
**MY LAWYER TOLD ME TO SAY I’M SORRY: LAWYERS,
DOCTORS, AND MEDICAL APOLOGIES**

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I. INTRODUCTION.....	1411
II. THE MEDICAL CONTEXT.....	1412
A. <i>Breaking the Code of Silence: From Consent to Disclosure to Apology</i>	1412
B. <i>Progress toward Disclosure and the Patient Safety Movement</i>	1418
C. <i>The Academic Case for Apologies in Health Care Disputes</i>	1421
D. <i>Empirical Research on Disclosure and Apology</i>	1422
II. EVIDENTIARY CONSIDERATIONS.....	1425
A. <i>The Backdrop of the Rules</i>	1425
B. <i>Statutory Development of Exclusions</i>	1429
III. MINNESOTA’S EXPERIENCE	1432
A. <i>Minnesota’s Experience: The Evidentiary Dimension</i>	1432
B. <i>Minnesota’s Experience: The Medical Dimension</i>	1433
1. <i>Malpractice in Minnesota</i>	1433
a. <i>Insurance Premiums</i>	1434
b. <i>Claim and Payment Rates</i>	1435
2. <i>Minnesota’s Pioneering Work in Disclosure of Adverse Events</i>	1435
IV. DISADVANTAGES AND DANGERS: THE PROBLEMS WITH EXCLUSIONS.....	1438
A. <i>It Won’t Work: Exclusions and the Nature of the Medical Profession</i>	1438
B. <i>It’s Immoral: Exclusions and the Nature of Apologies</i>	1441
C. <i>Here’s My Advice: The Nature of Lawyers</i>	1445
V. CONCLUSION	1451

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I. INTRODUCTION

The role of apologies in litigation received a great deal of attention in the last ten years. This is particularly true of “medical apologies,” those expressions of regret and, in some cases, admissions of responsibility made by medical professionals. Two recent trends prompted examination of medical apologies. First, widely reported empirical studies suggest that patients and their families may be less likely to bring malpractice lawsuits following adverse outcomes if treating physicians apologized. Second, over the past ten years, two-thirds of the states adopted statutes that exclude these apologies from evidence if there is a later malpractice trial.¹

Minnesota finds itself in the forefront of one of these trends and at the tail end of the other. For the last several years, the health care profession has given substantial attention to the importance of robust physician-patient communication following adverse medical events. Minnesota stands as a leader in adopting both medical standards and statutory requirements meant to foster disclosure and reporting in the aftermath of adverse health events. In contrast, Minnesota remains in the minority of states that have not adopted a statute or rule excluding medical apologies from litigation.

This article argues that Minnesota’s current approach is exactly right. In Part IV, this article contends that it is a mistake to attempt to use evidentiary standards to improve physician-patient communication. This article is in accord with other commentators who contend that evidentiary rules are unlikely to have much impact on health professionals’ decisions about appropriate communication with patients. This article also agrees that excluding apologies from later use at trial does, in some sense, undercut their moral weight. The principal objection to these statutes, however, does not stem from either the nature of doctors or the nature of apologies, but the nature of lawyers. Creating an evidentiary exclusion for medical apologies would inevitably enmesh lawyers in this kind of doctor-patient communication, and that would be a mistake. This article reaches its conclusion after a

1. See, e.g., ARIZ. REV. STAT. § 12-2605 (2008); CAL. EVID. CODE § 1160 (2008); COLO. REV. STAT. § 13-25-135 (2008).

review of the evidentiary considerations that gave rise to these types of statutes² and an examination of Minnesota's own experience with disclosure following adverse medical events.³ Understanding the medical culture surrounding communication between doctor and patient is central to understanding these issues, however. It is that culture, after all, that gave rise to the perception that a change in evidentiary rules might help foster better physician-patient communication. This article begins with an overview of that culture since it is the context for both the medical and evidentiary issues relevant to our argument.

II. THE MEDICAL CONTEXT

A. *Breaking the Code of Silence: From Consent to Disclosure to Apology*

In 1984, Jay Katz broke the unwritten code of silence in his book *The Silent World of Doctor and Patient*, criticizing traditional medical decision-making in which the physician, relying upon his or her best judgment, acts in the patient's presumed best interest. The traditional physician typically does so by donning a "mask of infallibility" and professing certainty as to the best course of treatment despite the uncertainty that engulfs medical knowledge.⁴ Instead, Katz advocated for shared decision-making. But to make shared decision-making work, patient-physician communications had to be more than a one-way street. As Katz noted, physicians are well trained to attend to physical needs. Their education, however, did not extend to caring for patients' decision-making needs.

Katz described a conversation with a surgeon about the uncertainties that surrounded the treatment (radiation, surgery, or chemotherapy) of breast cancer at the time. Yet when asked how the surgeon would speak with a patient about this, the surgeon said he briefly mentioned a number of possible treatments, but without indicating that any alternative to radical surgery merited serious consideration. As Katz relates,

Instead, he had quickly impressed on his patient the need for submitting to this operation. I commented that he had given short shrift to other treatment approaches even though a few minutes earlier he had agreed with me that

2. See *infra* Part II.

3. See *infra* Part III.

4. JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 166, 198 (The Free Press) (1984).

we still are so ignorant about which treatment is best. He seemed startled by my comment but responded with little hesitation that ours had been a theoretical discussion, of little relevance to practice. Moreover, he added emphatically that, in the light of present knowledge, radical surgery was the best treatment.⁵

While Katz was breaking ground in his description of this culture of silence, the phenomena itself was far from new. In the Hippocratic view, physicians should “reveal nothing of the patient’s future or present condition” while attending to patients. Plato’s advice reminded the physician of the duty to “persuade the patient to accept treatment and to employ ‘lies for good and noble purposes,’ if necessary.”⁶ When the American Medical Association (AMA) adopted its Code of Ethics in 1847, it described a physician’s “sacred duty” to “avoid all things which have a tendency to discourage the patient and to depress his spirits.”⁷

Dr. D. W. Cathell expanded upon this approach to patient relations in his widely-read how-to manual on medical practice for aspiring physicians, *The Physician Himself*.⁸ Consider the following advice regarding disclosure to the patient:

When called to attend cases of angina pectoris, aneurism, organic heart disease, desperate wounds or injuries, apoplexy, and other diseases that create liability to sudden death, prudence may require you to conceal the danger of death from the patient, lest he give up all hope and be overcome by apprehension and terror; but be sure to give,

5. *Id.* at 167. When the surgeon asked Katz how he would have responded, Katz replied that he would have clearly explained medicine’s ignorance about which treatment is best and then laid out all treatment options in detail and discussed them. *See id.*

Eventually, I would have made a recommendation but only after I had first elicited her preference and the reasons for her choice. Holding back for a while on giving her my recommendation would have served two purposes: one, to prevent her being pressured by my professional authority to accept my recommendation; and, two, to provide an additional opportunity to explore . . . why she had chosen that particular treatment.

Id.

6. Sheldon F. Kurtz, *The Law of Informed Consent: From “Doctor is Right” to “Patient has Rights,”* 50 SYRACUSE L. REV. 1243, 1243 (2000).

7. KATZ, *supra* note 4, at 231.

8. D. W. CATHELL, *THE PHYSICIAN HIMSELF* 1 (Cushings & Bailey 1882). This popular manual of personal advice for physicians ran through many editions between 1881 and its last revision in 1922.

privately, proper warning to those most interested.⁹

Or consider this advice regarding an unexpected outcome:

Never exhibit surprise at any possible event growing out of sickness. You will be supposed to foreknow all conceivable things relating to disease, its dangers and its terminations. Even when death has occurred to some one under your treatment unexpectedly, do not let your manner indicate that you were entirely ignorant of its possibility or that you feel yourself blamable.¹⁰

Cathell's advice sought to preserve physician authority and physician autonomy—with little thought to patient autonomy. Indeed, despite the many scientific advances and technological changes within the medical practice, the one-sided “doctor knows best” physician-patient relationship remained unchanged until late in the twentieth century.¹¹ The change began with two cases, *Salgo v. Leland Stanford Jr. University Board of Trustees*¹² and *Natanson v. Kline*.¹³ In both cases, the patients were treated with new technologies without any disclosure of the risks.¹⁴ Both suffered severe injuries from the treatments.¹⁵ From these facts, the legal doctrine of “informed consent” was born.¹⁶

9. *Id.* at 81.

10. *Id.* at 198.

11. See generally KATZ, *supra* note 4.

12. 317 P.2d 170 (Cal. Dist. Ct. App. 1957).

13. 350 P.2d 1093 (Kan. 1960).

14. In *Salgo*, the plaintiff was a 55-year-old man who complained of lower leg pain and abdominal pain. The plaintiff consulted with a surgical specialist who recommended further testing. Specifically, the specialist recommended that a procedure called an aortography was needed to determine the extent of the blockage in plaintiff's aorta. The procedure required the plaintiff to be anesthetized while a surgeon injected into his aorta sodium urokon, upon which x-rays are taken enabling a radiologist to see the blocked areas. After the first x-rays were viewed, it was determined that additional x-rays were needed. With the original needle still in place, the surgeon injected an additional amount of sodium urokon into plaintiff and more x-rays were taken. All physicians involved considered the procedure to have unfolded normally, and the plaintiff appeared to be recovering. It was not until the next morning that plaintiff awoke realizing that his lower extremities were paralyzed: a permanent condition. 317 P.2d at 172–75. In *Natanson*, the plaintiff was receiving radiation therapy after having a left mastectomy. The therapy involved injecting plaintiff with radioactive cobalt to shrink the remaining tumor under her left arm. Plaintiff alleged that the physician administered the cobalt excessively, such that the skin, flesh, and muscles beneath her left arm sloughed away and the ribs of her left chest were so burned that they died. 350 P.2d at 1095–97.

15. *Salgo*, 317 P.2d at 172–75; *Nathanson*, 350 P.2d at 1095–97.

16. While the modern doctrine found its roots in these opinions, it took a

Changing a legal doctrine across time is not the same, however, as changing physician-patient communication. In his best seller, *Complications*, Surgeon Atul Gawande writes of his father's medical practice in the 1970s and the 1980s when men came to him seeking vasectomies. It was accepted that his physician father would judge not only whether surgery was medically appropriate but also personally appropriate. As Gawande wrote, "[h]e routinely refused to do the operation if the men were unmarried, married but without children, or 'too young.'"¹⁷ Gawande's father was hardly the exception. Indeed, it took twenty-three years after the *Salgo* decision for the AMA to openly acknowledge the concept of "informed consent" and then it did so only in a short statement by its Judicial Council that "the patient should make his own determination on treatment. Informed consent is a basic social policy"¹⁸

After 1984, some progress was made. Medical schools began to

series of cases to develop the doctrine. See *Canterbury v. Spence*, 464 F.2d 772, 780–81 (D.C. Cir. 1972). In *Arato v. Avedon*, the court further developed the informed consent doctrine and said that a physician has a duty to disclose to the patient all "information which the physician knows or should know [that] would be regarded as significant by a reasonable person in the patient's position when deciding whether to accept or reject a recommended medical procedure" 858 P.2d 598, 607 (Cal. 1993). Eventually, the AMA issued an opinion stating that informed consent is a byproduct of both the physician and the patient. Informed consent "is a process of communication between a patient and physician that results in the patient's authorization or agreement to undergo a specific medical intervention." American Medical Association, *Informed Consent*, available at <http://www.ama-assn.org/ama/pub/physician-resources/legal-topics/patient-physician-relationship-topics/informed-consent.shtml>. The AMA lists a number of items the physician must discuss with the patient; in order for the consent to be "informed," a patient must have the opportunity to ask questions and obtain a clear picture of the treatment or procedure. See *id.*

17. ATUL GAWANDE, *COMPLICATIONS: A SURGEON'S NOTES ON AN IMPERFECT SCIENCE* 210 (Picador 2003).

18. Judicial Council of the Am. Med. Ass'n, *Current Opinions of the Judicial Council of the American Medical Association* 25 (1981). In his article, *Informed Consent—Must it Remain a Fairy Tale?*, 10 J. CONTEMP. HEALTH L. & POL'Y 69, 80–81 (1993), Jay Katz reflects on this AMA statement, noting:

To translate social policy into medical policy is an inordinately difficult task. It requires a reassessment of the limits of medical knowledge in the light of medical uncertainty, a reassessment of professional authority to make decisions for patients in light of the consequences of such conduct for the well-being of patients, and a reassessment of the limits of patients' capacities to assume responsibility for choice in the light of their ignorance about medical matters and their anxieties when ill [I]n the absence of such reassessments, informed consent will remain a charade, and joint decision making will elude us.

address doctor-patient communication as part of its curriculum.¹⁹ More accountability was introduced into the previously cloaked world of medical self-regulation by adding public members to medical practice boards, increasing disciplinary actions, and making more final disciplinary actions public.²⁰ The National Health Practitioners Databank, a clearinghouse for information about individual physicians that may be accessed by virtually any entity to which a physician applies for the privilege to practice, was created by the Health Care Quality Improvement Act of 1986.²¹ But in the closed world of medical practice, the ways to strengthen physician-patient communication while still publicly addressing incompetent physicians, were limited. And if physicians struggled to communicate with patients to share decision making *before* a conducting a procedure, how much harder was it to break the code of silence after a mistake was made? This reality became clear in 1999 when the Institute of Medicine (IOM) published its seminal report on safety, *To Err is Human*.²²

The report acknowledged the startling reality that between 44,000 and 98,000 Americans died each year in hospitals as a result of medical errors.²³ As the authors point out, even using the lower figure, the estimated errors in hospitals exceeded the number attributed to the eighth-leading cause of death.²⁴ Even more sobering, the report stated that these numbers represented only a small portion of the total population at risk as more and more care

19. GAWANDE, *supra* note 17, at 211–12 (stating that by the time he entered medical school in the early 1990s, students were taught to see patients as autonomous decision makers). See generally American Association of Medical Colleges, *Report 1: Learning Objectives for Medical Education: Guidelines for Medical Schools* (Jan. 1998), available at https://services.aamc.org/Publications/index.cfm?fuseaction=Product.displayForm&prd_id=198&prv_id=239 (follow “download now” hyperlink).

20. Marlynn Wei, *Doctors, Apologies, and the Law: An Analysis and Critique of Apology Laws*, 40 J. HEALTH L. 107, 146–47 (2007).

21. Health Care Quality Improvement Act of 1986, Pub. L. No. 99-660 (1986) (codified at 42 U.S.C. § 11101 *et seq.* (1986)). Hospitals must report actions, such as suspension or termination, which adversely affect clinical privileges of a physician for more than thirty days. *Id.* at § 11133. Medical malpractice payors must report settlements and judgments and State Medical Boards must report disciplinary actions. *Id.* at §§ 11131–11132. One goal of the NHPD is to address the issue of physician relocation after clinical privileges are limited or revoked. *Id.* at § 11101.

22. INST. OF MED., *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* (Linda T. Kohn et al. eds., 1999).

23. *Id.* at 1.

24. *Id.*

is provided outside the hospital in outpatient surgical centers, clinics, nursing homes, home care, and other settings.²⁵

The IOM report acknowledged that individual human error is inevitable. It suggested, however, that 90% of the medical errors were the result of system failures because, if properly designed, system procedures could better prevent individual human errors.²⁶ But understanding the causes of errors, and to put in place systems to catch and prevent them, requires discussion of the errors in the first place. As the executive summary of the report noted:

[S]ilence surrounds this issue. For the most part, consumers believe they are protected. Media coverage has been limited to reporting of anecdotal cases. Licensure and accreditation confer, in the eyes of the public, a “Good Housekeeping Seal of Approval.” Yet, licensing and accreditation processes have focused only limited attention on the issue, and even these minimal efforts have confronted some resistance from health care organizations and providers. Providers also perceive the medical liability systems as a serious impediment to systematic efforts to uncover and learn from errors.²⁷

The report harkened back to patient safety expert Lucian Leape who stated in his seminal article, *Error and Medicine*:

[T]he most important reason physicians and nurses have not developed more effective methods of error prevention is that they have a great deal of difficulty in dealing with human error when it does occur. The reasons are to be found in the culture of medical practice.

Physicians are socialized in medical school and residency to strive for error-free practice. There is a powerful emphasis on perfection, both in diagnosis and treatment. In every day hospital practice, the message is equally clear: mistakes are unacceptable. Physicians are expected to function without error, an expectation that physicians translate into the need to be infallible Role models in medical education reinforce the concept of infallibility. The young physician’s teachers are largely specialists, experts in their fields, and authorities. Authorities are not supposed to err. It has been suggested that this need to be infallible creates a strong pressure to

25. *Id.* at 2.

26. *See id.* at 3–4.

27. *Id.* at 3.

intellectual dishonesty, to cover up mistakes rather than to admit them. The organization of medical practice, particularly in the hospital, perpetuates these norms. Errors are rarely admitted or discussed among physicians in private practice. Physicians typically feel, not without reason, that admission of error will lead to censure or increased surveillance or, worse, that their colleagues will regard them as incompetent or careless. Far better to conceal a mistake or, if that is impossible, to try and shift the blame to another, even the patient.²⁸

The IOM Report called upon hospitals and other providers to identify and learn from errors and “near misses,” events that could have resulted in patient injury but were detected in time.²⁹ The report galvanized two different, but related, movements pushing for disclosure. First, patient safety advocates embraced the IOM Report’s recommendations to disclose and report errors so that they could be systematically tracked and with the aim of addressing the errors through the system-wide changes. The IOM Report also propelled the growing movement in the dispute resolution community towards promoting the role of apology in resolving civil disputes, particularly in the health care industry.³⁰

B. Progress toward Disclosure and the Patient Safety Movement

While the “deny and defend” strategy was alive and well at the turn of this century, both the Joint Commission and state governments heeded the IOM’s call for increased disclosure.³¹ The

28. Lucian L. Leape, *Error in Medicine*, 272 JAMA 1851 (1994).

29. See INST. OF MED., *supra* note 22, at 177.

30. See e.g., Jonathan R. Cohen, *Advising Clients to Apologize*, 72 S. CAL. L. REV. 1009 (1999); Aviva Orenstein, *Apology Accepted: Incorporating a Feminist Analysis Into Evidence Policy Where You Would Least Expect It*, 28 SW. U. L. REV. 221 (1999).

31. Why the reluctance by the medical profession to disclose errors and apologize? The answers are complex and the subject of many commentaries, but Lucian Leape summarized them well when he wrote:

- Admitting fault and apologizing is often very difficult for the caregiver. Medical injury, particularly if it is serious, is very different from other types of situations where people apologize, because it is a physical injury, albeit unintended.
- The consequences for patient and doctor can be substantial: the patient may die or suffer a lifelong disability.
- For the physician, in addition to provoking feelings of shame and guilt, the incident raises concerns about his or her reputation, and the possibility of a malpractice suit. The more profound the consequences, the more difficult it is to accept

Joint Commission, which accredits hospitals and other health care institutions, issued a Sentinel Event Policy in 1996.³² This policy required accredited institutions to investigate adverse events and implement measures to prevent the event from happening in the future.³³ But in 2001, the Joint Commission went further: it required accredited hospitals to tell patients of “unanticipated” outcomes.³⁴

The IOM report also recommended the establishment of a nationwide mandatory reporting system in which state governments would collect information about patient errors resulting in death or serious harm.³⁵ Minnesota was the first state to adopt mandatory disclosure of “never events” in 2003.³⁶ Other states followed suit and by January 2007, twenty-six states required the report of an adverse event or incident.³⁷ Pennsylvania became the first state to require hospitals to notify not only the state, but patients of a serious event resulting from a medical error.³⁸

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- responsibility and apologize.
 - The natural reluctance to “fess up as long been legitimized by lawyers and risk managers who have advised physicians not to admit responsibility or apologize—advice that is still given in many institutions.

Leape, *supra* note 28. We suggest an additional reason: in medicine, without disclosure by the provider, a serious error may go undetected by the patient. When a car runs a four way stop and crashes into your automobile, you have a pretty fair idea that an accident occurred and who caused it. If you are a patient in the hospital and have an unexpected medical outcome, you most likely will not know whether your condition was the result of medical error, or simply an unexpected turn in the illness that hospitalized you in the first place. The information gap between providers and patients is one of the reasons we view physicians as fiduciaries. But that information gap can also cloak mistakes, which makes acceptance of responsibility even more difficult.

32. JOINT COMM’N, SETTING THE STANDARD, *available at* [www.jointcommission.org/NR/rdonlyres/6C33FEDB-BB50-4CEE-950B-A6246DA4911E/\)/setting_the_standard.pdf](http://www.jointcommission.org/NR/rdonlyres/6C33FEDB-BB50-4CEE-950B-A6246DA4911E/)/setting_the_standard.pdf).

33. *Id.*

34. *Id.*

35. INST. OF MED., *supra* note 22, at 9.

36. Am. Med. News, *Minnesota Report Card on Patient Safety*, *available at* <http://www.ama-assn.org/amednews/2006/03/27/prca0327.htm>.

37. June M. Sullivan & Renee H. Martin, *Patient Safety Handbook*, 41, 41 (ABA 2008).

38. See <http://patientsafetyauthority.org/PA-PSRS/Pages/PAPSRs.aspx>. The Pennsylvania statute defines a “serious event” 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. § 1303.302 (2006). See also Patient Safety Authority, *Reporting Medical*

The federal regulatory response was slower, but Congress enacted the Patient Safety and Quality Improvement Act (PSQIA) in 2005. Rules implementing the Act went into effect January 19, 2009.³⁹ The PSQIA creates a voluntary system for reporting and aggregating patient safety information through newly created Patient Safety Organizations. In a more direct approach, Medicare and Medicaid announced in 2008 that they will not pay for certain “never events,” such as wrong-site surgery, pressure ulcers, or foreign bodies left in a patient after surgery.⁴⁰

In addition to payment consequences from CMS and disclosure directives from the Joint Commission and many states, the AMA issued a new opinion addressing disclosure from the perspective of physician ethics. In December 2003, the AMA’s Council in Ethical and Judicial Affairs Opinion 8.121 advised physicians that it was their ethical responsibility to study and prevent error and harm. Physicians, according to the opinion, should help establish and then “participate fully” in effective, confidential, and protected error-reporting mechanisms.⁴¹ Further, the opinion directs physicians to

Offer professional and compassionate concern toward patients who have been harmed, regardless of whether the harm was caused by a healthcare error. An expression of concern need not be an admission of responsibility. When patient harm has been caused by an error, physicians should offer a general explanation regarding the nature of the error and the measures being taken to prevent similar occurrences in the future. Such communication is fundamental to the trust that underlines the patient-physician relationship, and may help reduce the risk of liability.⁴²

Errors, available at <http://www.psa.state.pa.us/psa/cwp/view.asp?a=1147&q=440863&psaNav=|>.

39. Patient Safety Act, 42 U.S.C.A. § 299b-21.

40. *See, e.g.*, Press Release, CMS Proposes Three National Coverage Determinations to Protect Patients from Preventable Surgical Errors (Dec. 2, 2008), *available at* <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=3375&intNumPerPage=10>; Kevin Sack, *Medicare Rules Say “Do No Harm,”* N.Y. TIMES, Oct. 1, 2008, at A1.

41. AMA Council in Ethical and Judicial Affairs, Opinion 8.121 (discussing the ethical responsibility to study and prevent harm and error).

42. *Id.* This Opinion updated the 1994 Opinion 8.121 and provides further ethical guidance, stating in part: “Situations occasionally occur in which a patient suffers significant medical complications that may have resulted from the physician’s mistake or judgment. In these situations, the physician is ethically

C. *The Academic Case for Apologies in Health Care Disputes*

Taking note of studies that found one major reason patients sued their doctors was physicians' failure to be forthright about mistakes and apologize for them,⁴³ dispute resolution scholars began encouraging the use of apologies.⁴⁴ One of the early studies that motivated scholars was published in *Lancet* in 1994. The researchers surveyed 227 patients and their families who filed legal claims following an adverse medical outcome.⁴⁵ The study found that patients took legal action not just because of the injury, but because of the insensitivity of physicians after the accident.⁴⁶ More importantly, patients and their families did not want similar mistakes to happen to anyone else. Patients and their families wanted an explanation. They wanted the physician to understand how they felt. And they wanted compensation.⁴⁷

As Jonathan Cohen notes in his entertaining article that features a "debate" about laws excluding expressions of sympathy and benevolence between two law school friends, determining how many plaintiffs really would have walked away upon receipt of a heartfelt apology is next to impossible.⁴⁸ One of the debaters, Flo, remarks:

It is impossible to know with perfect certainty what

required to inform the patient of all the facts necessary to ensure understanding of what has occurred." *Id.*

43. See, e.g., Gerald B. Hickson et al., *Factors that Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries*, 267 JAMA 1359 (1992); Charles Vincent et al., *Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action*, 343 LANCET 1609, 1612 (1994); Amy B. Witman et al., *How Do Patients Want Physicians to Handle Mistakes*, 156 ARCHIVES OF INTERNAL MED. 2565, 2568 (1996) (stating that in cases of moderate physician error, only 12% would sue if informed of error, but 20% would do so if later learned of error).

44. See, e.g., Cohen, *supra* note 30; Ann J. Kellett, Comment, *Healing Angry Wounds: The Roles of Apology and Mediation in Disputes between Physicians and Patients*, 1987 MO. J. DISP. RESOL. 111, 126-27 (stating the importance of an apology in managing physician-patient disputes); Orenstein, *supra* note 30; Peter H. Rehm & Denise R. Beatty, *Legal Consequences of Apologizing*, 1996 J. DISP. RESOL. 115, 129 (1996).

45. Vincent, *supra* note 43.

46. *Id.* at 1611.

47. Vincent, *supra* note 43, at 1611. See, e.g., Hickson, *supra* note 43. Marlynn Wei points out, however, that there has been no "clear empirical study" of the impact of full disclosure on a patient's desire to sue. *Doctors, Apologies, and the Law*, 40 J. HEALTH L. 107, 142 (2007). Wei writes that "disclosure has been shown to increase, decrease, or not change at all the patient's desire to sue." *Id.*

48. Jonathan R. Cohen, *Legislating Apology: The Pros and Cons*, 70 U. CIN. L. REV. 819, 844 (2002).

fraction of patients would not have sued if they had received an apology. Some skepticism is warranted. When a patient says that he would not have sued if he had received an apology, you can never know for sure what he would have done if he had. But surely some patients can be taken at their word I can't say for sure whether the percentage of patients who would have forgone suit if they had received an apology is 5%, 15%, 25% or perhaps even 35%. But if the percentage is even half of what these studies suggest, it is a sizable percentage.⁴⁹

Other scholars, relying on both their personal mediation experiences, as well as empirical research, agree.⁵⁰ Advocates of apology and disclosure include medical practitioners and ethicists, who focused on their use not simply as a risk-management tool, but as a way to improve the physician-patient relationship and, in doing so, achieve better patient outcomes.⁵¹

D. Empirical Research on Disclosure and Apology

As scholars and medical practitioners wrote of the importance of medical apologies, researchers began to study in more detail how apologies affect dispute resolution and the prevalence of physician disclosure and apology after medical error. Professor Jennifer Robbennolt conducted empirical research on the role of apology in settlement that was published in 2003.⁵² Her study participants read an accident scenario, were assigned the role of accident victim and evaluated a settlement offer from the other party.⁵³ Some offers included “full” apologies—those with expression of sympathy and an acknowledgment of responsibility.⁵⁴ Others included a “partial apology”—an offer of sympathy and hope for a quick recovery, but the other party did not accept

49. *Id.*

50. *See supra* note 434 and accompanying text.

51. This article primarily addresses the work of legal scholars, but certainly *To Error is Human* sparked great interest by providers on the role of apologies. *See generally* NANCY BERLINGER, *AFTER HARM: MEDICAL ERROR AND THE ETHICS OF FORGIVENESS I* (Johns Hopkins U. Press 2005); MICHAEL S. WOODS, *HEALING WORDS: THE POWER OF APOLOGY IN MEDICINE I* (2d ed. 2007); Doug Wojcieszak et al., *The Sorry Works! Coalition: Making the Case for Full Disclosure*, 32 *Joint Commission J. on Quality & Patient Safety* 344–50 (June 2006).

52. Jennifer K. Robbennolt, *Apologies and Legal Settlement: An Empirical Examination*, 102 *MICH. L. REV.* 460 (2003).

53. *Id.* at 484.

54. *Id.* at 484–85.

responsibility.⁵⁵ Others included no apology at all.⁵⁶

Her research showed that while 52% of respondents said they would probably accept the settlement offer with no offered apology, 73% were inclined to accept the offer with a “full” apology.⁵⁷ As she described her findings,

Apologies, particularly those that accepted responsibility for having caused injury, favorably influenced a variety of attributions made about the situation and the other party, including perceptions of the character of and the degree of regret experienced by the other party, expectations about the way in which the other party would behave in the future, and expectations about the relationship between the parties going forward. Similarly, apologies influenced the emotions that participants reported they would feel—decreasing anger toward the other party and increasing sympathy for the other’s position. Full, responsibility-accepting apologies showed these effects consistently. Apologies that merely expressed sympathy were more context dependent, favorably influencing these attributions under some circumstances, but not in others.⁵⁸

In a follow up study, Robbennolt used the same scenario to assess the effects of apologies on attorneys.⁵⁹ The basic fact pattern varied with regard to the type of apology given, the evidentiary rule governing apology admissibility, and strength of the plaintiff’s case.⁶⁰ Robbennolt concluded that both the type of apology (full versus partial) and the type of evidentiary rule influenced attorneys’ views of the apology.⁶¹ Like claimants, attorneys had a more positive assessment of a full apology, as opposed to a partial apology or no apology at all.⁶² Attorney assessment of the apology was also influenced by whether it was “protected” by an evidentiary rule excluding the apology from evidence at trial. Claimants and attorney opinion diverged when it came to assessing settlement in light of effective apologies. While claimants became more

55. *Id.* at 485.

56. *Id.* at 484.

57. *Id.* at 485–86.

58. Jennifer K. Robbennolt, *Attorneys, Apologies, and Settlement Negotiation*, 13 HARV. NEGOT. L. REV. 349, 362 (Spring 2008) (citations omitted).

59. *Id.* at 350.

60. *Id.*

61. *Id.* at 351.

62. *Id.* at 372.

amenable to settlement, attorneys developed higher settlement expectations—and expected more money—post-apology.⁶³ As a result, Robbennolt notes, the involvement of attorneys in legal disputes “has the potential to change the dynamics of negotiations involving apologies.”⁶⁴

Of course, “full” apologies assume disclosure of a mistake. While Professor Robbennolt studied claimant and lawyer responses to apologies, other scholars addressed the more fundamental problem of whether unanticipated outcomes in medicine were being disclosed to begin with. Most of these studies track recent behavior, given that the disclosure push (driven by the Joint Commission and state and federal laws) largely occurred after the publication of *To Err is Human*.

The overall results of the studies are cause for concern. In 2005, the Joint Commission reports that “few caregivers and health care organizations voluntarily break through the wall of silence to report life-threatening medical errors beyond the walls of their institutions.”⁶⁵ A 2004 report found that half of the hospitals surveyed were reluctant to comply with the Joint Commission’s new accreditation standards (that require the disclosure of certain unanticipated outcomes to patients) because of fear of medical malpractice lawsuits.⁶⁶ A study of physicians-in-training found that only 24% discussed mistakes with the patient or patient’s family.⁶⁷ In a study of physicians who disclosed obvious errors, the surgeons described what happened to patients using the words “error” or “mistake” in 57% of cases, the word “complication” or “problem” in 27% of cases and did not suggest “error” at all in 16% of cases.⁶⁸ Yet another nationwide study suggests that physicians disclose

63. *Id.* at 374.

64. *Id.* at 383.

65. Joint Commission, *Health Care at the Crossroads: Strategies for Improving the Medical Liability System and Improving Patient Safety* 1, 28 (2005), available at http://www.jointcommission.org/NR/rdonlyres/167DD821-A395-48FD-87F9-6AB12BCACB0F/0/Medical_Liability.pdf.

66. Kelly J. Devers et al., *What Is Driving Hospitals’ Patient-Safety Efforts?*, 23 *HEALTH AFF.* 103, 111–12 (Mar.–Apr. 2004), available at <http://www.healthaffairs.org/RWJ/Devers.pdf>.

67. Albert W. Wu et al., *Do House Officers Learn from their Mistakes?*, 12 *QUALITY & SAFETY IN HEALTH CARE* 221, 224 (2003), available at <http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=1743709&blobtype=pdf>.

68. David K. Chan, *How Surgeons Disclose Medical Errors to Patients: A Study Using Standardized Patients*, 138 *SURGERY* 851, 854–55 (2005).

errors in only about 30% of cases.⁶⁹ In summary, while scholars, ethicists, and some practitioners were researching and advocating for medical apologies, disclosure of the underlying errors was far from routine.⁷⁰

II. EVIDENTIARY CONSIDERATIONS

A. *The Backdrop of the Rules*

The rules of evidence divide the universe of apologies into two categories. If an apology is a statement made during “compromise negotiations,” then, as a general rule, it will be excluded from evidence.⁷¹ However, there cannot be negotiations about a

69. Robert J. Blendon et al., *Views of Practicing Physicians and the Public on Medical Errors*, 347 N. ENGL. J. MED. 1933, 1935 (2002) (stating only about one third of physicians and patients responding to a survey reported that, after experiencing a medical error, physicians involved either discussed it with the patient or apologized). In response to the common wisdom that physicians were the “reluctant partners” (confirmed in large part by the studies described above) in reporting errors to hospitals where they practice, a Health Affairs study published in late 2008 sought to learn about physician attitudes. Jane Garbutt et al., *Lost Opportunities: How Physicians Communicate About Medical Errors*, 27 HEALTH AFF. 246 (2008). Most of the over one thousand physicians surveyed reported prior involvement with a serious error. The majority also agreed that to improve patient safety, errors should be reported, but few believed that they had access to a reporting system that was designed to improve patient safety. Only 30% agreed that current systems for physicians to report patient safety problems to their hospital or health organization were adequate.

70. Even before issuance of the IOM report, *To Err Is Human*, a few institutions began moving disclosure and apology from the pages of scholarship into reality. An early example was the VA Hospital in Lexington, Kentucky. Troubled by two large malpractice verdicts, the VA adopted a system in 1987 that sought out the patient and family after an adverse event. After informing the patient that an error occurred, and if the VA’s risk management committee determined that the hospital was at fault, the family would receive an apology, in person and in writing, and a fair settlement would be offered. Jonathan R. Cohen, *Apology and Organizations: Exploring an Example from Medical Practice*, 27 FORDHAM URB. L.J. 1447, 1448–51 (2000). The VA went so far as to post excerpts of its policy at hospital entrances. *Id.* at n.9. Shifting to this policy of “extreme honesty” resulted in lower costs in claims paid out. Other notable institutions which have formal policies in place include Children’s Hospital in Minneapolis, Johns Hopkins, Catholic Healthcare West, and the University of Michigan Health System. See e.g., MICHAEL S. WOODS, *HEALING WORDS: THE POWER OF APOLOGY IN MEDICINE* (2nd ed. 2007) (describing the VA and University of Michigan Programs); Ellen L. Barton & Mark A. Kadzielski, *Tell Me Now and Tell Me Later: Disclosure and Reporting of Medical Errors*, AHLA Seminar Materials, 56–57 (2007) (describing the Children’s, Johns Hopkins, and Catholic Healthcare West programs).

71. The “general rule” of evidence in question is Rule 408. Minnesota Rule

compromise until there is a “genuine dispute” about the validity or amount of a claim.⁷² A genuine dispute triggers setting and timing problems that give rise to the perceived need for a special rule or statute excluding evidence of medical apologies. If a medical apology is made in the setting of settlement negotiations about a genuine dispute, then evidence of the apology cannot be offered at a later trial of the dispute, should those negotiations prove unsuccessful. On the other hand, if the apology is made before the existence of a genuine dispute, or if the apology is made after the dispute exists but outside the context of compromise negotiations, then it is highly likely evidence of the apology will be admissible at a later trial.

The apology will likely be admissible because, like other states with evidentiary rules based on the federal model, Minnesota permits virtually unchecked admission of an opponent party’s statements.⁷³ The applicable Minnesota evidentiary rule provides, in pertinent part, that statements of a party are not hearsay if:

The statement is offered against a party and is (A) the party’s own statement, in either an individual or a representative capacity, or . . . (C) a statement by a person authorized by the party to make a statement concerning the subject, or (D) a statement by the party’s agent or servant concerning a matter within the scope of the agency or employment,⁷⁴ made during the existence of the relationship

Unlike other evidence proffered at trial, the statements of the opposing party can typically be admitted without any evidence that the opposing party had the personal knowledge necessary to form foundation for the statement.⁷⁵ As the Committee Comment to

of Evidence 408, like its federal progenitor and counterparts in other states, creates a broad prohibition on the admission of evidence of statements or conduct that occurs during settlement negotiations. Minnesota Rule of Evidence 408 also excludes from evidence at trial the existence of an agreement for corrective action (ACA). *See In re Buckmaster*, 755 N.W.2d 570, 580 (Minn. Ct. App. 2008). In that case, the court held that an ACA could not be used as evidence of liability or impeachment purposes. *Id.* at 581.

72. *See, e.g.*, MINN. R. EVID. 408, committee’s cmt. (1977).

73. *See generally* MINN. R. EVID. 801(d)(2) (2006).

74. *Id.* The omitted portions of Rule 801(d)(2) relate to adoptive admissions—statements of a party that are made through either express or implied agreement with the statement of another and statements made by a co-conspirator of a party.

75. Minnesota Rule of Evidence 602 provides, in pertinent part, that a “witness may not testify to a matter unless evidence is introduced sufficient to

Rule 801(d)(2) explains:

The rule excludes party admissions from its definition of hearsay. The requirements of trustworthiness, firsthand knowledge, or rules against opinion which may be applicable in determining whether or not a hearsay statement should be admissible do not apply when dealing with party admissions. Because the rationale for their admissibility is based more on the nature of the adversary system than in principles of trustworthiness or necessity, it makes sense to treat party admissions as nonhearsay.⁷⁶

In short, a statement made by the opposing party is freely admissible, even if the person making the statement did not have sufficient personal knowledge to support the statement.⁷⁷

As a practical matter, Rule 801(d)(2) means that so long as a statement is relevant for some purpose, *any* statement made following an accident, injury, or adverse medical outcome is

support a finding that the witness has personal knowledge of the matter.” As the Committee Comment indicates, this rule articulates a “fundamental principle of evidence law.” This fundamental principle is generally applicable to hearsay statements other than statements of a party-opponent:

With the exception of party admissions, which are admitted as a function of the adversary system (and are not hearsay under rule 801(d)(2)) the Courts have generally required that the declarant of a hearsay statement have firsthand knowledge, before the hearsay statement is admissible. The rule should be read to continue this practice.

MINN. R. EVID. 602, committee’s cmt. (1977).

76. MINN. R. EVID. 801(d)(2), committee’s cmt. (1989).

77. The Minnesota Supreme Court muddied the otherwise clear waters of this rule of law in *Kelly v. Ellefson*, 712 N.W.2d 759 (Minn. 2006). The case did not involve a claim of professional malpractice, but instead arose out of lawsuits filed following a motor vehicle accident allegedly occurring, in part, due to a violation of the state’s Dram Shop Act. *Id.* at 761–65. The plaintiff in *Kelly* entered a *Pierringer* settlement with two defendants shortly before trial. *Id.* at 761. During trial, one of the nonsettling defendants sought to prove the fault of a settling defendant by attempting to introduce three different pieces of evidence, all of which seemed to be statements of one of the parties-opponent. *Id.* at 761–66. The most significant, for purposes here, was the plaintiff’s interrogatory answers concerning the basis for the alleged fault of the settling defendants, and third, the plaintiff’s supplemental interrogatory answer outlining the testimony of an expert toxicologist who ultimately did not testify at trial. With respect to those answers, the Minnesota Supreme Court held that, because the plaintiff had no personal knowledge of the facts asserted in the interrogatory answers, those answers were inadmissible. *Id.* at 769. In the course of its decision, the supreme court took note of the language of the Committee Comment cited above, *supra* note 75, but nonetheless ruled that since the statements contained in the interrogatory answers would not have been admissible had the plaintiff attempted to testify to those matters at trial, it was not error for the district court to exclude use of those answers at trial. *Id.* at 769.

admissible. Automobile insurance companies have long been aware of this and recognized that in the heat of emotion following a car accident, policy holders may feel inclined to apologize even though they are not legally at fault. As a consequence, it is not unusual for insurance companies to give policyholders “what to do in the case of an accident” instructions that include warnings not to apologize or talk about fault.⁷⁸

Doctors have long behaved as if they were carrying cards in their pockets bearing much the same message. As set forth above, doctors and other health-care professionals traditionally practiced in the context of a culture of silence. Lawyers themselves are skeptical of post-event apologies, expressions of sympathy, or any other statements that could be construed as admissions of fault for the event in question. The free admission at trial of the statements made by doctors, nurses, or other hospital personnel following an adverse event—regardless of whether those individuals have sufficient bases of knowledge for making those statements—may alone be reason for a lawyer to counsel steadfast silence.

A lawyer may well have other legitimate reasons for advising limited communication with patients or their families following adverse medical outcomes. First, statements that imply someone did something wrong could prompt a patient to take the first steps down the road to filing a malpractice action. Second, a statement about the cause of an unwelcome or unforeseen outcome will become useful fodder during discovery, regardless of whether those statements are themselves admissible at trial. All of this may help explain why lawyers have traditionally been wary of apologies in the midst of litigation.⁷⁹

78. See, e.g., *What To Do In Case Of An Accident*, <http://www.certifiedfirst.com/accident/> (“Exchange insurance company information. DO NOT discuss ‘fault’ or make statements about the accident to anyone but the police.”); *Auto Insurance: What To Do In Case Of An Accident*, <http://www.autorisk.com/auto/whatTODoACCIDENT.htm> (“Be careful of what you say. Don’t talk about fault; even casual remarks can be used in court.”). Several state bar associations offer similar advice on their public websites. See, e.g., *Auto Accident: What Should I Do If I Have an Auto Accident?*, http://www.calbar.ca.gov/state/calbar/calbar_extend.jsp?cid=10581&id=2174:

Do not volunteer any information about who was to blame for the accident. You may think you are in the wrong and then learn that the other driver is as much or more to blame than you are. You should first talk to your insurance agent, your lawyer or both. Anything you say to the police or the other driver can be used against you later.

79. See, e.g., Cohen, *supra* note 30, at 1010.

B. Statutory Development of Exclusions

An early advocate for the potential benefits of apology in resolving disputes, Jonathan Cohen, urges lawyers to discuss the possibility of apology with clients. In *Advising Clients to Apologize*, Cohen defines the term “apology” to include three elements: 1) admitting one’s fault; 2) expressing regret for the injurious action; and 3) expressing sympathy for the other’s injury.⁸⁰ He surveys the benefits of apology; benefits that include permitting serious settlement negotiations, but also benefits of repairing relationships, offering psychological growth, and preventing antagonistic behavior (including litigation).⁸¹ Weighed against these benefits are concerns that an apology may be perceived as a sign of weakness and as evidence of liability, concerns that historically led attorneys to advise clients to “defend and deny” rather than accept responsibility and apologize.⁸²

Acknowledging that attorney warnings regarding apologies are not without basis, Cohen then discusses why lawyers do not recommend apologies.⁸³ While some of the purported reasons stem from ignorance (do not think of it/unaware that there are relatively “safe” ways to apologize, such as in mediation), more of the reasons reflect the role lawyers play in society.⁸⁴ Clients expect their lawyers to fight for them. Cohen quotes a client, “if I wanted someone to tell me to apologize, I would have gone to my minister, not my lawyer.”⁸⁵ According to Cohen, these client expectations are driven by many “macho” lawyers who see their role as fighters and, correspondingly, who do not want to appear “disloyal” by raising the subject of apology with clients.⁸⁶ To address these tensions, Cohen advocates the creation of an evidentiary exclusion for apologies and puts forward three possibilities for exclusion: any apology which occurred within a certain, brief period after the injury; any “sincere” apology; or an apology of any sort.⁸⁷

80. *Id.* at 1014–15. The other early advocate for excluding apologies from admissibility was raised by Aviva Orenstein. *See* Orenstein, *supra* note 30, at 223.

81. Cohen, *supra* note 30, at 1019–23.

82. *Id.* at 1023–30.

83. *Id.* at 1030–31.

84. *See generally id.* at 1031.

85. *Id.* at 1043.

86. *Id.* at 1043–44. Cohen also lists “loss aversion” and “divergent interests” stemming from the fact that apologies help bring disputes—from which lawyers derive income—to an end. *Id.* at 1046.

87. *Id.* at 1062–63. Cohen notes that “there is a certain irony under the

As scholars commented and physicians and patient-safety advocates weighed in on the value of apologies, state legislatures joined the debate. Massachusetts was the first state to enact legislation designed to protect wrongdoers who apologize and show remorse for their actions by excluding expressions of sympathy.⁸⁸

The impetus for the bill did not arise in a health-care setting. Rather, it came from a Massachusetts legislator whose daughter was struck by a car while riding her bicycle.⁸⁹ The driver of the car did not apologize, and the state senator was told that the reason for this was because the apology might have constituted an admission in a litigation surrounding the girl's death.⁹⁰ In response, the senator drafted a bill to protect wrongdoers who apologize.⁹¹ The Massachusetts statute provides as follows:

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 should be inadmissible as evidence of an admission of liability in a civil action.⁹²

For many years, Massachusetts stood alone. Particularly after the issuance of *To Err is Human*, however, other states began to follow suit. In 1999, Texas passed a law that protects statements of regret and statements of sympathy, but not statements "concerning negligence or culpable conduct."⁹³ In 2003, Colorado and Oregon enacted statutes that specifically protect expressions of sympathy in health-care settings.⁹⁴ The Colorado law not only creates an evidentiary privilege for health-care provider statements of remorse, but also for certain statements of fault. It applies only to "an unanticipated outcome of medical care" and gives protection

current Federal Rules, which through specific evidentiary exclusions for subsequent remedial measures and payment of medical and similar expenses, encourage offenders to take steps toward physical repair following an injury but discourage the often more fundamental relational and psychological repair potentially afforded, and only afforded, by an apology. *Id.*

88. MASS. GEN. LAWS ANN. ch. 233, § 23 D.

89. Cohen, *supra* note 48, at 827 (quoting Lee Taft, *Apology Subverted: The Commodification of Apology*, 109 YALE L.J. 1135, 1151 (2000)).

90. *Id.*

91. *Id.* at 827.

92. MASS. GEN. LAWS ANN. ch. 233, § 23D (2008).

93. TEX. CIV. PRAC. & REM. CODE ANN. § 18.061(c) (Vernon 2001).

94. COLO. REV. STAT. ANN. § 13-25-135 (2003); Or. Rev. Stat. § 677.082 (2003).

to statements accepting fault and anticipated outcome.⁹⁵

In summary, since the passage of the initial Massachusetts Apology Legislation, more than thirty-five states passed legislation to amend the rules of evidence to make inadmissible some form of apology.⁹⁶ A number of these statutes differ, much as the original Massachusetts, Texas, and Colorado bills protect different types of statements. Indeed, minor variations in the wording of the different state laws make a demonstrable difference in what evidence is admissible and, accordingly, what advice an attorney would provide a physician on how to craft an apology. Consider the examples set out below:

Washington: Admissibility of Sympathetic Gestures

The portion of statements, writings, or benevolent gestures expressing sympathy or a general sense of benevolence relating to the pain, suffering, or death of a person involved in an accident, and made to that person or to the family of that person, shall be inadmissible as evidence in a civil action. A statement of fault, however, which is part of, or in addition to, any of the above shall not be made inadmissible by this section.⁹⁷

Arizona: Evidence of Admissions; Civil Proceedings; Unanticipated Outcomes; Medical Care

In any civil action that is brought against a health care provider . . . any statement, affirmation, gesture or conduct expressing apology, responsibility, liability, sympathy, commiseration, condolence, compassion or a general sense of benevolence that was made by a health care provider or an employee of a health care provider to the patient, a relative of the patient . . . and relates to the discomfort, pain, suffering, injury or death of the patient as the result of an unanticipated outcome of medical care is inadmissible as evidence of an admission of liability or as evidence of an admission against interest.⁹⁸

Vermont: Expression of Regret or Apology by Health Care Provider Inadmissible

95. COLO. REV. STAT. ANN. § 13-25-135 (2)(d).

96. See Robbennolt, *supra* note 58.

97. WASH. REV. CODE § 5.66.010 (2008). The statute defines “accident” as “an occurrence resulting in injury or death to one or more persons that is not the result of willful action by a party.” “Benevolent gestures” means actions “that convey a sense of compassion or commiseration emanating from humane impulses.” *Id.*

98. ARIZ. REV. STAT. ANN. § 12-2605 (2005).

An oral expression of regret or apology, including any oral good faith explanation of how a medical error occurred, made by or on behalf of a health care provider or health care facility, that is provided within 30 days of when the provider or facility knew or should have known of the consequences of the error, does not constitute a legal admission of liability for any purpose⁹⁹

Consider just a few issues raised by these “apology laws.” In Vermont, an oral expression of regret for a medical error documented in the medical record, which calls for documentation of patient communication, raises an admissibility question for the medical record. The issue of how a judge determines whether an explanation is made in “good faith” is not addressed in the statute. In Arizona, a physician may wonder whether he can be deposed about a patient conversation, even if the conversation itself is inadmissible.¹⁰⁰ Consider the Washington physician who tells a patient: “I’m sorry about your reaction to the medication I prescribed. I wish I had prescribed a different one.” Is this a statement “of fault” made here so that the conversation is admissible—or would only part of the conversation that implies fault be admissible? Finally, none of these laws explicitly preclude the use of the apology for impeachment purposes at trial.

All of the ambiguities addressed above have one thing in common: they will drive health-care providers to call their lawyers.

III. MINNESOTA’S EXPERIENCE

As set forth in the preceding section, different states adopted wide varieties of evidentiary exclusions protecting medical apologies. An account of Minnesota’s own experience has two dimensions: one evidentiary and one medical; one quite succinct and one more nuanced.

A. *Minnesota’s Experience: The Evidentiary Dimension*

Minnesota does not have either a rule-based or statutory exclusion for medical apologies. With the exception of apologies made in the context of compromise negotiations, medical

99. VT. STAT. ANN. tit. 12, § 1912 (2005).

100. In Oregon, a licensed physician who makes an expression “of regret or apology” may not be examined by deposition with respect to an expression of regret or apology. OR. REV. STAT. § 677.082 (2003).

apologies are freely admissible at trial in Minnesota. In short, doctors and health-care professionals in Minnesota conduct their medical practice and communication with patients subject to the civil equivalent of a portion of the Miranda warning: anything you say can and will be used against you in a court of law.

B. Minnesota's Experience: The Medical Dimension

The medical dimension of Minnesota's experience with medical apologies is considerably more complex. Central to that experience is Minnesota's adverse reporting requirement. An understanding of Minnesota's experience must begin, however, with an overview of the medical malpractice climate in Minnesota relative to the rest of the country. Medical apologies raise important issues of patient care and communication that, in turn, touch upon concerns having to do with the responsible and ethical practice of medicine. Much of the recent attention to medical apologies, however, springs from the impact apologies have on malpractice claims.

1. Malpractice in Minnesota

The Robert Woods Johnson Foundation defines a medical malpractice crisis as "a period of volatility in the malpractice insurance market characterized by above-average increases in premiums, contractions in the supply of insurance and deterioration in the financial health of insurance carriers."¹⁰¹ Currently, the AMA recognizes twenty-two states as being in a state of medical liability crisis; Minnesota is not among them.¹⁰² The following discussion of medical malpractice insurance premiums, claim rates, and payment rates in Minnesota as compared with the rest of the nation illustrates that the medical malpractice situation in Minnesota is relatively stable.

101. CLAUDIA H. WILLIAMS & MICHELLE M. MELLO, ROBERT WOODS JOHNSON FOUND., *MEDICAL MALPRACTICE: THE IMPACT OF THE CRISIS AND THE EFFECT OF STATE TORT REFORMS 1* (2006), available at <http://www.rwjf.org/pr/product.jsp?id=15168> (follow download hyperlink).

102. AMERICAN MEDICAL ASSOCIATION, *MEDICAL LIABILITY REFORM—NOW! A COMPENDIUM OF FACTS SUPPORTING MEDICAL LIABILITY REFORM AND DEBUNKING ARGUMENTS AGAINST REFORM 8* (2008), available at <http://www.ama-assn.org/ama1/pub/upload/mm/-1/mlrnow.pdf>.

a. *Insurance Premiums*

Minnesota's malpractice premiums are among the lowest in the country.¹⁰³ Data from the most recent Medical Liability Monitor Rate Survey indicates that Minnesota has the lowest rates of insurance premiums in three major areas: internists, general surgeons, and obstetrics and gynecology (OB-GYN).¹⁰⁴ Furthermore, the rates for internists and general surgeons held steady between 2007 and 2008.¹⁰⁵ On the other end of the spectrum, the Miami-Dade region of Florida had the highest rates of insurance premiums in each of the three categories.¹⁰⁶ On a positive note, the Florida rates decreased from 2007 to 2008, indicating a softening of the market and perhaps a foreseeable stabilization of the medical liability climate.¹⁰⁷ Figure 1.1 compares the rates of Minnesota and Florida. Notice that the general surgery rate in Florida in 2008 is nineteen times the rate in Minnesota for the same year.

Figure	Minnesota			Florida		
	2007	2008	Change	2007	2008	Change
1.1						
Internists	\$3,375	\$3,375	0.0%	\$54,751	\$54,710	-0.1%
General Surgeons	\$11,306	\$11,306	0.0%	\$275,478	\$214,893	-22.0%
OB-GYNS	n/a	\$17,166	n/a	\$247,954	\$238,728	-3.7%

103. Medical Malpractice and Health Care Costs, *Background Information Prepared for the Health Care Transformation Task Force* Dec. 3, 2007, <http://www.health.state.mn.us/divs/hpsc/hep/transform/dec03documents/medicalmalpractice.pdf> (last visited Mar. 30, 2009).

104. Amy Lynn Sorrel, *Liability Premium Outlook Improves as Many Physicians See Lower Rates*, Am. Med. News (Jan. 5, 2009), <http://www.ama-assn.org/amednews/2008/images/gpr11229a.pdf> (last visited Mar. 30, 2009).

105. *Id.* The 2007 rate for OB-GYNS was not available.

106. *Id.*

107. *Id.*

b. *Claim and Payment Rates*

In addition to a steady medical liability market, Minnesota is also low on the scale of paid-malpractice claims, with a total of eighty-three claims in 2007.¹⁰⁸ While not the lowest in the nation, Minnesota falls in the bottom 50%.¹⁰⁹ Despite the relatively low number of claims, the average dollar amount for paid claims in Minnesota is higher than the national average: Minnesota's average paid claim in 2007 was \$367,537, compared to a national average of \$323,266.¹¹⁰ Minnesota's average rate is higher than that of thirty-seven other states.¹¹¹ Unlike many states, however, Minnesota does not cap economic or noneconomic damages in medical malpractice claims.¹¹²

2. *Minnesota's Pioneering Work in Disclosure of Adverse Events*

In 1999, before the Adverse Health Care Events Law and even before the seminal report of the Institute of Medicine, *To Err is Human*, Children's Hospitals and Clinics of Minnesota (hereinafter Children's) instituted a patient-safety program nationally recognized for its innovation.¹¹³ Part of its program was the

108. Statehealthfacts.org, <http://www.statehealthfacts.org/profileind.jsp?cmp=1&cat=8&rgn=25&ind=436&sub=102> (last visited Mar. 30, 2009).

109. Statehealthfacts.org, <http://www.statehealthfacts.org/comparemactable.jsp?ind=436&cat=8&sub=102&yr=18&typ=1&o=d&rgn=25&sort=1093> (last visited Mar. 30, 2009). The state with the lowest number, Alaska, had just nine paid medical malpractice claims in 2007. New York, on the other hand, ranked highest with 1,528 paid claims. *Id.*

110. Statehealthfacts.org, <http://www.statehealthfacts.org/comparemactable.jsp?ind=437&cat=8&sub=102&yr=18&typ=4&o=a&sort=698> (last visited Mar. 30, 2009).

111. *Id.* Minnesota has adopted other tort reform measures which attempt to decrease the number and costs of lawsuits. These include a requirement that a plaintiff's attorney file an "affidavit of expert review" within 180 days of filing a lawsuit; a "collateral source rule" that reduces a health care provider's liability by the amount that the injured person receives from other sources such as workers compensation; and proportional liability except in cases where one defendant is found to be more than 50% responsible for the injury. Medical Malpractice and Health Care Costs, *supra* note 103 (citing MINN. STAT. § 604.02).

112. United States General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Contributed to Increased Premium Rates*, GAO-03-702, at 61 (2003), available at <http://www.gao.gov/new.items/d03702.pdf>.

113. Children's Hospitals and Clinics of Minnesota, *What We've Learned: Stories and Milestones from the Patient Safety Journey* 4 (2006), available at

adoption of a disclosure policy, under which Children's disclosed to families whenever something had happened that either caused harm or will potentially cause harm to their child.¹¹⁴ Describing this policy, Don Brunnquell, Ph. D., chair of the Children's Ethics Committee said:

We disclose to families when there is anything significant that affects a child's care, telling them what happened and what we're doing to help their child. We also tell families what we're doing to prevent something similar from happening again. Families appreciate this openness. They recognize that we value the importance of trust in a care giving relationship.

Children's was an early adopter of this disclosure policy among health care organizations. In 1999, Children's board of directors recognized that telling families about a medical accident was the right thing to do. This was controversial at the time, because it countered the traditional reluctance in health care to disclose this information to families, for fear of malpractice lawsuits.¹¹⁵

As a result of the policy, Children's reduced the number of lawsuits by half in what one commentator described as a "high liability exposure setting because of its young patients."¹¹⁶

Shortly after the National Quality forum published its 2002 report titled *Serious Reportable Events in Healthcare*, recommending that the occurrence of twenty-seven serious, largely preventable events be reported by all licensed health care facilities, Minnesota became the first state to pass an Adverse Health Events Reporting Law. This law requires hospitals and ambulatory surgical centers to report to the Minnesota Department of Health whenever one of the twenty-seven, now twenty-eight, serious adverse health events occur.¹¹⁷ The events that must be reported parallel the list of so-called "never events" determined by the National Quality Forum and are grouped into six categories: surgical events, product or device events, patient protection events, care management events,

<http://www.childrensmn.org/web/aboutus/072550.pdf>. Children's Hospital's pioneering work is widely mentioned by practitioners and scholars. See, e.g., Aaron Lazare, *Apology in Medical Practice: An Emerging Clinical Skill*, 296 JAMA 1401 (2006).

114. Children's Hospitals and Clinics of Minnesota, *supra* note 113, at 9.

115. *Id.*

116. Barton and Kadzielski, *supra* note 70, at 57.

117. See Minnesota Hospital Association, *Adverse Health Event Report Indicates Care is More Transparent, Safer* (Jan. 16, 2009), <http://www.health.state.mn.us/patientsafety/ae/09ahereport.pdf> (last visited Mar. 30, 2009).

environmental events, and criminal events.¹¹⁸ While other states subsequently adopted adverse event reporting laws, Minnesota's is broader than most others in that it requires professional boards, such as the Minnesota Medical Practice Board, to report events. It also requires more information (including a root cause analysis and corrective action plan) be reported than most other states.¹¹⁹

Although the law only requires that adverse events be reported to the state health department,¹²⁰ a survey of providers taken five years after the law's passage indicates that almost 90% of hospitals reported adopting a policy of disclosing adverse events to patients and family members.¹²¹ After evaluating the Department of Health's five-year review of the law, the Minnesota Hospital Association reported that "care is more transparent, safer" and that "Minnesota continues to lead [the] nation in openness."¹²² Both the Hospital Association and the Department of Health attribute promoting a safer culture to the law for improving systems and behaviors.¹²³

The transparency affirmed by the Department of Health was demonstrated last year in a well-publicized incident. On January 22, 2008, a newborn infant at Mercy Hospital in Coon Rapids, Minnesota, suffered burn injuries after a fire erupted in his bassinet eleven hours after the infant's birth.¹²⁴ The bassinet included a radiant warmer and supplied pure oxygen to the infant to assist with breathing.¹²⁵ The fire was quickly extinguished, and the infant

118. MINN. STAT. §§ 144.7065(2)–(7) (2008).

119. Barton & Kadzielski, *Tell Me Now and Tell Me Later*, *supra* note 70, at 40–42. The Minnesota law does not, however, require patient notification.

120. MINN. STAT. § 144.7065(1).

121. Minn. Dep't of Health, *Adverse Health Care Events Reporting System: What Have We Learned?*, 5-YEAR REVIEW, 12 (Jan. 2009), available at <http://www.health.state.mn.us/patientsafety/publications/09aheeval.pdf>. Sixty percent of hospitals responding to the survey reported having a policy of disclosing adverse events to patients and family members before enactment of the reporting law; almost 90% reported having such a policy after the law.

122. Minnesota Hospital Association, *Adverse Health Event Report Indicates Care is More Transparent, Safer* (Jan. 16, 2009), <http://www.mnhospitals.org/index/news-mhaindex-action/story.2243?archived=1> (last visited Mar. 25, 2009).

123. *See id.*; *see also* Minn. Dept. of Health, *supra* note 121, at 2.

124. Allina Hospitals and Clinics, *Mercy Hospital Fire Investigation Executive Summary*, [http://www.allina.com/ahs/news.nsf/page/Mercy_Hospital_Executive_Summary_Final.pdf/\\$FILE/Mercy_Hospital_Executive_Summary_Final.pdf](http://www.allina.com/ahs/news.nsf/page/Mercy_Hospital_Executive_Summary_Final.pdf/$FILE/Mercy_Hospital_Executive_Summary_Final.pdf) (last visited Mar. 25, 2009).

125. *Id.*

was transferred to Hennepin County Medical Center for treatment of the burns; the infant was discharged within a few days.¹²⁶ Responding quickly to the event, Allina issued a public statement disclosing limited details of the incident and immediately began an investigation.¹²⁷

IV. DISADVANTAGES AND DANGERS: THE PROBLEMS WITH EXCLUSIONS

Arguments against the adoption of an evidentiary exclusion for medical apologies fall largely into one of two categories. First, some commentators familiar with the medical profession argued that exclusions will not promote disclosure because doctors are educated and acculturated in a way that makes them unlikely to offer an apology following an adverse outcome regardless of whether those apologies are excluded from evidence in later malpractice actions.¹²⁸ Second, some commentators focused on the nature of apologies and contended that evidentiary exclusions rob apologies of their moral content and, in so doing, undermine the sincerity and, ultimately, the healing efficacy of apologies.¹²⁹

A. *It Won't Work: Exclusions and the Nature of the Medical Profession*

Promoting apology is the principal—if not only—reason to consider adopting an exclusionary rule or statute barring evidence of medical apologies at subsequent malpractice trials. It stands to reason that if exclusion of apologies will not actually increase the practice of medical apology, then a statutory exclusion has no utility. There is good reason to be skeptical about the ability of an exclusionary statute, or any evidentiary rule, to influence the behavior of people in the real world who are not lawyers or judges. The evidentiary rules, after all, are written and read by lawyers and

126. *Id.*

127. Allina Hospitals and Clinics, *Statement about Incident Involving Infant at Mercy Hospital* (Jan. 23, 2008), http://www.allina.com/ahs/news.nsf/newspage/01_23_08_Mercy_Hospital_Incident_Statement (last visited Mar. 25, 2009).

128. See Daniel Eisenberg, *When Doctors Say, "We're Sorry,"* TIME, Aug. 8, 2005, at 50.

129. Brent T. White, *Say You're Sorry: Court-Ordered Apologies as a Civil Rights Remedy*, 91 CORNELL L. REV. 1261, 1294 (2006) (discussing generally that apologies lose their moral dimension when they are protected under statutes that exclude apologies from admission as evidence); see Lee Taft, *Apology Subverted: The Commodification of Apology*, 109 YALE L.J. 1135 (2000).

judges and meant, by and large, to guide the behavior of lawyers and judges in the courtroom. There is something presumptuous about believing that a change in evidentiary rules can influence the behavior of anyone acting outside the confines of the justice system. In moments of doubt or crisis, people do not turn to the rules of evidence for wisdom.

That being said, there are at least a few evidentiary rules which are meant to guide, or at least not discourage, the behavior of real-world actors. Chief among these is Rule 407, which excludes evidence of repair made or remedial actions taken following an accident, if offered to prove fault.¹³⁰ As the Advisory Committee notes to Rule 407 explain, the fundamental “ground for exclusion rests on a social policy of encouraging people to take, or at least not discouraging them from taking, steps in furtherance of added safety.”¹³¹ However, this ground for the rule seems shaky, at best. As one treatise provides:

What seems the most important rationale (encouraging subsequent repairs) is open to considerable doubt. Most ordinary citizens are unaware of FRE 407 and do not consult a lawyer in deciding whether to undertake repairs. And it is doubtful that large manufacturers, even if well-advised and familiar with litigation, need the incentive of FRE 407 to make their products safer. They are likely to do so regardless of evidentiary consequences in order to prevent further injuries and lawsuits and avoid the possibility that inaction in the face of repeated accidents or injuries will itself be taken as proof of negligence, or even as the basis of the award of punitive damages.¹³²

Hospitals are invariably well-advised and familiar with litigation, and an adverse medical outcome is, of course, the sort of event that triggers the realization that it may be time to call a

130. FED. R. EVID. 407, identical to its Minnesota counterpart, provides:

When, after an injury or harm allegedly caused by an event, measures are taken which, if taken previously, would have made the event less likely to occur, evidence of the subsequent measures is not admissible to prove negligence, culpable conduct, a defect in a product, a defect in a product's design, or a need for a warning or instruction. This rule does not require the exclusion of evidence of subsequent measures when offered for another purpose, such as proving ownership, control, or feasibility of precautionary measures, if controverted, or impeachment.

131. FED. R. EVID. 702, advisory committee notes (1972).

132. CHRISTOPHER MUELLER & LAIRD KIRKPATRICK, EVIDENCE § 4.23 (2d ed. 1999).

lawyer. Nonetheless, there is good reason to believe that, like ordinary citizens and large manufacturers, doctors and hospitals are unlikely to first look to evidentiary rules as a guide for their behavior in the real world.

Indeed, one recent commentator contends that doctors are particularly unlikely to be influenced by changes in the admissibility of medical apologies. *In Doctors, Apologies, and the Law: An Analysis and Critique of Apology Laws*, Marlynn Wei (now Dr. Marlynn Wei) argues at length that there are deep, systemic reasons that doctors are reluctant to disclose or apologize following an adverse outcome.¹³³ To be sure, some of this reluctance is rooted in a distrust of the legal system:

The AMA Code of Ethics clearly forbids physicians from considering legal liability during disclosure, but fear of malpractice litigation is pervasive and potent. Physicians see the tort system as an irrational “lawsuit lottery” and “revile malpractice claims as random events that visit unwarranted expense and emotional pain on competent, hardworking practitioners.” But physicians overestimate the certainty and severity of legal sanctions, and the actual risk of getting sued by threefold. Studies suggest that physicians believe erroneously that most negligent adverse events lead to lawsuits, estimating that sixty percent of cases involving negligence result in litigation, which is thirty times higher than most estimates.¹³⁴

But a doctor’s reluctance to apologize goes beyond mistrust of the legal system, Wei argues. It is the more fundamental failure to disclose an error.

Wei traces the deeper roots of the reluctance to disclose, citing desire for self-regulation in medicine;¹³⁵ the expectation of physician perfection;¹³⁶ a concern that admission of error will result in a loss of trust;¹³⁷ guilt and shame;¹³⁸ a belief that it is the role of the physician to heal, not deliver bad news;¹³⁹ and an asymmetry in the physician-patient relationship that enables the doctor to keep silent, “particularly when there is no obvious harm done.”¹⁴⁰

133. 40 J. HEALTH L. 107 (2007).

134. *Id.* at 137–38 (citations omitted).

135. *Id.* at 146.

136. *Id.* at 147.

137. *Id.* at 149.

138. *Id.* at 151.

139. *Id.* at 152.

140. *Id.* at 153.

Essentially, Wei addresses the problems discussed in *The Silent World of Doctor and Patient* with which we began this article. From Wei's perspective, little changed—despite the calls for disclosure of medical errors—since 1984. As Wei summarizes the situation:

[These] deeply ingrained traditions in medicine have made the discussion of medical errors uncomfortable or foreign to physicians. Apology laws do nothing to change these norms and habits. As long as they are present, physicians will continue to remain as silent as before.¹⁴¹

As support for her conclusion, Wei points to studies detailing failure of many physicians to disclose.¹⁴² Assuming the continued efficacy of these studies (one may hope that time, education, and ethical guidance post—*To Err is Human* will have an impact not seen in early studies) is not a compelling reason on its own to oppose changing the evidentiary status of medical apologies. Instead, for those who favor increasing the incidence of apology and disclosure following an adverse medical outcome, once the evidentiary exclusion is in place, should turn their attention to reform of medical education and culture. In the end, the argument that other factors also make doctors reluctant to apologize is not an objection to evidentiary exclusion for medical apologies; it is an argument that changing the evidentiary status is just a one step in solving this problem.

B. It's Immoral: Exclusions and the Nature of Apologies

The second objection to excluding medical apologies from evidence is more subtle and more troubling. This objection looks to the nature of apologies and concludes that there is something about evidentiary exclusions that would taint an apology. Lee Taft wrote persuasively—and frequently—about the ethical context of medical apologies.¹⁴³ Taft draws a sharp line between what he terms “authentic apologies” and other statements that express remorse, regret, sympathy, or empathy, but stop short of acknowledging fault. Similarly, writing about medical apologies,

141. *Id.* at 155 (citation omitted).

142. *Id.* at 124–46.

143. See, e.g., Lee Taft, *On Bended Knee (With Fingers Crossed)*, 55 DEPAUL L. REV. 601, 603–04 (2006); Lee Taft, *Apology and Medical Mistake: Opportunity or Foil?*, 14 ANNALS OF HEALTH LAW 55, 59 (Winter 2005) [hereinafter *Apology and Medical Mistake*]; Lee Taft, *Apology Within a Moral Dialectic: A Reply to Professor Robbennolt*, 103 MICH. L. REV. 1010, 1010–11 (2005); Taft, *supra* note 129, at 1138.

Dr. Aaron Lazare stated, “[a]n apology, in its simplest terms, is an acknowledgement of responsibility for an offense coupled with an expression of remorse.”¹⁴⁴ Both components are essential for a statement to qualify as an apology. “The expression ‘I am sorry,’ by itself, is an expression of regret or compassion, not an apology.”¹⁴⁵ Drawing from some of Dr. Lazare’s earlier work, Taft terms an expression of remorse that does not include an acknowledgement of fault a “botched apology.”¹⁴⁶

As seen, the distinction between an expression of remorse and an acknowledgement of fault is critical to the two different general approaches taken in state statutes establishing exclusions for medical apologies. The Texas-California approach creates an exclusion for expressions of remorse, but does not protect statements concerning negligence or culpable conduct. On the other hand, the Colorado statute excludes any statement made by a health care provider (or the employee of a health care provider), including those that express fault. Though this is an important distinction between the two statutory approaches, Taft’s objection extends to both types of statutes.

In situations involving serious injury resulting from unexpected medical outcomes, Taft is critical of the statutory approach adopted in Texas and California:

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.¹⁴⁷

For Taft, protection for these types of “botched apologies” is a

144. Aaron Lazare, *The Healing Forces of Apology in Medical Practice and Beyond*, 57 DEPAUL L. REV. 251, 255 (2008).

145. *Id.* at 256.

146. *Apology and Medical Mistake*, *supra* note 143, at 55, 72, n.119 (citing to Aaron Lazare, *Go Ahead and Say You’re Sorry*, PSYCH. TODAY 40 (Jan.–Feb. 1995)). Robbennolt uses the term “partial apology” for a statement of remorse that does not touch on fault. *See, e.g.*, Jennifer Robbennolt, *Apologies and Legal Settlement: An Empirical Examination*, 102 MICH. L. REV. 460, 498 (2003). Unlike Taft, however, Robbennolt argues that half an apology is better than none.

147. *Apology and Medical Mistake*, *supra* note 143, at 79.

cure worse than the disease.¹⁴⁸ Encouraging this type of statement is also a mistake because, citing Lazare, botched apologies can “fuel bitter vengeance rather than assuage the anger the gesture was strategically designed to alleviate.”¹⁴⁹

If the Texas-California approach to medical apologies is bad, the Colorado approach is, for Taft, even worse. Taft conjures the specter of a doctor offering an apology replete with an explanation of the medical mishap, an admission of fault, and a promise of recompense.¹⁵⁰ When the promise is not kept, the Colorado doctor, cloaked in immunity, can recant the explanation and deny fault. Taft argues that no good can come from this situation.¹⁵¹

To a great extent, Taft's objections are correct. No doubt, exclusionary protections for medical apologies do have an adverse impact on the ethical and moral caliber of apologies. Taft's arguments are flawed in two respects, however. First, barring courtroom use of an apology may reduce the quanta of “moral courage” necessary to make an apology, but that does not mean that the apology is so cheapened it is cost-free. Even if courtroom use is no longer possible, a medical apology still carries legal costs. Returning to Taft's Colorado example, the doctor making the apology alerted the potential plaintiffs to the nature of the medical error and must certainly realize that if the promise to compensate is not kept, the apology not only made a lawsuit more likely, it gave would-be plaintiffs a leg up in finding a lawyer and proving their case. In addition, a host of considerations beyond legal liability may prevent those lacking sufficient “moral courage” from making an apology. After an adverse outcome, a doctor may find making an authentic apology difficult or even impossible because of a range of factors, such as shame, damage to professional reputation or self-esteem, fear of betraying the trust of others involved in the procedure, or simple personal discomfort.¹⁵² As Wei argues, there are strong currents in medical culture that make apology difficult

148. *Id.*

149. *Id.*

150. *Id.* at 81.

151. *Id.*

152. *See, e.g.,* Lazare, *supra* note 144, at 265 (stating that “[m]edical professionals fear that admission of fault and apology will be perceived as signs of weakness and expose them to humiliation and punishment, such as malpractice suits and formal complaints to hospital administration and the Board of Registration”).

for doctors even if concerns of legal liability can be alleviated.¹⁵³ A doctor who swims against those currents will need a measure of moral courage. Yes, for some, evidentiary exclusion may undermine the ethical content of an apology, but it does not vitiate the ethical content altogether.

The second objection to Taft's argument is more significant. It may well be true that we would all be better off if we lived in a world where men and women of moral courage communicated with each other honestly, fearlessly, and compassionately. We do not.¹⁵⁴ In situations of conflict and risk, there is a wide constellation of motivations for any person's statements. The law is not particularly adept at identifying which star in that constellation twinkles most brightly. It may well be true that exclusionary statutes degrade the moral content of apologies. It is also true, however, that refusing to adopt exclusionary statutes cannot insure the moral integrity of apologies.

Here, in a nutshell, is the problem. As set forth above, doctors and hospitals are learning that open communication with patients and patients' families following adverse outcomes is beneficial. One of the reasons apologies may be beneficial is that they seem to reduce the likelihood of later medical malpractice lawsuits. There is nothing wrong with doctors and hospitals taking note of this, but it does mean that from here on in, all medical apologies will be made in a realm of moral ambiguity. We will not know whether an apology is an authentic expression of sorrow meant to facilitate healing or a well-crafted statement meant to minimize the likelihood of future litigation—or both.¹⁵⁵

The point here is not that Taft's objections have no merit. The point, instead, is that those objections do not provide a solid basis for rejecting exclusionary protections for medical apologies. The basis for rejecting statutory protections for medical apologies is best found, not in the nature of the medical profession or the moral nature of apologies, but in the nature of lawyers and legal advice.

153. See Wei, *supra* note 20, at 121–36.

154. See, e.g., this morning's paper or this evening's nightly news.

155. For an example of an amoral, or perhaps immoral, apology see *Apology and Medical Mistake*, *supra* note 143, at 80–81.

C. *Here's My Advice: The Nature of Lawyers*

Statutes and rules are the stuff of law, and the creation of a new statute or a new rule will inevitably mean the creation of new work for lawyers. The creation of an evidentiary exclusion for medical apologies is no exception to this axiom. As illustrated above, the different state statutes governing medical apologies may fall into two general categories, but the variations among the statutes within each of those categories are numerous and subtle. As such, the protections and contours of each of these statutory safe harbors are slightly different, and ought not be navigated without the assistance of a knowledgeable pilot. Were Minnesota to adopt an evidentiary exclusion for medical apologies, the task of interpreting that exclusion would fall to Minnesota lawyers. While thoughtful and experienced health care professionals would no doubt play a role in the implementation of the exclusion, the expertise about the exclusion would be the province of lawyers. It is lawyers who would be called upon to opine which statements qualified for the protections of the exclusion and which did not.

Consider again the text of the Colorado exclusion:

(1) In any civil action brought by an alleged victim of an unanticipated outcome of medical care, or in any arbitration proceeding related to such civil action, any and all statements, affirmations, gestures, or conduct expressing apology, fault, sympathy, commiseration, condolence, compassion, or a general sense of benevolence which are made by a health care provider or an employee of a health care provider to the alleged victim, a relative of the alleged victim, or a representative of the alleged victim and which relate to the discomfort, pain, suffering, injury, or death of the alleged victim as the result of the unanticipated outcome of medical care shall be inadmissible as evidence of an admission of liability or as evidence of an admission against interest.

(2) For purposes of this section, unless the context otherwise requires:

(a) "Health care provider" means any person licensed or certified by the state of Colorado to deliver health care and any clinic, health dispensary, or health facility licensed by the state of Colorado. The term includes any professional corporation or other professional entity comprised of such health

care providers as permitted by the laws of this state.

(b) “Relative” means a victim’s spouse, parent, grandparent, stepfather, stepmother, child, grandchild, brother, sister, half brother, half sister, or spouse’s parents. The term includes said relationships that are created as a result of adoption. In addition, “relative” includes any person who has a family-type relationship with a victim.

(c) “Representative” means a legal guardian, attorney, person designated to make decisions on behalf of a patient under a medical power of attorney, or any person recognized in law or custom as a patient’s agent.

(d) “Unanticipated outcome” means the outcome of a medical treatment or procedure that differs from an expected result.¹⁵⁶

Though the Colorado statute provides broad protection for medical apologies, that protection is not unlimited. The language of the statute raises several questions that call for legal interpretation, such as:

- What constitutes a gesture expressing fault?
- Subpart (1) of the statute indicates that a statement is inadmissible if it expresses, for example, fault *and* also relates to “the discomfort, pain, suffering, injury, or death of the alleged victim.” Is a statement inadmissible if it does not relate to the victim’s discomfort, pain, suffering, injury, or death?
- With respect to subpart (2), when might the “context otherwise require”?
- Are statements made to other health care professionals rendered inadmissible, if it could have been reasonably anticipated that the statements would be overheard by family members?
- Conversely, are statements made to family members rendered admissible by virtue of the fact

156. COLO. REV. STAT. § 13-25-135 (2005).

that others outside the family are present when they are made?

- Is a life partner who is not a spouse a “person who has a family-type relationship” with a victim?
- Is every adverse medical outcome an “unanticipated outcome”?

This is not meant to fault the drafting of the Colorado statute. This is the nature of statutes. This is why we have lawyers.

To be sure, Colorado hospital administrators and health care risk managers and doctors will all acquire some measure of experience with the Colorado law and that experience will no doubt be important in considering the parameters of the statute. Inevitably, however, it will be lawyers who acquire and wield expertise in interpretation of the Colorado law. It will be lawyers who decide how the experience of health care professionals bears on questions of statutory interpretation. It will be lawyers who must render opinions on whether particular statements qualify for the protection of the statute. As it is in Colorado, so must it be in every other state in which legally created safe harbors protect some statements and, perforce, not others. Once a statute or evidentiary rule is in place, communication between doctors and patients will inevitably be triangulated through lawyers.

Defining the boundaries of medical apologies legally creates at least three types of problems for effective communication between doctors and patients or their families. First, lawyers will become involved in the apology process earlier. At present, a medical apology is excluded from evidence at trial, but only when that apology is made in the course of “compromise negotiations” concerning “a claim which was disputed as to either validity or amount.”¹⁵⁷ Apologies made during settlement negotiations, after a lawsuit has begun and lawyers have been hired, will, in most instances, be excluded by Rule 408.¹⁵⁸ As a matter of course,

157. MINN. R. EVID. 408. In addition, Rule 409 excludes offers to pay “medical, hospital, or similar expenses occasioned by an injury,” if that evidence is offered as proof of liability.

158. On the other hand, even offers to settle in exchange for a release of claims may be admissible if the offer was made prior to any dispute. *See, e.g.,* C.J. Duffey Paper Co. v. Reger, 588 N.W.2d 519, 524–25 (Minn. Ct. App. 1999). In *Greenstreet v. Brown*, Greenstreet learned that the judgment in his divorce had been amended. 623 A.2d 1270, 1272 (Me. 1993). When he called Brown, his lawyer, to ask about the amended judgment, Brown told Greenstreet he had made a mistake in not opposing the motion to amend and “that he would pay Greenstreet money to make amends for his conduct.” *Id.* On appeal from the judgment in the

lawyers will be involved in settlement negotiations and might well counsel health care clients about the utility and appropriateness of making an apology. By the time this occurs, however, all the parties are in the middle of a lawsuit. A medical apology exclusion, be it broad or narrow, creates a role for lawyers in the process of apology well before any lawsuit is filed or, perhaps, even contemplated.

This will interfere with doctor-patient communication by causing delay. Effective apologies, experts tell us, are those which are made as quickly as possible after the event or realizing the error—within twenty-four hours according to the Joint Commission's book, *Disclosing Medical Errors: A Guide to An Effective Explanation and Apology*.¹⁵⁹ Yet the rationale espoused for medical apology exclusions is that medical personnel will be more likely to apologize if they are assured that their statements cannot be used in a later malpractice trial. If the logic of that rationale is correct, if it is the assurance of exclusion that promotes apology, then that assurance will have to come from lawyers. Health care professionals will have a strong incentive to communicate with counsel before making any statement they hope will qualify for the protection of the exclusion. And while some lawyers embrace the disclosure and apology movement¹⁶⁰ others are reluctant to advise clients to apologize, concerned that disclosure will provoke litigation and "make a bad situation worse."¹⁶¹ And at a time when

ensuing malpractice action, Brown argued that Rule 408 should have excluded his statements on the telephone. *Id.* The Maine Supreme Court disagreed. Noting that "Brown's statement informed Greenstreet for the first time about facts that might give rise to a claim" the court held there was no evidence that a dispute existed about the validity of a claim or the amount claimed at the time of Brown's admission. *Id.* (emphasis added).

159. Joint Commission, *Disclosing Medical Errors: A Guide to An Effective Explanation and Apology* (Joint Commission Resources 2006). See also Lucian Leape, *Disclose, Apologize, Explain*, NEWSWEEK, Oct. 16, 2006, at 50 (outlining four steps: disclose; take responsibility; apologize at once; explain what will be done differently in the future) (emphasis added).

160. See AHLA'S GUIDE TO HEALTHCARE LEGAL FORMS, AGREEMENTS AND POLICIES (AHLA 2008). For two excellent pieces describing the need for attorneys to encourage full disclosure to patients see, e.g., *Charity Scott, Doctors as Advocates, Lawyers as Healers*, 29 HAMLINE J. PUB. L. & POL'Y 331, 372 (2008); Winslade & McKinney, *The Ethical Health Lawyer: To Tell or Not to Tell. Disclosing Medical Error*, 34 J.L. MED. & ETHICS 478, 482 (2006). We doubt that these scholars saw a need to write these recent articles, however, if there was widespread acceptance of the disclosure/apology movement by lawyers.

161. Lola Butcher, *Lawyers Say 'Sorry' May Sink You in Court*, THE PHYSICIAN EXECUTIVE (Mar/April 2006) at p. 20-23. See, e.g., Kevin Quinley, 'Sorry Works'—or

responsiveness to the patient is at a premium, even the perfectly responsive lawyer remains always at least a phone call away.

A second and more significant problem is that inviting the lawyer to analyze the apology means that the apology itself will be parsed and revised by the lawyer. Consider some of the following advice:

[I]n apologizing, it is essential to shun unnecessarily incriminating expressions such as “I *regret* that we didn’t anticipate . . .” or “I wish that we had done . . .” Also in the category of risky disclosures are “*My weekend coverage didn’t know* that you had been taking blah, blah . . .” or “*My nurse didn’t understand* that you had been told . . .”¹⁶²

This advice is consistent with a “tip sheet” from an insurer of eighteen thousand health care providers which cautions against uttering the words “error,” “mistake,” “fault” or “negligence” while discussing unanticipated outcomes.¹⁶³

This may be sound legal advice. But when proposed statements of apology are ghost written by lawyers some of the attributes of apologies most valued will be lost.¹⁶⁴ The beneficial effects of apologies, whether framed in terms of fostering healing or avoiding litigation, stem from the openness of communication

Does It?, 25 MED. MALPRACTICE L & STRATEGY 3 (Dec. 2007) (warning practitioners of the insurance coverage perils lurking in “so-called apology programs”); Marthadra J. Beckworth, *Admissibility of Statements of Condolence or Apology*, PHYSICIANS LIABILITY INS. COMPANY (Oklahoma State Med. Ass., Oklahoma City, O.K.), Fourth Quarter, 2006 (noting that there “is a fine line between an expression of condolence and an admission” and that this fact should “give one pause before meeting with the patient or the family to offer condolences”), available at <http://www.plico-ok.com/sites/plico/uploads/images/4Q06%20newsletter.pdf>.

162. Alvin L. Block, *Disclosure of Adverse Outcome and Apologizing to the Injured Patient*, in FUNDAMENTALS OF HEALTH LAW 279.

163. Ray Henry, *More States Weigh ‘Apology’ Options for Doctors Leery of Lawsuits*, ASSOCIATED PRESS, Apr. 12, 2007.

164. As Robin Ebert writes, “with the increasing presence of “I’m sorry” laws, some practitioners and activist groups started to develop strategies on how to communicate an effective apology.” Robin E. Ebert, *Attorneys, Tell Your Clients To Say They’re Sorry: Apologies in the Health Care Industry*, 5 IND. HEALTH L. REV. 337, 363 (2008). “The problem with these strategies and guidelines is that they may begin to depreciate the true value of the apology.” *Id.* “A scripted apology may engender more anger on behalf of the injured party than had there been no communication between the two parties at all.” *Id.* For examples of suggested “apology” language written by lawyers, see Marshall H. Tanick and Teresa Ayling, *Alternative Dispute Resolution by Apology: Settlement by Saying “I’m Sorry,”* THE HENNEPIN LAWYER, July–Aug. 1996, at 22–25.

between doctor and patient.¹⁶⁵ Triangulating a doctor's communication with a patient through a lawyer will result in a loss of openness. Rather than a physician focused on the patient, the physician will be trying to remember the words the attorney crafted. Communication will become less direct and more guarded.

There is no better example of the phenomena of legalization of physician-patient communication than medicine's experience with informed consent. As Carol E. Schneider concludes in *After Autonomy*, the evidence that doctors fully inform patients is disheartening and even where serious efforts are made to explain, the level of patient comprehension of that information is dismaying.¹⁶⁶ Yet informed consent written documents drafted by lawyers and signed by patients proliferate. Nurses refer to these documents (not the conversation between physician and patient) as "the permit." Rather than patients knowingly consenting to a procedure, they are "consented." As Ellen Meisel and Mark Kuczewxai write, "[a]s practiced, and certainly as symbolized by consent forms, informed consent is often no more than a medical Miranda warning."¹⁶⁷

Acknowledgement of this, in part, led to increased emphasis on improving physician-patient communication. The Federation of State Medical Boards, for example, put a clinical and communication skills assessment in place as a requirement of physician licensure in 2004.¹⁶⁸ It proposes that physicians seeking re-licensure demonstrate competence in communication skills.¹⁶⁹

165. See *supra* note 113 and accompanying text.

166. Carl E. Schneider, *After Autonomy*, 41 WAKE FOREST L. REV. 411, 417-18 (2006). Schneider relies, in part, on the Herz study of 106 patients facing routine neurosurgical procedures. The authors wrote of their study, "consideration must be given to the concept that fulfillment of the doctrine of informed consent . . . may very well be mythical." David A. Herz et al, *Informed Consent: Is It a Myth?*, 30 NEUROSURGERY 453 (1992) (suggesting that where prudent neurosurgeons making a concerted effort at patient education, one still cannot expect patient understanding or comprehension).

167. Ellen Meisel & Mark Kuczewxai, *Legal and Ethics Myths without Informed Consent*, 156 ARCHIVES INTERNAL MEDICINE 2,521, 2,522 (1996). This is echoed by Jay Katz when he wrote "[i]nformed consent in today's world, is largely a charade which misleads patients into thinking that they are making decisions when indeed they are not." Katz, *supra* note 18, at 84.

168. Joint Commission, *Health Care at the Crossroads*, *supra* note 65, at 18.

169. FED'N OF STATE MED. BOARDS, SPECIAL COMM. ON MAINT. OF LICENSURE, DRAFT REPORT 12 (2007). For a discussion of the recent initiatives that call for communication skills training, see Bobbi McAdoo, *Physicians: Listen Up and Take*

Medical schools now teach communication skills, but the resistance by many physicians¹⁷⁰ to these efforts is a telling sign of the need they address: improved communication between doctor and patient.

Finally, creation of an evidentiary exclusion for medical apologies will result in apologies conforming to the contours of the exclusion. Simply put, once there is a safe harbor, all boats will moor there. Predictably and appropriately, health care professionals will seek advice from their lawyer about whether a particular planned statement will be protected by the exclusion. Predictably and appropriately, the lawyer will proffer advice and amendment so that the planned statement will enjoy that protection. Predictably and appropriately, that advice will err on the side of caution. And at that moment, the health care professionals face a decision: do we use the apology the lawyer approved or do we ignore the legal advice we received and permit the doctor to offer a statement that goes further? Predictably and appropriately, health care professionals will heed their lawyer's advice. Apologies will inevitably and understandably be shaped so that they will be protected by the exclusion.

Once again, something will be lost. Apologies will be tailored and truncated so they fit the exclusion. Immediacy and openness will be sacrificed for the protection of the exclusion. And that loss is significant, because the virtue and efficacy of apologies are largely rooted in those two attributes. In the absence of a medical apology exclusion, some hospitals and doctors may make decisions about patient communication based on professional considerations of candor and the welfare of patients and their families. Other hospitals and doctors may make these decisions based on assessments about risk management and lawsuit-avoidance. Either provides more appropriate and rational guidance for doctor-patient communication than the language of an evidentiary exclusion.

V. CONCLUSION

Minnesota finds itself in the fortunate position of having

Your Communication Skills Training Seriously, 29 HAMLINE J. PUB. L. & POL'Y 287 (2008).

170. See, e.g., Joint Commission, *Health Care at the Crossroads*, *supra* note 65, at 18 (describing a "firestorm of resistance" to the communication skills assessment).

relatively low medical malpractice rates and also being at the forefront of the movement to foster fuller disclosure after an adverse medical event. Minnesota also stands among the fifteen or so states without a statute or evidentiary rule excluding the use of medical apologies at trial. There is, admittedly, no scientific proof that there is a causal relationship among these three phenomena. There is, however, good reason to believe that adopting an exclusion for medical apologies will give lawyers a new and more significant role in crafting the communication between doctors and patients following an adverse medical event. And, as we argued, there is good reason to believe that in the diligent exercise of that role, lawyers may impinge on the openness of that communication and, as a consequence, on its efficacy.

In the end, states that hope to improve the communication between doctors and their patients should turn their attention to changing medical culture rather than evidentiary rules. It is, no doubt, easier to draft evidentiary rules, but Minnesota's experience demonstrates that more profound change will come from focusing on what happens in hospitals rather than what happens in courtrooms.