch. 233, § 79L (2012) (making inadmissible "all statements, affirmations, gestures, activities or conduct expressing benevolence, regret, apology, sympathy, commiseration, condolence, compassion, mistake, error or a general sense of concern"); MONT. CODE ANN. § 26-1-814 (West 2005) (protecting any "statement, affirmation, gesture, or conduct expressing apology, sympathy, commiseration, condolence, compassion, or a general sense of benevolence relating to the pain, suffering, or death of a person"); N.D. CENT. CODE § 31-04-12 (2007) (protecting any statement of "apology, sympathy, commiseration, condolence, compassion, or benevolence"); OHIO REV. CODE ANN. § 2317.43 (West 2004) (protection "all statements, affirmations, gestures, or conduct expressing apology, sympathy, commiseration, condolence, compassion, or a general sense of benevolence"); OKLA. STAT. tit. 63, § 1-1708.1H (West 2004) (protecting "all statements, affirmations, gestures, or conduct expressing apology, sympathy, commiseration, condolence, compassion, or a general sense of benevolence"); OR. REV. STAT. ANN. § 677.082 (West 2003) (protecting "any expression of regret or apology"); S.C. CODE ANN. § 19-1-190 (2006) (protecting "conduct, statements, or activity constituting voluntary offers of assistance or expressions of benevolence, regret, mistake, error, sympathy, or apology"); S.D. CODIFIED LAWS § 19-12-14 (2005) (protecting statements of apology "for an adverse outcome in medical treatment," offers "to undertake corrective or remedial treatment or action," and "gratuitous act[s] to assist affected persons"); UTAH CODE ANN. § 78B-3-422 (LexisNexis 2008) (protecting statements of "apology, sympathy, commiseration, condolence, or compassion" or "a general sense of benevolence"); VT. STAT. ANN. tit. 12, § 1912 (2005) (protecting statements of "regret or apology"); W. VA. CODE ANN. § 55-7-11a (LexisNexis 2008) (protecting statements of "apology, sympathy, commiseration, condolence, compassion or a general sense of benevolence"); WYO. STAT. ANN. § 1-1-130 (2004) (protecting statements of "apology, sympathy, commiseration, condolence, compassion or a general sense of benevolence").

⁵⁵ *Accord Woods v. Zeluff*, 158 P.3d 552 (Utah Ct. App. 2007); see *Raper, supra* note 18, at 297-302 (noting the requirement for a "particularized fact assessment that is difficult to reconcile with any given state statute"); see also *Davis v. Wooster Orthopaedics & Sports Med., Inc.*, 952 N.E.2d 1216, 1221 (Ohio Ct. App. 2011) (deciding that Ohio's statute that does not address admissions of fault does not protect them).

⁵⁶ FLA. STAT. § 90.4026 (2001); HAW. REV. STAT. § 626-1 (2007); IND. CODE § 34-43.5-1-4 (2006); MASS. GEN. LAWS ch. 233, § 23D (1986); MO. REV. STAT. § 538.229.1 (2005); TEX. CIV. PRAC. & REM. CODE ANN. § 18.061 (West 1999); CAL. EVID. CODE § 1160; TENN. R. EVID. 409.1.

professionals, including physicians, nurses, pharmacists, chiropractors, engineers, accountants, architects, landscape architects, and barbers, as well as “any other licensed profession recognized” in the state.⁵⁷ The rest of the state laws protect the apologies, expressions of sorrow or condolence and, in some cases as noted above, admissions of fault, of only health care providers and their employees or agents.⁵⁸ It is noteworthy that Massachusetts, in 2012, passed a law that applies only to health care providers, even though it already had on its books a law protecting any tortfeasor facing a negligence claim.⁵⁹

The reason offered for all of these laws, whether they protect only physicians or all tortfeasors, is to alleviate the fear that an apology will be used to establish liability in an eventual lawsuit.⁶⁰ Without explaining why their laws do not protect all tortfeasors, the states with statutes that protect health care providers and their employees and agents make clear that the intention of these laws is to provide “opportunities for healthcare providers to apologize and console victims of unanticipated outcomes of medical care without fear that their statements will be used against them in a malpractice suit, by making the statements inadmissible as evidence of an admission of liability or a statement against interest.”⁶¹

Hawaii’s statute protects all tortfeasors, but the legislature initially considered limiting the protection of its apology law to health care providers, as other states have done, and the state’s Supreme Court explained the legislature’s reasoning.⁶² In *State v. Lealao*, a criminal case, the defendant was

⁵⁷ IOWA CODE § 622.31.

⁵⁸ See, e.g., OHIO REV. CODE ANN. §2317.43 (limiting protection in only civil actions “brought by an alleged victim of an unanticipated outcome of medical care”); 35 PA. STAT. ANN. §10228.3 (protecting statements of apology by a health care provider or an officer, employee or agent of a health care provider).

⁵⁹ Compare MASS. GEN. LAWS ch. 233, § 79L (2012) (protecting apologies by health care providers), with MASS. GEN. LAWS ch. 233, § 23D (protecting apologies by all tortfeasors).

⁶⁰ See Jonathan R. Cohen, *Legislating Apology: The Pros and Cons*, 70 U. CIN. L. REV. 819, 820 (2002) (noting that the apology laws respond to the concern that “apologies are often not offered after injuries, in part from the fear of liability”); Helmreich, *supra* note 22, at 575 (noting that the laws are intended to encourage apologies by explicitly denying their admissibility as evidence).

⁶¹ Estate of Johnson v. Randall Smith, Inc., 989 N.E.2d 35, 36 (Ohio 2013); see also UTAH R. EVID. 409(b) (2011) (legislative note) (explaining that the “intent and purpose of amending the rule with paragraph (b) is to encourage expressions of apology, empathy, and condolence and the disclosure of facts and circumstances related to unanticipated outcomes in the provision of health care in an effort to facilitate the timely and satisfactory resolution of patient concerns arising from unanticipated outcomes in the provision of health care. Patient records are not statements made to patients, and therefore are not inadmissible under this rule.”); Raper, *supra* note 18, at 302 (noting that “apology laws are supposed to encourage doctors to speak up when medical errors occur—to push doctors to engage in apologies as part of disclosure.”).

⁶² See *State v. Lealao*, 272 P.3d 1227, 1228 (Haw. 2012) (holding that the state’s apology statute applies to all civil cases, but not to criminal cases).

convicted of assault and challenged the admissibility of his apology to his victim as evidence of liability for the crime.⁶³ Deciding that the apology statute applied only to civil cases, the Supreme Court considered the breadth of the statute's protection and noted that the state legislature had questioned limiting it only to health care providers.⁶⁴ As explained by the court, the "original purpose of the measure proposed to the legislature was 'to make benevolent gestures inadmissible as evidence of an admission of liability in medical malpractice claims.'"⁶⁵ Upon reflection, however, the legislature "found it appropriate to allow individuals and entities to express sympathy and condolence without the expression being used against the individual or entity *to establish civil liability*, even if the individual or entity is not a health care provider."⁶⁶ Accordingly, the legislators revised bill to protect apologies in all civil actions.⁶⁷

While most states continue to protect only statements of health care providers, all states have rules of evidence that treat all litigants alike, and they have been applied in medical malpractice cases.⁶⁸ These rules and examples of how they are applied are reviewed in the following section.

IV. THE RULES OF EVIDENCE AND THE IMPACT OF ADMITTING APOLOGIES INTO EVIDENCE

Generally, relevant evidence is admissible in all civil actions.⁶⁹ Relevant evidence will be inadmissible, however, "if its probative value is substantially outweighed by a danger of one or more of the following: unfair prejudice, confusing the issues, misleading the jury, undue delay, wasting time, or needlessly presenting cumulative evidence."⁷⁰ The basic hearsay rule establishes that out of court statements are not admissible "in evidence to prove the truth of the matter asserted."⁷¹ Statements of party-opponents,

⁶³ *Id.* at 1229.

⁶⁴ *Id.* at 1235.

⁶⁵ *Id.* (citation omitted).

⁶⁶ *Id.*

⁶⁷ *Lealao*, 272 P.3d at 1235.

⁶⁸ *See, e.g., Woods v. Zeluff*, 158 P.3d 552, 554 (Utah Ct. App. 2007) (balancing the apology's probative value with its potential prejudicial effect under the state's rules of evidence).

⁶⁹ FED. R. EVID. 402. State rules of evidence are analogous to the federal rules and will be separately addressed in this section only where there are substantive differences between them. *See, e.g., Bonser v. Shainholtz*, 983 P.2d 162, 166 (Colo. App. 1991), *rev'd on other grounds*, 3 P.3d 422 (Colo. 2000) (noting that the state's rule 409 "was adopted verbatim from the Federal Rules of Evidence").

⁷⁰ FED. R. EVID. 403.

⁷¹ *See* FED. R. EVID. 801(c) (defining hearsay as a statement that "(1) the declarant does not make while testifying at the current trial or hearing; and (2) a party offers in evidence to prove the truth of the matter asserted" in the statement.").

however, are defined by the rules as “not hearsay” and, therefore, admissible as an exception to the hearsay rule.⁷² Without specific protection, therefore, statements of sorrow, regret, or condolence are admissible under this exception.⁷³

Although admissible, statements of apology or condolence, or even fault, may nevertheless be kept from the jury if their probative value is outweighed by their prejudicial effect.⁷⁴ As addressed above in Section II, the Utah Court of Appeals considered the argument that statements admitting fault should be excluded based on the rules of evidence alone, and the trial court and the appellate court balanced the relevance of the evidence against the potential prejudicial effect.⁷⁵ The trial and appellate courts agreed that statements by the physician that he “missed something,” “jumped the gun,” and shouldn’t “have done this surgery” were relevant to the question of the physician’s negligence, but disagreed about how that relevance weighed against the potential prejudicial effect.⁷⁶

The appellate court, agreeing with the trial court that the statements might be prejudicial, decided that the statements were “not *unfairly* prejudicial,” and, therefore, held that the statements should have been admitted.⁷⁷ It should be noted that the admission of this evidence did not lead to the conclusion that the plaintiff should win.⁷⁸ Rather, the court acknowledged the defendants’ argument that the statements, alone, may not be sufficient to prove negligence, but emphasized that allowing the evidence will allow the jury to do its job to consider all of the evidence on remand, because, as the court observed, the physician’s statement were probative and, “if believed, would be central to Plaintiffs’ case.”⁷⁹ Emphasizing the importance of allowing the jury to do its job, the court also noted the defendants’ argument that the physician denied ever making the statements but described this factual dispute over whether he said them or not as a call “for a routine credibility determination, which is completely within the province of the jury.”⁸⁰

⁷² FED. R. EVID. 801(d)(2).

⁷³ See Cohen, *supra* note 60, at 824–25 (noting that “even though an apology would fit the classical definition of hearsay as ‘an out of court statement offered in evidence to prove the truth of the matter asserted’, the Federal Rules treat it as non-hearsay.” (footnote omitted)).

⁷⁴ See *Woods v. Zeluff*, 158 P.3d 552 (Utah Ct. App. 2007).

⁷⁵ *Id.* at 554.

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ *Id.* at 556.

⁷⁹ *Woods*, 158 P.3d at 555–56.

⁸⁰ *Id.* at 555 n.3.

Other rules of evidence also shield evidence of regret or offers to assist or pay money, even without the special protection offered by the apology laws. Federal Rule of Evidence 407, for example, defines as inadmissible evidence of subsequent remedial steps the tortfeasor may have taken after the tort occurred.⁸¹ Offers of settlement or compromise in a tort claim are inadmissible under Rule 408,⁸² and Rule 409 protects “[e]vidence of furnishing, promising to pay, or offering to pay medical, hospital, or similar expenses resulting from an injury is not admissible to prove liability for the injury.”⁸³

In *Bonser v. Shainholtz*, the Colorado Appellate Court relied on Rule 409 in holding that the trial court erred when it allowed evidence of a dentist’s statements that he was sorry for injuring the plaintiff, that he “would do what he could,” and “would make things right.”⁸⁴ The application of these rules is justified by the need to “encourag[e] people to take, or at least not discourag[e] them,” from taking the actions defined by those rules.⁸⁵ As the court noted regarding Rule 409: “It is the product of a desire to encourage humanitarianism. This goal would be undercut if an offer to pay medical expenses were penalized by allowing it as evidence against the payor. In addition, the inference that the conduct means anything other than humanitarianism is unreliable.”⁸⁶

The Supreme Court of Maine recently considered the effect of the state’s rules of evidence and its apology law, which explicitly removed admissions of fault from protection, on a physician’s statements of apology and fault.⁸⁷ In that case, a physician, without waiting for the pathology results, informed a patient that he was “likely” suffering from an inoperable and deadly cancer when, in fact, he was suffering from a lymphoma that was treatable and had a very high rate of survival.⁸⁸ After conducting an investigation, the hospital wrote the patient a letter explaining what had happened, reassuring the patient that the treating physician “in no way wanted

⁸¹ FED R. EVID. 407. State rules of evidence are analogous and need not be separately addressed. *See, e.g., Bonser v. Shainholtz*, 983 P.2d 162, 166 (Colo. App. 1999), *rev’d on other grounds*, 3 P.3d 422 (Colo. 2000) (noting that the state’s rule 409 “was adopted verbatim from the Federal Rules of Evidence”).

⁸² FED R. EVID. 408.

⁸³ FED R. EVID. 409.

⁸⁴ *Bonser*, 983 P.2d at 166.

⁸⁵ FED. R. EVID. 407 (advisory committee’s note); *accord* FED. R. EVID. 409 (advisory committee’s note) (admitting offers to pay medical expenses “would tend to discourage assistance to the injured person.”).

⁸⁶ *Bonser*, 983 P.2d at 166.

⁸⁷ *See Strout v. Cent. Maine Med. Ctr.*, 94 A.3d 786 (Me. 2014) (applying ME. REV. STAT. tit. 24, § 2907 (2005)).

⁸⁸ *Id.* at 787–88.

to harm either you or your wife but wanted you to have a full understanding of what he thought he would be helping you to deal with.”⁸⁹ The letter also explained that the physician “realizes now that prior to sharing his clinical impressions with you, he needed to wait for the results of the biopsy to confirm what the cancer was.”⁹⁰

The defendant argued that the letter was an expression of sympathy or benevolence and therefore inadmissible under the state’s apology law. That law reads as follows:

In any civil action for professional negligence . . . any statement, affirmation, gesture or conduct expressing apology, sympathy, commiseration, condolence, compassion or a general sense of benevolence that is made by a health care practitioner or health care provider or an employee of a health care practitioner or health care provider to the alleged victim, a relative of the alleged victim or a representative of the alleged victim and that relates to the discomfort, pain, suffering, injury or death of the alleged victim as the result of the unanticipated outcome is inadmissible as evidence of an admission of liability or as evidence of an admission against interest. Nothing in this section prohibits the admissibility of a statement of fault.⁹¹

The defendant also argued that the letter was inadmissible pursuant to the state’s Rule of Evidence 408, making inadmissible offers of compromise,⁹² Rule 403, excluding evidence when its probative value is “substantially outweighed by the danger of unfair prejudice,”⁹³ and Rule 409, excluding evidence of offers to pay medical expenses.⁹⁴

In response to the defendant’s motion in limine, the trial judge admitted into evidence a redacted version of the letter, which included only the statement that the physician “realizes now that prior to sharing his clinical impressions with you, he needed to wait for the results of the biopsy to confirm what the cancer was.”⁹⁵ Based on that letter, as well as testimony on the facts, the jury determined that the treating physician was negligent and awarded the plaintiff \$200,000.⁹⁶

On appeal, the Supreme Court of Maine addressed the defendant’s argument that “important policy considerations underlie Maine’s apology statute

⁸⁹ *Id.* at 788.

⁹⁰ *Id.*

⁹¹ ME. REV. STAT. tit. 24, § 2907(2) (2005).

⁹² ME. R. EVID. 408 (2009).

⁹³ ME. R. EVID. 403.

⁹⁴ ME. R. EVID. 409. The defendant did not rely on this rule in its appeal of the jury’s verdict. *Strout*, 94 A.3d at 789 n.3.

⁹⁵ *Strout*, 94 A.3d at 788–89.

⁹⁶ *Id.* at 789.

and similar statutes in other jurisdictions, and that these policy considerations justify characterizing the statement contained in Covey's letter as a statement of sympathy or benevolence rather than as an admission of fault."⁹⁷ The court disagreed, however, and noted that the statute explicitly differentiated between expressions of apology or benevolence and statements of fault and that "[n]othing in the language of the statute suggests that statements of fault are inadmissible if they are accompanied by expressions of apology or benevolence."⁹⁸ Relying on the statute's language that "[n]othing in this section prohibits the admissibility of a statement of fault," the court held that the treating physician's statement "that prior to sharing his clinical impressions with you, he needed to wait for the results of the biopsy to confirm what the cancer was" was an admission of fault that was admissible, "even when coupled with other statements that may be inadmissible."⁹⁹ The court then rejected the defendant's arguments that the letter should have been excluded under the state's evidentiary rules.¹⁰⁰

Thus, in a state like Maine whose statute protects expressions of sympathy and apology, but not statements of fault, consideration of the admissibility of those statements defaults to the state's rules of evidence.¹⁰¹ These rules have long guided courts in deciding what evidence should come in and what should be excluded and, as recently observed after a thorough analysis of the applicable case law, even in cases where statements of apology are admitted, they may not alone be sufficient to prove liability.¹⁰² These statements are also not enough to prove that the errors caused the harm, where expressions of fault are admissible and liability has been established.¹⁰³

Importantly, it should also be noted that even when a physician's apologies are admitted, plaintiffs may nevertheless lose.¹⁰⁴ In every medical

⁹⁷ *Id.*

⁹⁸ *Id.*

⁹⁹ *Id.* at 789–90 (quoting ME. REV. STAT. tit. 24, § 2907(2) (2005)).

¹⁰⁰ *Id.* (rejecting the defendant's argument that the letter was inadmissible as an offer to compromise under Rule 408(a) because no dispute yet existed about the validity of the claim, and refusing to consider whether the letter was unduly prejudicial on the jury because the defendant failed to provide the court with a transcript of the trial.)

¹⁰¹ *Id.*

¹⁰² See Helmreich, *supra* note 22, at 572.

¹⁰³ See Lawrence v. Mountainstar Healthcare, 320 P.3d 1037, 1051 (Utah Ct. App. 2014), *cert. denied*, 329 P.3d 36 (Utah 2014) (holding statements that there had been an accident or complication and that "[w]e messed up" were statements of fault not protected by the state's apology statute but that they were insufficient to prove that the mistakes caused the plaintiff's harm).

¹⁰⁴ See, e.g., Senesac v. Assoc. in Obstetrics & Gynecology, 449 A.2d 900, 903 (Vt. 1982) (affirming a directed verdict in favor of a physician defendant who admitted that she made a mistake and that she was sorry for perforating her patient's uterus during the course of a therapeutic abortion).

malpractice case, the plaintiff has the burden of proving that the defendant deviated from the accepted standard of care and that that deviation caused the damages that the plaintiff suffered.¹⁰⁵ Evidence that the treating physician apologized, or even admitted fault, may not be enough to carry that burden.¹⁰⁶

For example, in *Giles v. Brookwood Health Services, Inc.*, decided by the Alabama Supreme Court in a state without an apology statute, the defendant prevailed on summary judgment.¹⁰⁷ In that case, the plaintiff alleged that the treating physician injured her bowel while improperly removing her right ovary, instead of the left that had been diagnosed with a cyst.¹⁰⁸ The plaintiff also alleged that the physician apologized and admitted that he had taken out the wrong ovary and that he “forgot to look at the charts or his notes before starting the surgery.”¹⁰⁹ Even taking “every reasonable factual inference” in favor of plaintiff, as the summary judgment standard required, the court considered the physician’s admissions and apology and decided that they amounted to “no more than an admission of bona fide mistake of judgment or untoward result of treatment.”¹¹⁰ That admission, according to the court, not only did not prove that the physician was negligent, but it did not even “provide substantial evidence creating a genuine issue of material fact” as to the allegations of malpractice.¹¹¹ Accordingly, in light of all of the evidence presented, the court affirmed the trial court’s decision that the physician was entitled to judgment as a matter of law.¹¹²

Given a court’s power under the rules of evidence to admit or exclude evidence and the court’s and jury’s role to weigh evidence that is admitted, it is fair to ask why health care providers need any additional protection at all. The answer to this question becomes even more important when viewed in light of a physician’s ethical duty of full disclosure and the positive effects that full disclosure has on patients and their propensity to sue.

¹⁰⁵ See *Giles v. Brookwood Health Serv., Inc.*, 5 So. 3d 533, 548 (Ala. 2008); *Phinney v. Vinson*, 605 A.2d 849, 849 (Vt. 1992).

¹⁰⁶ See, e.g., *Sutton v. Calhoun*, 593 F.2d 127, 128 (10th Cir. 1979) (deciding that the trial court was “well within its discretion to conclude that the doctor’s statements did not amount to an admission of negligence. The jury was thus charged to decide what was meant by the doctor’s statements in the circumstances surrounding the incident. . . .”); see also *Giles*, 5 So. 3d at 552 (doctor’s apologies “do not constitute expert testimony that he injured Giles by breaching the standard of care”).

¹⁰⁷ 5 So. 3d at 533.

¹⁰⁸ *Id.* at 549.

¹⁰⁹ *Id.* at 540–41.

¹¹⁰ *Id.* at 552.

¹¹¹ *Id.* at 553.

¹¹² *Giles*, 5 So. 3d at 556.

V. FULL DISCLOSURE IS ETHICALLY REQUIRED AND MUTUALLY BENEFICIAL TO PHYSICIANS AND PATIENTS

Like other states, the South Carolina General Assembly justified its apology law on the basis that “studies have shown such discussions foster improved communications and respect between provider and patient, promote quicker recovery by the patient, and reduce the incidence of claims and lawsuits arising out of such unanticipated outcomes.”¹¹³ Based on this observation, the legislators concluded that “certain steps should be taken to promote such conduct, statements, or activity by limiting their admissibility in civil actions.”¹¹⁴ The step the legislators took, as the many other states with apology laws, was to enact the state’s apology law, making inadmissible:

“in any claim or civil action brought by or on behalf of a patient allegedly experiencing an unanticipated outcome of medical care, any and all statements, affirmations, gestures, activities, or conduct expressing benevolence, regret, apology, sympathy, commiseration, condolence, compassion, mistake, error, or a general sense of benevolence which are made by a health care provider, an employee or agent of a health care provider, or by a health care institution to the patient, a relative of the patient, or a representative of the patient”¹¹⁵

What South Carolina and the other states with similar laws have overlooked is that health care providers are ethically required to explain the details of their care and that full disclosure actually benefits both patient and physician. Each of these ideas is addressed separately below.

A. A Physician’s Ethical Duty To Disclose

It is by now axiomatic that before treating patients, physicians are required to obtain their patients’ consent.¹¹⁶ To obtain meaningful consent, physicians must disclose the risks and benefits of the treatment they recommend, foregoing treatment, and alternative treatment options.¹¹⁷ The reasons for requiring disclosure are based on the notion that it “promotes

¹¹³ S.C. CODE ANN. § 19-1-190 (B) (2006).

¹¹⁴ *Id.*

¹¹⁵ S.C. CODE ANN. § 19-1-190 (D).

¹¹⁶ *Spencer v. Goodill*, 17 A.3d 552, 554–55 (Del. 2011); *Quintilla v. Dunkelman*, 34 Cal. Rptr. 3d 557, 572 (Cal. Ct. App. 2005).

¹¹⁷ *See Cobbs v. Grant*, 502 P.2d 1, 9–10 (1972) (requiring “divulgence by the physician to his patient of all information relevant to a meaningful decisional process”).

communication and fosters trust” between physicians and they people they treat.¹¹⁸

It is just as clear that this duty of full disclosure continues throughout the course of treatment, even if a mistake is made. As explained by the AMA’s Code of Medical Ethics: It is “a fundamental ethical requirement that a physician should at all times deal honestly and openly with patients.”¹¹⁹ Acknowledging that “[s]ituations occasionally occur in which a patient suffers significant medical complications that may have resulted from the physician’s mistake or judgment,” the AMA directs in Opinion 8.12 that “the physician is ethically required to inform the patient of all the facts necessary to ensure understanding of what has occurred.”¹²⁰ Thus, to comply with these ethical requirements, a physician has no choice but to admit to mistakes, without regard to how those admissions might be used in a lawsuit, should one be filed against him or her. Importantly, the AMA considers the possibility that anything the physician says may have a legal impact and reiterates the necessity of honesty and full disclosure: “Concern regarding legal liability which might result following truthful disclosure should not affect the physician’s honesty with a patient.”¹²¹

B. Honesty Benefits Physician and Patient

There is little if any dispute that patient care improves when mistakes are identified and understood so that efforts can be made to avoid them in the future.¹²² As noted above, in “To Err is Human,” the IOM identified the high rate of patient deaths due to medical mistakes and called on health care providers to identify their mistakes and learn from them.¹²³ To ensure the identification of mistakes, the IOM urged Congress to set up a national reporting system under which health-care providers would be required to report serious errors and encouraged to report less serious ones.¹²⁴ To ensure that change would come of this reporting, the IOM recommended that the

¹¹⁸ Marc A. Rodwin, *Physicians’ Conflicts of Interest: The Limitations of Disclosure*, 321 NEW ENG. J. MED. 1405, 1405 (1989); see Nancy L. Zisk, *Investing in Health Care: What Happens When Physicians Invest and Why the Recent Changes in the Patient Protection and Affordable Care Act Fail to Protect Patients From Their Physicians’ Self Interest*, 36 SEATTLE UNIV. L. REV. 189, 192–93 (Fall 2012).

¹¹⁹ AMA OPINION 8.12.

¹²⁰ AMA OPINION 8.12.

¹²¹ *Id.*

¹²² See Raper, *supra* note 18, at 275 (“Accurate reporting of outcomes is crucial to improving patient safety.”); see also Jesson & Knapp, *supra* note 15, at 1417.

¹²³ See *To Err is Human*, *supra* note 8, at 1, 3.

¹²⁴ See *To Err is Human*, *supra* note 8, at 3.

serious mistakes be made available to the public which would impel health care providers to develop procedures to avoid them in the future.¹²⁵ To encourage the reporting of the mistakes that would ultimately lead to the development of procedures to prevent less serious errors as well, the IOM recommended that the data reported be kept from the public but analyzed to identify possibilities for improvement.¹²⁶

Following the IOM report, and based on its recommendation, the federal and state governments began requiring health care providers to identify and report medical errors.¹²⁷ In 2005, Congress enacted the Patient Safety and Quality Improvement Act (PSQIA) that created a voluntary system for reporting and aggregating patient safety information through "Patient Safety Organizations."¹²⁸ Responding directly to the IOM's call, the PSQIA was designed to encourage a "culture of safety" by "providing for broad confidentiality and legal protections of information collected and reported voluntarily for the purposes of improving the quality of medical care and patient safety."¹²⁹ More recently, the Patient Protection and Affordable Health Care Act (PPACA) affirmed the need to report treatment outcomes and links payment to the quality of care.¹³⁰

¹²⁵ See *To Err is Human*, *supra* note 8, at 3.

¹²⁶ See *To Err is Human*, *supra* note 8, at 3.

¹²⁷ See *Jesson & Knapp*, *supra* note 15, at 1418–20 (reviewing state and federal reporting requirements). Pennsylvania, for example, required hospitals to report serious events to patients. See 40 PA. CONS. STAT. ANN. § 1303.308(b) (West 2002) (providing that a "medical facility through an appropriate designee shall provide written notification to a patient affected by a serious event or, with the consent of the patient, to an available family member or designee within seven days of the occurrence or discovery of a serious event."). A "serious event" is defined by the statute as "[a]n event, occurrence or situation involving the clinical care of a patient in a medical facility that results in death or compromises patient safety and results in an unanticipated injury requiring the delivery of additional health care services to the patient." 40 PA. CONS. STAT. ANN. § 1303.302 (West 2006); see *Jesson & Knapp*, *supra* note 15, at 1419, n.38. The Patient Protection and Affordable Health Care Act incorporates disclosure requirements and rewards positive patient outcomes by linking payment to the quality of care. See 42 U.S.C. §1395ww (2012).

¹²⁸ Patient Safety & Quality Improvement Act, 42 U.S.C. §§ 299b-21 to -26 (2000).

¹²⁹ S. REP. NO. 108–196, at 4 (2003). The PSQIA followed the enactment of the Health Care Quality Improvement Act (HCQIA) that required health care entities to report adverse actions taken against physicians to a national practitioner data bank. Health Care Quality Improvement Act, 42 U.S.C. §§ 11101–11152 (1982). Unlike the PSQIA, geared directly to improving care and patient safety, the stated goal of the HCQIA was "to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance." § 11101. To encourage physicians to report these problems, Congress assured immunity from damages for persons participating in peer review if certain standards are satisfied" and made clear that the data received would be available only to health care entities and not to the public. §§ 11111, 11112, 11137(a).

¹³⁰ See 42 U.S.C. §1395ww (2012). Since 2008, the Centers for Medicare and Medicaid Services have refused payment for what have been referred to as "never events," which has continued under the PPACA. See Medicaid Program; Payment Adjustment for Provider-Preventable Conditions Including Health Care-Acquired Conditions, 76 Fed. Reg. 32816, 32817, 32821 (June 6, 2011) (to be codified at

The AMA has also called for the reporting and examination of adverse outcomes and medical mistakes. In December 2003, the AMA advised physicians that it was their ethical responsibility to study and prevent error and harm.¹³¹ Physicians, according to the opinion, should help establish and then “participate fully” in effective, confidential, and protected error-reporting mechanisms.¹³² Although all of these reporting requirements are directed to reporting agencies that can then analyze the data and identify corrective action, the AMA’s opinion goes further and directs physicians to talk with their patients and “offer a general explanation regarding the nature of the error and the measures begin taken to prevent similar occurrences in the future.”¹³³ The opinion does not explain what a “general explanation” means, but it does acknowledge that the “communication is fundamental to the trust that underlines the patient-physician relations, and may help reduce the risk of liability.”¹³⁴

Putting aside a physician’s ethical duty to communicate what happened and why, physicians would be well-advised to be honest with their patients, because there is evidence that disclosure actually reduces the chances that they will be sued or, if they are, that the suit will actually go to trial.¹³⁵ Contrary to the belief that admitting a mistake will lead to a lawsuit, studies suggest that patients sue their physicians because their physicians failed to admit their mistakes or apologize for them.¹³⁶ In one study of families who sued physicians over prenatal injuries, for example, almost one quarter of

42 C.F.R. pt. 434, 438, 447) (classifying wrong-patient and wrong-site surgery as “never events” that “should never happen” and that “are entirely preventable,” and refusing to provide reimbursement for such events and consequent corrective treatment).

¹³¹ AM. MED. ASS’N, CODE OF MED. ETHICS, OPINION 8.121-ETHICAL RESPONSIBILITY TO STUDY AND PREVENT ERROR AND HARM (2003), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion8121.page>.

¹³² *Id.*

¹³³ *Id.*

¹³⁴ *Id.*

¹³⁵ See Helmreich, note 22, at 574 (citing several studies that suggest that apologies prevent lawsuits and increase settlements of those that are filed); see also Pavlick, *supra* note 1, at 862 (“The practice of never apologizing is not in the public interest because it leads to litigation rather than reconciliation.”) (quoting Peter Rehm & Denise R. Beatty, *Legal Consequences of Apologizing*, 1996 J. DISP. RESOL. 115, 119 (1996)); Lee Taft, *Apology Subverted: The Commodification of Apology*, 109 YALE L.J. 1135, 1148 (2000) (quoting Marshall H. Tanick & Teresa J. Ayling, *Alternative Dispute Resolution by Apology: Settlement by Saying “I’m Sorry,”* HENNEPIN LAW., July-Aug. 1996, at 23 (noting that an apology “can be an important element that lubricates settlement discussion.”)).

¹³⁶ See Boothman, et al., *supra* note 13, at 133 (citing one study suggesting that patients hire lawyers when they have not received “adequate answers to questions about their outcomes, when they sense the absence of accountability for what happened to them, and when they worry the same mistake could be made in another patient’s care”); Helmreich, *supra* note 22, at 574, n.35 (citing a British study suggesting that patients who sued would not have if their physicians had apologized and explained what happened); Jesson & Knapp, *supra* note 15, at 1421, n.43 (citing a number of studies suggesting that patients who sued did so because of their physicians’ lack of disclosure).

the families who sued indicated that they sued only when they realized that their physicians had not been “completely honest with them about what happened, allowed them to believe things that were not true, or intentionally misled them.”¹³⁷

While there are certainly examples where an apology gives an injured patient ammunition to use against his physician,¹³⁸ there is compelling evidence from two major hospital systems that being open and honest with patients after mistakes are made has a direct impact on the number of lawsuits filed and the time it takes to settle the ones that are, calling into question the need for the special protection afforded by each state’s apology law.¹³⁹

The first example comes from a pioneering program instituted at Children’s Hospitals and Clinics of Minnesota (“Children’s”).¹⁴⁰ Even before the publication of the IOM’s report highlighting the frequency of patient deaths due to medical mistakes, Children’s required their physicians to disclose errors to patients and their families.¹⁴¹ Revolutionary at the time when it was instituted in 1999, the program required the physicians in their health care system to disclose to the families of their patients whenever “anything significant” happened in connection with their child’s care.¹⁴² The physicians were also instructed to explain what they would do in the future to prevent a similar event to occur in the future.¹⁴³ According to the Chair of the Ethics Committee at Children’s, “[f]amilies appreciate this openness.”¹⁴⁴ Indeed, as a direct result of the newly instituted procedures, the number of lawsuits brought against the hospital system was reduced by half.¹⁴⁵

¹³⁷ Cohen, *supra* note 49, at 1011 (citation omitted).

¹³⁸ See, e.g., *Fognani v. Young*, 115 P.3d 1268, 1270 (Colo. 2005) (discussing that after a physician told the patient’s son that he was “sorry about [his] father’s situation and that things might have turned out better had [the doctor] been at a major hospital and ‘more up to date’ on current treatment options,” the patient increased his settlement demand).

¹³⁹ Boothman, et al., *supra* note 13, at 137–44 (discussing the results of a study by the University of Michigan Health System which found that honest disclosure reduces the instance of malpractice suits by more than 200%); Jesson & Knapp, *supra* note 15, at 1435–36 (citing CHILDREN’S HOSP.’S & CLINICS OF MINN., WHAT WE’VE LEARNED: STORIES AND MILESTONES FROM THE PATIENT SAFETY JOURNEY 4 (2006), available at <http://www.childresmn.org/web/aboutus/072550.pdf> (requiring disclosure whenever something had happened that either caused harm or will potentially cause harm to their child)).

¹⁴⁰ Jesson & Knapp, *supra* note 15, at 1435–36.

¹⁴¹ Jesson & Knapp, *supra* note 15, at 1435–36.

¹⁴² Jesson & Knapp, *supra* note 15, at 1435–36.

¹⁴³ Jesson & Knapp, *supra* note 15, at 1436.

¹⁴⁴ Jesson & Knapp, *supra* note 15, at 1436 (citation omitted).

¹⁴⁵ Jesson & Knapp, *supra* note 15, at 1436.

A similar program was instituted by the University of Michigan Health System (“UMHS”), with similar results.¹⁴⁶ Under UMHS’s system, and Michigan law, a prospective plaintiff is required to file notice of his or her intent to bring a medical malpractice claim six months before filing suit.¹⁴⁷ This notice must contain the specifics about the claim, including the facts supporting the claim and the standard of care that was breached.¹⁴⁸ This allows the would-be defendants the opportunity to investigate the claim.¹⁴⁹ UMHS went beyond what the law required, however, and set up reporting procedures and review within the hospital system, made changes based on those reviews to improve patient care, met with patients, their families, and their lawyers to discuss what happened and what was being done to correct the problem if one was found, and promptly paid for injuries caused by conduct that deviated from the proper standard of care.¹⁵⁰ Central to UMHS’s approach to handling claims was its “open and honest” communications with the patient and the patient’s lawyer once it received notice of the claim.¹⁵¹ These communications allowed for review of what happened and possible ways to resolve any claim the patient intended to bring, which might include dropping the claim or settling it before suit was actually filed.¹⁵² Similar to what Children’s experienced in Minnesota, UMHS saw lawsuits against it fall by about half and suits that had been filed were settled more quickly.¹⁵³

VI. CONCLUSION

In light of the powerful empirical data suggesting that physicians can reduce their chances of being sued by communicating openly and honestly with their patients, together with the well-established ethical duty of full disclosure, the conclusion seems inescapable that physicians must disclose mistakes and admit responsibility for those mistakes. As proven by the case

¹⁴⁶ See Boothman et al., *supra* note 13, at 137–46 (reviewing in detail the UMHS program).

¹⁴⁷ See Boothman, et al., *supra* note 13, at 137.

¹⁴⁸ See Boothman et al., *supra* note 13, at 137–138 (citing MICH. COMP. LAWS. § 600.2912b (1994)).

¹⁴⁹ See Boothman et al., *supra* note 13, at 138.

¹⁵⁰ See Boothman et al., *supra* note 13, at 139. Although determining what does or does not meet the proper standard of care may be open to debate, UMHS’s Risk Management Department hired experienced nurses who understood the medical issues raised by each claim to ensure a fair assessment. See Boothman et al., *supra* note 13, at 139. UMHS also formed committees that would review the Risk Management Department’s decision on whether reasonable care had been taken. See Boothman et al., *supra* note 13, at 140.

¹⁵¹ See Boothman et al., *supra* note 13, at 142.

¹⁵² See Boothman et al., *supra* note 13, at 142.

¹⁵³ See Boothman et al., *supra* note 13, at 143–44.

law, admitting statements of regret and even fault do not make the loss of a medical malpractice case a foregone conclusion.

State apology laws are not necessary to encourage health care providers to do what they otherwise required to do.¹⁵⁴ If a physician's statements help a patient forgive the physician, then the patient and the physician both benefit and a lawsuit may never be brought. If those statements help a plaintiff state a claim, then the physician should accept that responsibility. It is, after all, exactly what we expect from children and we should expect no less from health care providers who, at times, holds our lives in their hands.

¹⁵⁴ Jesson & Knapp, *supra* note 15, at 1411 ("it is a mistake to attempt to use evidentiary standards to improve physician-patient communication").

