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Why Mediation & “Sorry” Make Sense: Apology Statutes as a Catalyst for Change in Medical Malpractice

Zaina Afrassiab*

I. INTRODUCTION

Children are taught the most basic common courtesy, apologizing, not long after they learn to speak.¹ While children are *expected* to say, “I’m sorry,” there are different expectations of and consequences for adults, particularly in professional settings.² “As we age, it becomes more difficult to acknowledge harms caused because . . . we are . . . afraid of the consequences that truth-telling sometimes demands.”³ Can physicians tell patients they are sorry? *Should* they? In recent years, amidst an ever-increasing fear of litigation, so-called physician apology laws have gained traction in the United States.⁴ In fact, apology laws—revisions of state evidentiary codes that prohibit the introduction of expressions of sympathy—are in the lead for the nation’s most widespread tort reform.⁵ Consequently, medical professionals and those who represent them in malpractice suits have started to pay more attention to the efficacy of saying “I’m sorry.”⁶

Apologies are not just a way for providers to demonstrate empathy, they are also a tool for reducing medical malpractice claims and promoting alternatives to trial in the healthcare setting.⁷ Due to the widespread enactment of apology statutes, most U.S. physicians do not have to choose between an instinctive, sympathetic reaction and self-preservation following adverse medical outcomes.⁸ Although the language and application of these statutes varies widely across jurisdictions, sympathy is generally no longer synonymous with guilt and cannot be construed as such

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1. Robin E. Ebert, *Attorneys, Tell Your Clients to Say They’re Sorry: Apologies in the Health Care Industry*, 5 IND. HEALTH L. REV. 337, 338 (2008).

2. *Id.* at 338 (stating the intrinsic human behavior of apologizing taught to children does not translate well into adulthood); Lee Taft, *Apology and Medical Mistake: Opportunity or Foil?*, 14 ANNALS HEALTH L. 55, 55 (2005).

3. Taft, *supra* note 2, at 55.

4. Nicole Saitta & Samuel D. Hodge, Jr., *Efficacy of a Physician’s Words of Empathy: An Overview of State Apology Laws*, 112 J. AM. OSTEOPATHIC ASS’N 302, 302 (2012), <http://jaoa.org/article.aspx?articleid=2094499>.

5. Benjamin J. McMichael, R. Lawrence Van Horn & W. Kip Viscusi, *‘Sorry’ Is Never Enough: How State Apology Laws Fail to Reduce Medical Malpractice Liability Risk*, 71 STAN. L. REV. 341, 345 (2019).

6. Saitta & Hodge, *supra* note 4, at 303.

7. *Id.*

8. *Id.* at 302 (referencing physicians’ moral dilemma: “wanting to soothe the feelings of the patient or family while simultaneously wishing to avoid having an apology used against him or her in court”).

in court.⁹ While there are many criticisms of apology statutes and little data to support their effectiveness, they should not be altogether dismissed. There is still a largely untapped opportunity to employ alternative dispute resolution (ADR) in the context of medical malpractice litigation.¹⁰ Apology laws, when used as a means of facilitating mediation, may be just what the doctor ordered to heal the broken malpractice system.¹¹

This article argues apology statutes fit well within existing ADR mechanisms and have the potential to prompt use of ADR—specifically mediation—on a broader scale in the medical field. Just as apologies from provider to patient have cathartic (and potentially financial) value, so does mediation between them, much more so than litigation. “Alternative dispute resolution models mitigate stress on clinicians, de-emphasize tendencies of health systems to try to hide fault, and help avoid dragging clinicians, patients, and others through time-consuming, costly, and reputation-damaging litigation.”¹² Together, then, apology statutes and mediation can begin to address an issue policymakers have struggled to combat for decades: frequent, costly, and relationship-altering litigation of medical malpractice claims.

Section II of this comment analyzes several seminal cases that prompted and shaped apology law. Next, Section III situates apology law within the broader context of medical malpractice litigation. Section IV reviews previous attempts to apply ADR techniques in the healthcare setting. Section V discusses problems within the current tort system and is followed by commentary on the breadth of apology acts and the efficacy of saying “I’m sorry” in the medical context in Sections VI and VII, respectively. Finally, the discussion concludes by reiterating the opportunity an apology-mediation approach presents to promote doctor-patient communication and, consequently, further legislative goals.

II. CONTEXT THROUGH CASES

Patients bring claims of medical negligence by asserting their doctor failed to do what a reasonable provider in the same specialty would have done in a similar situation.¹³ To establish a case of medical malpractice negligence, a plaintiff must plead and prove the following four elements: “(1) the applicable standard of care; (2) a breach of that standard of care; (3) an injury; [and] (4) proximate cause between the breach of duty and injury.”¹⁴ If the patient prevails, he or she can be compensated for medical bills, lost earnings, and/or pain and suffering.¹⁵ Patients seeking relief have a high burden to bear, as they must demonstrate the defendant

9. *Id.*

10. David H. Sohn & B. Sonny Bal, *Medical Malpractice Reform: The Role of Alternative Dispute Resolution*, 470 CLINICAL ORTHOPAEDICS & RELATED RES. 1370, 1371, 1377 (2012) (stating “ADR has the potential to help reform the current tort system, reducing cost and increasing both parties’ satisfaction . . . The current political and legal environment is optimal for embracing ADR.”).

11. *Id.* at 1374.

12. Joseph S. Kass & Rachel V. Rose, *Medical Malpractice Reform: Historical Approaches, Alternative Models, and Communication and Resolution Programs*, 18 AMA J. ETHICS 299 (2016).

13. Lydia Nussbaum, *Trial and Error: Legislating ADR for Medical Malpractice Reform*, 76 MD. L. REV. 247, 255 (2017).

14. Marlynn Wei, *Doctors, Apologies, and the Law: An Analysis and Critique of Apology Laws*, 39 J. HEALTH L. 107, 110 (2006).

15. Nussbaum, *supra* note 13, at 255.

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physician’s sub-standard care by a greater weight of the evidence.¹⁶ Hence, they may attempt to use physicians’ sympathetic statements to indicate culpability, negligence, or failure to meet the standard of care.

The cases summarized below formed the canon of apology jurisprudence. Each case predates enactment of its respective state’s apology statute and serves to illustrate why physicians have historically been reluctant to apologize to patients following adverse outcomes.¹⁷ Regardless of each fact-dependent outcome,¹⁸ these cases all offer examples of courts admitting physician apologies as evidence in civil malpractice suits, thereby demonstrating the need for legislative intervention.¹⁹

In *Cobbs v. Grant*,²⁰ a patient who underwent surgery for an ulcer brought a claim in the Superior Court of Alameda County after experiencing complications.²¹ He was discharged a little over a week later, but returned the next day with severe abdominal pain; emergency surgery revealed internal bleeding, and Dr. Grant made the decision to remove the source of the bleed, the patient’s spleen.²² Two weeks after that, the patient again returned home, only to develop another, more severe ulcer four months later.²³ When a strict diet and medication did not ease the patient’s pain, doctors again performed surgery and removed part of his stomach.²⁴ After recovery and discharge, the patient was readmitted a fourth time for post-surgery complications.²⁵ The patient testified Dr. Grant “blamed himself for me being back in there (the hospital for a second time)” and emphasized Dr. Grant’s testimony that surgery is not always necessary to treat ulcers.²⁶ The jury found for the patient, but Dr. Grant appealed, and the California Supreme Court reversed the decision, holding Dr. Grant’s statements signified “compassion” or “remorse,” as opposed to an admission of negligence.²⁷

In *Senesac v. Associate in Obstetrics and Gynecology*,²⁸ a physician performed an emergency hysterectomy after perforating the patient’s uterus during an abortion.²⁹ The patient sued in the Superior Court of Chittenden County, alleging the doctor negligently performed the abortion.³⁰ In spite of the patient’s claims the doctor “admitted that she had made a mistake,” the doctor won a directed verdict, and the Vermont Supreme Court affirmed, stating the doctor’s expressed failure to

16. Taft, *supra* note 2, at 89.

17. Wei, *supra* note 14, at 110.

18. Ebert, *supra* note 1, at 348.

19. Wei, *supra* note 14, at 110.

20. *Cobbs v. Grant*, 8 Cal.3d 229 (1972).

21. *Id.* at 235.

22. *Id.*

23. *Id.*

24. *Id.*

25. *Id.*

26. *Cobbs*, 8 Cal.3d at 237-38.

27. *Id.* at 238 (“Defendant’s statement that surgery is not usually warranted is not an admission of a negligent decision to operate when all the medical experts testified that in plaintiff’s case surgery was indicated . . . [D]efendant’s statement signifies compassion, or at most, a feeling of remorse, for plaintiff’s ordeal. Since a medical doctor is not an insurer of result, such an equivocal admission does not constitute a concession that he lacked or failed to use the reasonable degree of learning and skill ordinarily possessed by other members of the profession in good standing in the community, or that he failed to exercise due care.”).

28. *Senesac v. Assocs. in Obstetrics & Gynecology*, 141 Vt. 310 (1982).

29. *Id.* at 312.

30. *Id.*

live up to her own personal standards was not equivalent to a departure from the ordinary standard of care.³¹

In *Lashley v. Koerber*,³² a woman visited her doctor with an injured finger.³³ In the Superior Court of Alameda County, she testified that rather than ordering an X-ray, the physician sent her home and requested she come back every two weeks so he could monitor the healing process.³⁴ Approximately two months later, the patient independently obtained an X-ray, which revealed arthritis had prevented the fracture from healing.³⁵ The patient's husband testified that when his wife voiced frustration that her earlier requests for an X-ray were ignored, Dr. Koerber responded, "Yes, I know, it is not your fault, Mrs. Lashley, it is all my own."³⁶ In reversing a nonsuit and finding in favor of the patient, the California Supreme Court noted Dr. Koerber's use of the word "fault" signified his "responsibility for wrongdoing" or "failure" to exercise ordinary care.³⁷

In *Woronka v. Sewall*,³⁸ a woman developed second degree burns from a sterilizing solution applied to her legs and backside during labor.³⁹ In an action brought in the Superior Court of Suffolk County, the woman testified that upon examining the burns, the doctor said, "My God, what a mess; my God, what happened here. It is a darn shame to have this happen. . . . [I]t was because of negligence when they were upstairs."⁴⁰ The judge directed a verdict for the doctor, but the Supreme Judicial Court of Massachusetts sustained the patient's exceptions on appeal. The court held the doctor's references to "negligence" and explicit description of the cause of injury were not merely excusable "statements of regret."⁴¹

In *Greenwood v. Harris*,⁴² a physician advised his patient she had a tumor that needed to be removed right away.⁴³ During surgery, the physician discovered the

31. *Id.* at 314-15 ("[T]he asserted statement of Dr. Gray that she 'made a mistake, that she was sorry, and that it [the perforation of the uterus] had never happened before' does not establish a departure from the standard of care ordinarily exercised by a reasonably skillful gynecologist. The fact the physician may have believed, and, if so, verbalized the belief that her performance was not in accordance with her own personal standards of care and skill, is not sufficient in the absence of expert medical evidence showing a departure from the standards of care and skill *ordinarily* exercised by physicians in similar cases.").

32. *Lashley v. Koerber*, 26 Cal.2d 83 (1945).

33. *Id.* at 84.

34. *Id.* at 85.

35. *Id.*

36. *Id.* at 86.

37. *Id.* at 90 ("The jury would have a right to believe that defendant, as a physician and surgeon, was using the word 'should' to import the duty which he, as a physician and surgeon practicing his profession in that community, owed to his patient in the exercise of ordinary care . . . coupled with defendant's statement as to what he should have done 'in the beginning' is the admission that the failure to have an X-ray taken was all his own 'fault.' The word 'fault' in one of its meanings signifies '[r]esponsibility for wrongdoing or failure; culpable cause.'").

38. *Woronka v. Sewall*, 320 Mass. 362 (1946).

39. *Id.* at 363-64.

40. *Id.* at 364.

41. *Id.* at 366 ("It is no answer to say that the statements that the negligence occurred 'upstairs' did not show that it took place in the delivery room. Some of the admissions were specifically related to the delivery room and to the time of delivery. . . . It is likewise no answer to say that the admissions were merely statements of regret, sympathy, and benevolence evoked by human suffering. This is, of course, true of the statements that it was a 'shame' and 'unfortunate.' But it is in no way true of the references to 'negligence' and to the definite declaration that the burns were attributable to the solution being on the 'mat' and to the plaintiff's skin being exposed to the solution 'for too long a period.'").

42. *Greenwood v. Harris*, 362 P.2d 85 (1961).

43. *Id.* at 86.

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patient did not have a tumor, but she was pregnant.⁴⁴ At trial in the District Court of Oklahoma County, the patient’s husband testified the doctor approached him afterwards and stated, “Your wife is approximately three to three and a half months pregnant, this is a terrible thing I have done, I wasn’t satisfied with the lab report, she did have signs of being pregnant. I should have had tests run again . . . I am sorry.”⁴⁵ After a verdict in favor of the physician, the patient appealed.⁴⁶ The Supreme Court of Oklahoma reversed and remanded, stating as follows: “We can interpret these statements in no other way than as an admission that a faulty diagnosis had been made due to the failure of the defendant to use and apply the customary and usual degree of skill exercised by physicians in the community.”⁴⁷

Given precedent such as this, it is no wonder there are difficulties convincing physicians that apologies and disclosure are not just right, but *effective*. “The legal considerations of a physician’s actions have not always been at the forefront of a physician’s mind while treating a patient, but the litigious nature of today’s society has changed this dynamic.”⁴⁸

III. THE MEDICAL MALPRACTICE MALADY

The abovementioned cases occurred over a period of time when the number of medical malpractice cases in the U.S. was increasing dramatically. The 1960s represented the height of the litigation boom.⁴⁹ Forty years later, the Institute of Medicine’s jarring report on medical errors, *To Err is Human*,⁵⁰ shone new light on the devastating, widespread effects of human fallibility.⁵¹ Thereafter, physicians, understandably fearful of litigation, grew more prone to practicing “defensive medicine.”⁵² Doctors who perceived an increased threat of being sued started practicing differently, ordering duplicative tests or prescribing unnecessary treatments to safeguard themselves against claims they did not meet the applicable standard of care.⁵³ Defensive medicine is problematic, as it “moves the focus of medical care away from the best interests of the patient toward the best interests of the physician,” resulting in unproductive, cost-intensive, and even potentially harmful care.⁵⁴ According to the American Medical Association, “our medical liability system causes health care expenditures to be higher than they otherwise would be” because “the fear of lawsuits affects the way in which physicians practice.”⁵⁵

44. *Id.*

45. *Id.* at 87.

46. *Id.*

47. *Id.* at 88.

48. Saitta & Hodge, *supra* note 4, at 304.

49. Kass & Rose, *supra* note 12.

50. INST. OF MED. ET AL., *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* (2000).

51. Nussbaum, *supra* note 13, at 283.

52. Kass & Rose, *supra* note 12.

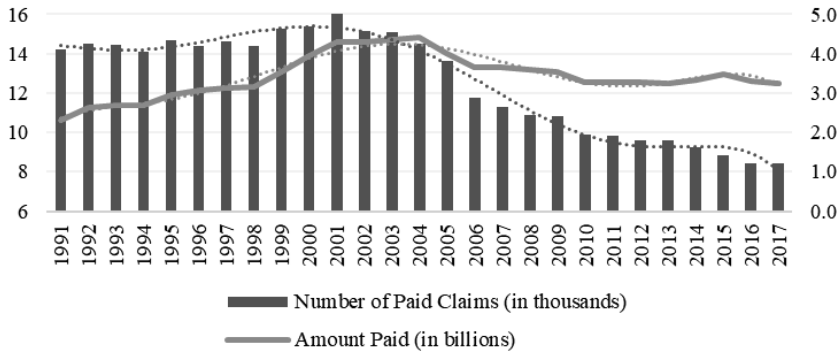
53. Haavi Morreim, *Malpractice, Mediation, and Moral Hazard: The Virtues of Dodging the Data Bank*, 27 OHIO ST. J. ON DISP. RESOL. 109, 115 (2012) (defining defensive medicine as “tests and procedures ordered by physicians principally to reduce perceived threats of medical malpractice liability”).

54. Kass & Rose, *supra* note 12 (“Defensive medicine is medical practice performed primarily to limit future risk of a successful lawsuit against the physician and only secondarily to adhere to the medical standard of care.”).

55. *Medical Liability Reform NOW!: The Facts You Need to Know to Address the Broken Medical Liability System*, AM. MED. ASS’N 5 (2018), <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/premium/arc/mlr-now.pdf>.

Why are doctors so afraid? The chart below summarizes trends in U.S. medical malpractice over the past three decades.⁵⁶ The blue bar graph, which coincides with the left axis, represents the total number of claims (in thousands) filed against physicians—both Medical Doctors and Doctors of Osteopathic Medicine—that resulted in a payout.⁵⁷ The orange line graph, which coincides with the right axis, illustrates the total amount paid (in billions) as a result of those lawsuits.⁵⁸

United States Medical Malpractice Trends



As this chart demonstrates, “deny and defend” is a costly and often ineffective way to respond to malpractice claims.⁵⁹ The number of paid claims was highest in 2001, at just over 16,000.⁶⁰ In 2017, there were a little over half as many claims: 8,400.⁶¹ Total payout was highest in 2004, reaching 4.42 billion dollars, and last year, paid claims totaled 3.23 billion.⁶² The number of paid claims has decreased by approximately 45% since the turn of the century, while the total amount paid has decreased by less than 18%.⁶³ This suggests that over time, patients have won fewer cases, but payouts in those cases have increased dramatically.⁶⁴ Legislators, observing these trends, hypothesized unmeritorious claims and unreasonably inflated jury awards were the cause of the malpractice crisis, and lawmakers reacted accordingly.⁶⁵

56. David Belk, *Malpractice Statistics*, TRUE COST OF HEALTH-CARE, http://truecostof-healthcare.org/malpractice_statistics/ (last visited Mar. 27, 2019) (citing U.S. DEP’T OF HEALTH & HUMAN SERVICES, National Practitioner Data Bank (2017)).

57. *Id.*

58. *Id.*

59. Richard C. Boothman, Amy C. Blackwell, Darrell A. Campbell, Jr., Elaine Commiskey & Susan Anderson, *A Better Approach to Medical Malpractice Claims? The University of Michigan Experience*, 2 J. HEALTH & LIFE SCI. L. 125, 129 (2009).

60. Belk, *supra* note 56.

61. *Id.*

62. *Id.*

63. *Id.*

64. Nussbaum, *supra* note 13, at 256. Note: there are differences between states.

65. *Id.* at 250.

IV. AILING ATTEMPTS AT ADR

Unfortunately, various reforms designed to combat the rise in malpractice litigation have only exacerbated the problem.⁶⁶ Recently, states have tried to limit litigation by implementing interventions, including some ADR techniques like screening panels and pretreatment arbitration agreements, but such interventions have not had the intended result.⁶⁷ In addition, the National Practitioner Data Bank (NPDB), originally created to help health facilities identify poorly performing (negligent-prone) providers, has hindered doctors’ willingness to engage with these interventions.⁶⁸

Screening panels issue non-binding judgments advising patients whether or not to pursue litigation and exist in seventeen jurisdictions.⁶⁹ While lawmakers hoped these neutral evaluations would conserve resources by discouraging non-meritorious claims, empirical studies found them ineffective.⁷⁰ The panels may actually *increase* costs to the parties by evaluating claims that would otherwise have settled and claims that inevitably proceeded to litigation.⁷¹

Arbitration clauses included in hospital intake agreements, admissions materials, or enrollment documents have had a similar effect; rather than reducing medical liability system costs, they spread payouts among a higher percentage of claims.⁷² Moreover, arbitration has many of the same drawbacks as traditional litigation, i.e., it is both adversarial and binding.⁷³ States have reacted differently to pretreatment arbitration agreements, with some courts holding them enforceable and others ruling them invalid.⁷⁴ This uncertainty prompted the continued search for alternatives.⁷⁵

The NPDB, a part of the Health Care Quality Improvement Act of 1986,⁷⁶ mandates reporting malpractice payments and requires institutions to review the data during the physician credentialing process.⁷⁷ Though well-intended, the NPDB’s

66. *Id.* at 264.

67. *Id.* at 266.

68. Morreim, *supra* note 53, at 127-30.

69. Nussbaum, *supra* note 13, at 267-69 (Alaska, Delaware, Hawaii, Idaho, Indiana, Kansas, Louisiana, Maine, Massachusetts, Montana, Nebraska, New Hampshire, New Mexico, Utah, Virginia, Wyoming, and the U.S. Virgin Islands).

70. *Id.* at 270-71 (stating panels might actually increase litigation by giving patients access to less costly expert testimony).

71. *Id.* at 271.

72. *Id.* at 273-76.

73. *Id.* at 277.

74. *Id.* at 274-75.

75. Nussbaum, *supra* note 13, at 277.

76. 42 U.S.C. § 11101(1) (2018) (“The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual State.”).

77. Morreim, *supra* note 53, at 127-129.

reporting standard⁷⁸ and definition of “medical malpractice⁷⁹ action or claim”⁸⁰ have hampered providers’ willingness to participate in ADR.⁸¹ Essentially, *any*⁸² settlement or judgment against a physician—regardless of the facts or dollar amount paid—must be reported if, at any point, the patient submitted a “demand for payment.”⁸³ Thus, many providers would rather go to court where their chances of prevailing are relatively high than settle and accept a permanent mark on their reputation.⁸⁴

Attempts at incorporating various ADR practices into the healthcare field have proven ineffective at decreasing the frequency of medical malpractice claims. Thus, the current system, which remains primarily adversarial and litigation-focused despite reforms, *still* fails to adequately resolve problems left in the wake of adverse medical events.⁸⁵

V. THE STATE OF THE SYSTEM

The conventional system for addressing healthcare disputes falls short for two primary reasons. First, medical care inherently exposes patients to risk.⁸⁶ When risks materialize into errors, punishing individual physicians for often system-wide problems is an ineffective catalyst for change.⁸⁷ Second, the adversarial process inhibits communication precisely when it is most essential for both emotional and financial reasons.⁸⁸ These factors create an unfortunate disconnect between published ethical guidelines and what doctors are told behind closed doors in the aftermath of unintended medical consequences.⁸⁹

78. 42 U.S.C. § 11131(a) (2018) (“Each entity (including an insurance company) which makes payment under a policy of insurance, self-insurance, or otherwise in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical malpractice action or claim shall report . . . information respecting the payment and circumstances thereof.”).

79. 42 U.S.C. § 11137(d) (2018) (interestingly, the statute also states the following: “In interpreting information reported under this subchapter, a payment in settlement of a medical malpractice action or claim shall not be construed as creating a presumption that medical malpractice has occurred.”).

80. 42 U.S.C. § 11151(7) (2018) (“[A] written claim or demand for payment based on a health care provider’s furnishing (or failure to furnish) health care services, and includes the filing of a cause of action, based on the law of tort, brought in court of any State or the United States seeking monetary damages.”).

81. Morreim, *supra* note 53, at 127-29.

82. *Id.* at 132-36 (stating providers can avoid NPDB reporting by paying out of pocket, waiving patient debt or offering refund payment, and initiating communication before the patient puts something in writing); see also Christopher Guadagnino, *Malpractice Mediation Poised to Expand*, PHYSICIANS NEWS DIG., <https://physiciansnews.com/2004/04/23/malpractice-mediation-poised-to-expand/> (last visited Mar. 28, 2019) (“[I]f all parties can be brought to the mediation table soon enough, before a written demand for compensation is presented by the plaintiff’s attorney to the physician defendant, a settlement payment is *not* reportable to the NPDB”).

83. Morreim, *supra* note 53, at 129.

84. *Id.* at 129-30.

85. *Id.* at 111.

86. Sonia Dahan, Dominique Ducard & Laurence Caeymaex, *Apology in Cases of Medical Error Disclosure: Thoughts Based on a Preliminary Study*, PLOS.ORG (July 31, 2017), <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0181854>; see also Stephen E. Raper, *No Role for Apology: Remedial Work and the Problem of Medical Injury*, 11 YALE J. HEALTH POL’Y, L., & ETHICS 267, 272 (2011) (“Each step in the medical process imposes the possibility of error and injury.”).

87. Raper, *supra* note 86, at 272.

88. Morreim, *supra* note 53, at 116.

89. Ebert, *supra* note 1, at 365.

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The ethical codes of both M.D.s and D.O.s suggest physicians should display honesty and empathy following adverse events and errors.⁹⁰ According to the American Medical Association, “a physician should at all times deal honestly and openly with patients. . . . Concern regarding legal liability which might result following truthful disclosure should not affect the physician’s honesty.”⁹¹ Similarly, the American Osteopathic Association states that “physician[s] shall give a candid account of the patient’s condition.”⁹² If these are the codes physicians are expected to adhere to, why do errors often go undisclosed? The Institute of Medicine takes the stance that “[p]atient safety is . . . hindered through the liability system and the threat of malpractice, which discourages the disclosure of errors.”⁹³

Even the most skilled, experienced, and focused physicians will face complications and adverse outcomes while on the job.⁹⁴ “The occurrence of an adverse incident does not necessarily mean that the incident was caused by a breach in the standard of care. Known complications from medical interventions and undesired outcomes can and do occur absent medical negligence.”⁹⁵ Numerous studies have shown there to be little connection between patients who suffer negligent injuries and those who end up bringing a case in court.⁹⁶ A large majority of claims filed involve injuries that are not actually a consequence of individual medical negligence but, rather, an anticipated risk of medical care or a symptom of a flaw within a complex healthcare system.⁹⁷ In fact, payouts to plaintiffs are more strongly correlated with the severity of patients’ resulting disabilities than doctors’ negligent acts.⁹⁸ Furthermore, the existing adversarial system teaches plaintiffs to pinpoint blame on a single provider, a wholly ineffective approach to improving quality and safety in a complicated, multi-player industry.⁹⁹ Punishing individual providers neither deters future negligence nor improves care quality.¹⁰⁰ The routine “name, blame, and shame” game is focused more on assigning fault than facilitating a dialogue to enhance the quality of medical care.¹⁰¹

Even though most physicians recognize apologizing is the compassionate thing to do, they may be reluctant to expose their careers and reputations to the “lawsuit lottery.”¹⁰² When insurers or employers anticipate litigation, they often “hush” providers, advising them not to discuss the circumstances of the adverse event with patients or their families.¹⁰³ “Despite the benefits of apologies, potential defendants have historically been counseled against apologizing because apologies themselves

90. Saitta & Hodge, *supra* note 4, at 302.

91. *Id.*

92. *Id.*

93. INST. OF MED. ET AL., *supra* note 50.

94. Daniel J. D’Alesio Jr., *A Litigation Attorney’s Formula for Changing the Factors That Influence a Patient’s Decision to Sue*, 11 J. HEALTH & LIFE SCI. L. 58, 68 (2017).

95. *Id.* at 73.

96. Nussbaum, *supra* note 13, at 257.

97. Morreim, *supra* note 53, at 111.

98. Wei, *supra* note 14, at 140 (“[R]esearchers found that the severity of the patient’s disability, not the presence of negligence, was more predictive of payment to plaintiff.”).

99. Morreim, *supra* note 53, at 119.

100. *Id.* at 113.

101. *Id.* at 117.

102. Wei, *supra* note 14, at 137.

103. Morreim, *supra* note 53, at 119.

may . . . increase the likelihood that victims seek legal redress.”¹⁰⁴ Ironically, a provider’s decision *not* to apologize or communicate with a patient for fear of litigation could itself be the precipitating cause of litigation.¹⁰⁵ One of the most commonly cited reasons why patients sue is that their questions were left unanswered in the aftermath.¹⁰⁶ Patients may equate their provider’s silence with a lack of sympathy or remorse, then further assume the same harm will come to someone else in the future if they do not act.¹⁰⁷ “A recipient’s interpretation of an apology as an indication that the behavior will not be repeated may predict willingness to settle.”¹⁰⁸ Additionally, a patient who expects an apology but is not offered one might develop feelings of resentment or anger, increasing his or her desire to sue.¹⁰⁹

How are physicians to console their patients without implying, from patients’ perspectives, a level of culpability? Massachusetts was the first state to address this paradox and formally recognize the importance of facilitating consequence-free expressions of sympathy.¹¹⁰

VI. THE ADVENT OF APOLOGY ACTS

In 1986,¹¹¹ Massachusetts enacted America’s pioneer apology law.¹¹² Since then, 37 other states have enacted comparable statutes.¹¹³ Apology laws fall into two general categories: “partial” apology laws and “full” apology laws.¹¹⁴ Five states, denoted in the table below with asterisks, have full apology laws that offer broad protections for statements of sympathy, fault, error, mistake, and even negligence.¹¹⁵ The remaining 33 states have partial apology laws only pertaining to statements of sympathy.¹¹⁶ In other words, partial apology states protect statements of “goodwill, such as regret, sympathy and benevolence,” while full apology states permit admissions and self-critical expressions as well.¹¹⁷ The following table lists all states with apology statutes, the year in which each statute was enacted, and the applicable citation.

Massachusetts	1986	MASS. GEN. LAWS ANN. CH. 233, § 23D
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104. Benjamin J. McMichael, *The Failure of “Sorry”: An Empirical Evaluation of Apology Laws, Health Care, and Medical Malpractice*, LEWIS & CLARK L. REV. 1, 3 (2017).

105. Erika R. Davis, *I’m Sorry I’m Scared of Litigation: Evaluating the Effectiveness of Apology Laws*, 3 FORUM: A TENN. STUDENT LEGAL J. 70, 78 (2016).

106. Morreim, *supra* note 53, at 120; *see also* Nussbaum, *supra* note 13, at 261 (stating “the menace of tort litigation deters constructive, positive behavior such as open communication between patients and providers.”).

107. Ebert, *supra* note 1, at 353.

108. *Id.* (citing Jennifer K. Robbennolt, *Apologies and Legal Settlement: An Empirical Examination*, 102 MICH. L. REV. 460, 479 (2003)).

109. *Id.* at 343.

110. Saitta & Hodge, *supra* note 4, at 304.

111. MASS. GEN. LAWS ANN. ch. 233, § 23D (West 2018) (“Statements, writings, or benevolent gestures expressing sympathy or a general sense of benevolence relating to the pain, suffering or death of a person involved in an accident and made to such person or to the family of such person shall be inadmissible as evidence of an admission of liability in a civil action.”).

112. Saitta & Hodge, *supra* note 4, at 304.

113. McMichael, Van Horn & Viscusi, *supra* note 5, at 4.

114. *Id.* at 12.

115. *Id.* (Arizona, Colorado, Georgia, South Carolina, and Connecticut).

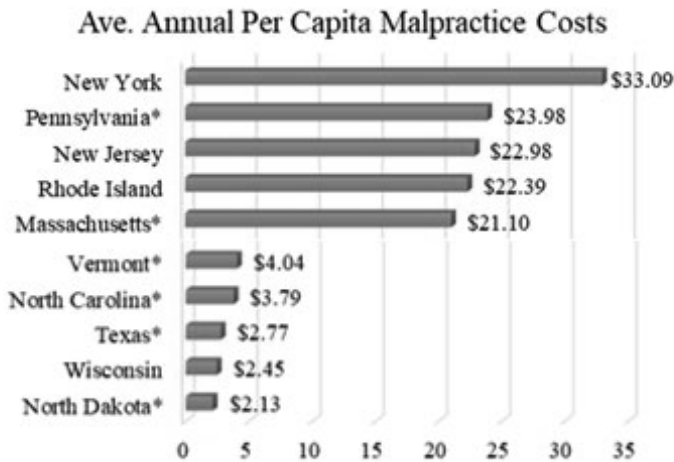
116. *Id.*

117. Dahan, Ducard & Caeymaex, *supra* note 86.

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Texas	1999	TEX. CIV. PRAC. & REM. CODE ANN. § 18.061
California	2000	CAL. EVID. CODE § 1160
Florida	2001	FLA. STAT. ANN. § 90.4026
Washington	2002	WASH. REV. CODE ANN. § 5.66.010
Tennessee	2003	TENN. R. EVID. § 409.1
Colorado*	2003	COLO. REV. STAT. § 13-25-135
Oregon	2003	OR. REV. STAT. ANN. § 677.082
Maryland	2004	MD. CODE ANN., CTS. & JUD. PROC. § 10-920
North Carolina	2004	N.C. GEN. STAT. ANN. § 8C-1, 413
Ohio	2004	OHIO REV. CODE ANN. § 2317.43
Oklahoma	2004	OKLA. STAT. ANN. TIT. 63, § 1-1708.1H
Wyoming	2004	WYO. STAT. ANN. § 1-1-130
Connecticut*	2005	CONN. GEN. STAT. § 52-184d
Louisiana	2005	LA. STAT. ANN. § 13:3715.5
Maine	2005	ME. REV. STAT. TIT. 24, § 2907
Missouri	2005	MO. ANN. STAT. § 538.229
New Hampshire	2005	N.H. REV. STAT. ANN. § 507-E:4
South Dakota	2005	S.D. CODIFIED LAWS § 19-19-411.1
Virginia	2005	VA. CODE ANN. § 8.01-581.20:1
Arizona*	2005	A.R.S. § 12-2605
Georgia*	2005	O.C.G.A. § 24-4-416
Illinois	2005	735 ILL. COMP. STAT. ANN. § 5/8-1901
Montana	2005	MONT. CODE ANN. § 26-1-814
West Virginia	2005	W. VA. CODE ANN. § 55-7-11A
Delaware	2006	DEL. CODE ANN. TIT. 10, § 4318
Idaho	2006	IDAHO CODE ANN. § 9-207
Indiana	2006	IND. CODE ANN. § 34-43.5-1-1 ET SEQ.
Iowa	2006	IOWA CODE ANN. § 622.31
South Carolina*	2006	S.C. CODE ANN. § 19-1-190
Utah	2006	UTAH R. EVID. 409
Vermont	2006	VT. STAT. ANN. TIT. 12, § 1912
Hawaii	2006	HAW. REV. STAT. ANN. § 626-1, RULE 409.5
Nebraska	2007	NEB. REV. STAT. ANN. § 27-1201
North Dakota	2007	N.D. CENT. CODE ANN. § 31-04-12
District of Columbia	2007	D.C. CODE ANN. § 16-2841
Michigan	2011	MICH. COMP. LAWS ANN. § 600.2155
Pennsylvania	2013	35 PA STAT. ANN. § 10228.3

Data from 2012 through 2016 were aggregated to create the follow graph,¹¹⁸ which displays the five highest and five lowest-ranked states based on annual per capita malpractice costs. States with apology statutes are denoted with asterisks, while the remaining states have no apology laws in place (though they may have some other type of statutory reform).¹¹⁹ New York, which does not have an apology law, ranks number one with an average per capita cost of just over \$33.¹²⁰ North Dakota, which implemented an apology law in 2007, has the lowest per capita cost: a mere \$2.13.¹²¹ Though correlation does not equal causation, it bears noting that three of the five highest-cost states have not joined the apology trend, while four of the five lowest-cost states have.



Even though these protections are now prevalent, doctors and their lawyers must exercise caution when interpreting their specific state's apology laws.¹²² "Minor differences in the wording of a statute can have a dramatic effect on what a court deems admissible evidence."¹²³ Legally, there is a difference between acknowledging an adverse outcome—"I'm sorry that you are hurt"—and admitting fault for a mistake that caused the outcome—"I'm sorry that I hurt you."¹²⁴ An expression of sympathy does not have to be a fault-admitting apology.¹²⁵ There are nuances in the types of statements covered: mode of apology (orally versus in writing), to whom the apology may be given, and timeframes of admissibility.¹²⁶ Phy-

118. Belk, *supra* note 56.

119. *Id.*

120. *Id.*

121. *Id.*

122. Ebert, *supra* note 1, at 348.

123. *Id.*

124. *Id.* at 361 (citing Ashley A. Davenport, Note, *Forgive and Forget: Recognition of Error and Use of Apology as Preemptive Steps to ADR or Litigation in Medical Malpractice Cases*, 6 PEPP. DISP. RESOL. L.J. 81, 99 (2006)).

125. Ebert, *supra* note 1, at 352.

126. Saitta & Hodge, *supra* note 4, at 304-05.

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sicians must take care to understand the language of the particular statute that applies to them and be cognizant of its likely interpretation when communicating with patients.¹²⁷

Most current case law suggests apologies are insufficient to show prima facie medical negligence.¹²⁸ “Judges and juries understand that expression of sympathy, regret, remorse and apology are not necessarily admissions of responsibility or liability.”¹²⁹ In fact, most juries view apologies favorably.¹³⁰ Yet, case law on this subject is not, by any means, consistent.¹³¹

“In some cases physician statements have been treated as an extrajudicial admission that establishes both the standard of care and its breach. . . . Equally as many courts have found that apologies are insufficient evidence to establish the standard of care or its breach. . . . Therefore, the case law on the legal liability of apologies is not uniform or clear.”¹³²

The variation in the interpretation of physicians’ extrajudicial statements can be partially attributed to differences in the language of apology statutes between states.¹³³ Regardless of specific statutory language, however, apologies *in general* can be used to encourage and improve mediation of medical negligence claims.

VII. THE EFFICACY OF EMPATHY

The therapeutic value of apologies is well-documented.¹³⁴ By reducing the risks associated with apologizing, apology statutes aim to encourage physicians to express sympathy, thereby lessening some of the anger felt by patients who have experienced adverse events.¹³⁵ Physicians’ ability to offer condolences without repercussions can preserve doctor-patient relationships¹³⁶ and begin to heal patients’ emotional injuries.¹³⁷ “Trust is broken when an adverse medical event is concealed, and trust is rebuilt with disclosure, apology, and responsibility.”¹³⁸ There may also be financial benefits for providers and their institutions in the form of fewer malpractice lawsuits, quicker resolutions, and lower payouts in malpractice settlements.¹³⁹ Communication and compassion are key in minimizing the risk of claims and lawsuits.¹⁴⁰ Honesty and transparency can “go a long way toward defusing a

127. Ebert, *supra* note 1, at 348.

128. *Id.* at 349 (“[T]he use of apologies and other extrajudicial statements made by [a] physician following a medical error are not alone sufficient to prove negligence.”).

129. *Id.* at 351 (citing Jennifer K. Robbenolt, *Apologies and Legal Settlement: An Empirical Examination*, 102 MICH. L. REV. 460, 470 (2003)).

130. *Id.*

131. Wei, *supra* note 14, at 113.

132. *Id.* at 111-13.

133. Ebert, *supra* note 1, at 348.

134. McMichael, Van Horn & Viscusi, *supra* note 5, at 7.

135. *Id.* at 12.

136. Dahan, Ducard & Caeymaex, *supra* note 86.

137. Ebert, *supra* note 1, at 340.

138. Gerald Monk, Stacey Sinclair & Michael Nelson, *Narrative and Conflict: Explorations of Theory and Practice*, 3 DEP’T COUNSELING & SCH. PSYCHOL., SAN DIEGO ST. 25, 32 (2015).

139. D’Alesio, *supra* note 94, at 72 (“A physician’s objective, non-speculative, non-accusatory, and compassionate communication to the patient concerning the outcome may reduce the likelihood of ensuing litigation or reduce the cost of litigation if a claim is made.”).

140. *Id.* at 68.

patient's initial reaction to sue for damages."¹⁴¹ If a patient does bring a claim, an apology can serve to advance settlement talks.¹⁴²

While these benefits make sense in theory, some doubts have been raised as to their legitimacy in practice.¹⁴³ Those skeptical of apology statutes argue plaintiffs' attorneys are unlikely to introduce apologies or sympathetic statements as evidence in malpractice cases, as it would be counterintuitive to their attempts to paint defendant physicians as indifferent or uncaring.¹⁴⁴ Others argue apologies may actually *increase* the number of claims by giving patients the idea to sue in the first place.¹⁴⁵ Still others feel physician non-apology stems from factors beyond mere legal liability, as even jurisdictions with more legal protection for doctors are not more effective at encouraging disclosure and sympathetic expression.¹⁴⁶ Although there have been attempts to quantify the impact of apology laws, tracking settlements and other resolutions outside the courtroom is difficult and often imprecise.¹⁴⁷ The recent consensus is that apology laws do not actually reduce physicians' malpractice risk¹⁴⁸ or make patients safer in the healthcare setting.¹⁴⁹

Rather than denouncing the efficacy of apology statutes altogether, however, states could use ADR—specifically mediation—to help reach the intended legislative goals of such statutes. Apologies, if offered sincerely and under the protection of apology laws, can facilitate mediation by allowing physicians to openly acknowledge when errors have occurred.

A. The Merits of Medical Mediation

While apology statutes exist in some form in thirty-eight states, only a few states currently require parties in a medical malpractice dispute to mediate prior to going to court.¹⁵⁰ In the remaining states, mediation is sorely underutilized.¹⁵¹ Mediation can offer a forum for confidential, meaningful communication, and apology statutes can serve as a catalyst; together, they can move parties smoothly from adverse outcomes to resolution. If properly and timely employed, the apology-mediation combination can bypass many of the downfalls inherent in litigation that apology statutes originally sought to avoid.¹⁵²

Parties bear the cost of the mediator, and mediation requires minimal administrative resources, making it a cheaper alternative to other dispute resolution options.¹⁵³ Mediation also has extremely high satisfaction rates for both parties, cases are typically closed within six months, and attorney fees are markedly decreased as

141. *Id.* at 59.

142. Taft, *supra* note 2, at 77.

143. Ebert, *supra* note 1, at 365.

144. Kass & Rose, *supra* note 12.

145. Wei, *supra* note 14, at 154.

146. *Id.* at 145.

147. Ebert, *supra* note 1, at 364.

148. McMichael, Van Horn & Viscusi, *supra* note 5, at 34.

149. Raper, *supra* note 86, at 316.

150. Michelle Andrews, *Mediation Offers an Alternative to Malpractice Lawsuits*, KAISER HEALTH NEWS (Feb. 1, 2011), <https://khn.org/news/michelle-andrews-on-malpractice-and-mediation/>.

151. *Id.*

152. Morreim, *supra* note 53, at 121.

153. Nussbaum, *supra* note 13, at 279.

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compared to litigation.¹⁵⁴ In addition, private mediation negotiations are not “written claims or demands” under NPDB standards and thus would not unnecessarily stain physician reputations.¹⁵⁵

Unlike litigation, mediation acknowledges the parties have goals beyond financial compensation¹⁵⁶ by allowing them to address their self-interests and emotions in a less formal setting than a courtroom.¹⁵⁷ Perhaps more importantly, mediation gives the parties autonomy to determine the best outcome—a mutually acceptable resolution—based on those interests and emotions.¹⁵⁸ Distinct from the zero-sum game of litigation, mediation offers the opportunity for a win-win through personalized solutions.¹⁵⁹ The confidentiality of mediation ensures parties can engage in candid discussion.¹⁶⁰ In doing so, it balances physicians’ desires to be human and patients’ desires to get answers.¹⁶¹

Mediation, especially when tailored for the healthcare context, can be a starting point for rebuilding trust and facilitating understanding between doctors and patients.¹⁶² Rather than focusing only on past acts with a “battle” mentality, mediation is forward-looking and relationship-focused.¹⁶³ When patients simply want to know what went wrong, apology-mediation can help them “develop a thorough understanding of what happened before misconceptions and bogus information drive them to the courthouse.”¹⁶⁴ Furthermore, even if the parties decide to proceed with litigation, they have not lost anything; instead, they have potentially identified and clarified issues prior to entering the courtroom.¹⁶⁵

B. A Sincere, Successful “I’m Sorry”

Medical school teaches physicians to examine, research, diagnose, and treat, but not how to err and recover.¹⁶⁶ Rather than encouraging physicians to keep quiet, legal counsel for healthcare organizations and independent providers should counsel doctors on the *right* way to say, “I’m sorry.” Health professionals report apologizing more often than patients report receiving apologies, indicating a disconnect between doctor and patient views of what constitutes an apology.¹⁶⁷ In order for the apology-mediation approach to be effective, physicians must understand patient

154. Sohn & Bal, *supra* note 10, at 1373.

155. Morreim, *supra* note 53, at 152; *see also* David T. Caldon, *Medical Malpractice Disputes in the Age of Managed Care*, MEDIATE.COM, <https://www.mediate.com/articles/caldon.cfm> (last visited Mar. 28, 2019) (noting, however, the confidential nature of mediations prevents the development of legal precedent, potentially wasting resources on previously-decided disputes).

156. Morreim, *supra* note 53, at 121.

157. Rita Lowery Gitchell & Andrew Plattner, *Mediation: A Viable Alternative to Litigation for Medical Malpractice Cases*, 2 DEPAUL J. HEALTH CARE L. 421, 422 (1999).

158. *Id.*

159. *Id.* at 423.

160. *Id.* at 444.

161. *Id.*

162. Monk, Sinclair & Nelson, *supra* note 138, at 35.

163. Gitchell & Plattner, *supra* note 157, at 425.

164. Morreim, *supra* note 53, at 123 (citing Boothman et al., *supra* note 59, at 142).

165. Gitchell & Plattner, *supra* note 157, at 423.

166. Sara M. Peskin, *My Human Doctor*, N.Y. TIMES (Oct. 4, 2018), <https://www.nytimes.com/2018/10/04/well/live/doctors-errors-apologies.html>.

167. Nussbaum, *supra* note 13, at 300.

perspectives and consider not just how patients will interpret *what* they say, but also *how* they say it.¹⁶⁸

Typically, patients who have experienced an adverse event want to know three things: why or how the incident happened, what the doctor has done to prevent future incidents, and that the doctor is sorry for the outcome.¹⁶⁹ The doctor should address each of these questions in plain language easily understandable to the patient.¹⁷⁰

Words like mistake, error, accident, mishap, and fault should be avoided because they imply blame.¹⁷¹ Instead, physicians can convey empathy by verbally acknowledging patients' emotions regarding the situation (i.e., pain, anger, loss, grief, confusion, etc.).¹⁷² Unreasonably delayed or obviously scripted apologies are counterproductive.¹⁷³ Providers should carefully consider their words before approaching a patient, but apologies should be offered sooner rather than later (preferably within 72 hours).¹⁷⁴ Apologies should be authentic, not over-rehearsed, as patients will likely assume insincerity or ulterior motives.¹⁷⁵ Though there is a long way to go before the apology-mediation tactic takes hold, educating physicians on the merits of apology and proper ways to apologize is a strong first step in the right direction.

VIII. CONCLUSIONS

This paper examines influential case law, the history of medical malpractice, failed attempts at ADR, the state of the tort system, apology legislation, and the efficacy of apologizing in the medical context. Most importantly, it identifies an untapped opportunity to further implement mediation to minimize costly medical malpractice litigation. Moving forward, if physicians internalize the "right" way to apologize, apology statutes can encourage patients and providers to engage in mediation above litigation. An authentic apology can ameliorate a patient's anger and confusion, which often prompt them to sue in the first place.¹⁷⁶ "It may be the best medicine available to soothe the feelings of a patient or family and to avoid a malpractice lawsuit."¹⁷⁷

All in all, apology statutes have promising potential to expand mediation in healthcare. "Future implementations of ADR should focus on flexibility and early interventions, and both first-generation tort reform and more consistent, comprehensive apology protection laws will almost certainly aid in its successful implementation."¹⁷⁸ Apology statutes and medical mediation can and *should* be used in tandem to overcome the undeniable downfalls of the adversarial system and preserve relationships between providers and patients often shattered following litigation.

168. Ebert, *supra* note 1, at 363.

169. Morreim, *supra* note 53, at 123.

170. Gitchell & Plattner, *supra* note 157, at 446.

171. Ebert, *supra* note 1, at 361.

172. D'Alesio, *supra* note 94, at 78.

173. Ebert, *supra* note 1, at 363.

174. *Id.* at 362.

175. *Id.* at 363.

176. Saitta & Hodge, *supra* note 4, at 306.

177. *Id.*

178. Sohn & Bal, *supra* note 10, at 1374.