The Limits of Apology Laws

by Rebecca Dresser

During the 1990s, apology laws emerged as an initiative that could help reduce the rate of medical error. The laws are designed to reduce the liability risks associated with disclosing mistakes. Many states have laws that prevent a health care worker's expression of sympathy or regret from being used as evidence of negligence in a malpractice action. Some also exclude as evidence statements that acknowledge responsibility or fault related to an adverse patient outcome.

The link between apology laws and reducing medical errors is indirect. In theory, apology laws diminish clinicians' and administrators' reluctance to disclose errors by dispelling their fear that a malpractice suit will follow. In turn, more openness about medical errors will encourage the systemic changes needed to improve patient safety.

Improved patient safety is not the sole justification for apology laws, however. If the laws encourage physicians to disclose medical errors, then they could also advance other ethical objectives. By informing patients and families about deficiencies in patient care, physicians fulfill their fiduciary responsibilities to tell the truth and promote patients' best interests. Disclosure gives patients the information they need to make health care and other important personal decisions. It also prevents unnecessary anxiety about what caused a health problem and allows patients to receive appropriate follow-up care. Finally, disclosure allows patients and families to be fairly compensated for further care, missed wages, and other related losses.[1]

Apology laws are just one component of a broader regulatory and institutional effort to pierce the traditional veil of silence about medical errors. A few states require notification of unexpected events. The Joint Commission on Accreditation of Health Care Organizations includes among its accreditation standards a requirement that hospitals inform patients about unanticipated outcomes. The National Quality Forum, an influential, standard-setting organization, has issued guidelines endorsing disclosure and prescribing implementation measures like clinician training and monitoring outcomes.[2]

Questionable Impact

Although apology laws are popular among state legislatures, their impact on medical practice remains uncertain. Many questions arise concerning the relationship between apology laws and malpractice litigation.

One question is whether apology laws confer sufficient protection. Because the majority of states exclude only expressions of sympathy, not admissions of fault, the malpractice threat could still deter most clinicians and administrators from fully disclosing a harmful error. Moreover, even excluded evidence can be useful to attorneys preparing a case against clinicians and hospitals.[3]

Another set of questions concerns the effect of apologies on patients and families injured by medical mistakes. Apology proponents, such as the Sorry Works! Coalition, contend that when health care workers apologize, patients and families are less likely to sue. By reducing the injured person's anger and promoting trust in physicians and health care institutions, apologies reduce the chance that the person will pursue a legal claim. Supporters cite statistics from the Veteran's Administration, the University of Michigan, and other health systems showing that full disclosure and apology programs have produced savings in litigation costs. They also say that if a malpractice case goes to court, judges and jurors will be more sympathetic to defendants who apologized.[4] (Of course, if the latter claim is accurate, then clinicians and institutions will benefit if apologies are admitted into evidence, rather than excluded by apology laws.)

Although it makes sense to suppose that apologies make error victims less likely to seek legal redress, some observers think that increased communication about medical errors could increase malpractice litigation. This could occur because the vast majority of patients harmed by medical errors never pursue legal claims. In many cases, patients injured due to medical errors do not know what caused their injuries. More openness about medical errors will enlighten this group, and some of them will respond by filing legal claims. Even if apologies make some injured parties less inclined to sue, they could cause a larger group of otherwise ignorant patients to pursue legal remedies. According to this theory, "[l]aws that prohibit admission of disclosures into evidence will do little to alter the outcome; disclosure's primary impact will come from the flagging function it serves for patients and their attorneys."[5]

Toward a Broader Policy Response

The debate over what effect the laws will have on malpractice sidesteps a more fundamental ethical question: what is owed to people harmed by medical errors? Currently, malpractice litigation may provide the only opportunity for injured patients to be compensated

for their losses. If apology laws reduce the risk of malpractice claims, they could unfairly burden patients and families. In an attempt to promote one good objective, apology laws could hinder progress toward another.[6]

Even many proponents of apology laws recognize that disclosure is only one step in developing a better system. For this reason, the Sorry Works! Coalition urges institutions to adopt policies that combine error disclosure and apology with an offer of speedy compensation for injuries resulting from failures to meet the standard of care. And even some who think that more apologies are likely to generate more litigation see this as a positive. "Among its many virtues," write David Studdert and colleagues, "disclosure represents a valuable opportunity to correct a well-documented shortcoming of the medical malpractice system: Most patients who sustain debilitating injury from negligent care obtain no compensation."[7]

When apologies and disclosures are accompanied by reasonable financial settlements, patients, families, and institutions can avoid the high costs of litigation. Institutions that combine disclosure and financial assistance could compensate more people without a concomitant increase in overall costs. A system that channels more resources to injured parties and fewer resources to litigation costs would be superior to the current malpractice system.

Barriers to Transparency

Whether apology laws and mandatory disclosure programs will have a significant impact on medical practice remains to be seen. Most commentators note that the malpractice threat is just one reason physicians are reluctant to admit harmful errors. Physicians may also worry that settlements related to medical errors will be reported to disciplinary boards, such as the National Practitioner Data Bank. (Although compensation may be structured to avoid such reporting, this strategy could detract from the worthwhile goal of identifying bad physicians.[8])

As Doug Wojcieszak notes, the most significant barrier to disclosure and apology may "not be the 'outside world' of patients, lawyers, and courts, but the 'inside culture' of hospitals and the medical community."[9] Marlynn Wei points to several professional norms that conflict with disclosure. One is the ideal of physician infallibility; patients who see physicians as fallible might lack the trust for a strong patient-physician relationship. Other barriers to openness about errors are the overwhelming guilt and shame that physicians experience when acknowledging mistakes to themselves and others. Pressure to conform to the infallibility ideal can heighten the temptation to devise a cover-up whenever possible. And physicians' considerable knowledge and power enables them to achieve success in concealing errors in many instances.[10]

Wei and others contend that without alterations in medical culture, significant movement toward transparency about errors is unlikely. Until professional norms change, apology laws and other policy revisions aimed at encouraging disclosure will be ineffective, they say. Physicians and other staff will subvert disclosure or exacerbate patients' distress by making insincere or disingenuous apologies.

Certainly, changes in medical norms are uncommon. Nonetheless, they are achievable. Physicians once thought that patients should not be informed of a terminal diagnosis, but now disclosure is the usual practice. Physicians convinced of the ethical value of apologies call for medicine to recognize that an "effective apology is one of the most profound healing processes between individuals."[11] Advocates note that apologies are not only in patients' best interests, but in clinicians' best interests, as well.[12] As such, they say, apology should be considered among the activities essential to the practice of medicine, and one included as part of clinical training.

Apology laws will achieve a positive ethical outcome only if they are accompanied by full disclosure and fair compensation programs. And the influence of legal and other external requirements, such as accreditation standards, will depend on how strictly they are enforced. Experts suggest that top-down mandates will be less influential than disclosure programs that "emerge locally, are driven by an institutional leadership and a work force committed to transparency, and focus on providing health care workers with the skills needed to confront these difficult conversations."[13] Without leadership, modeling, and instruction, many clinicians will prefer to avoid the painful task of acknowledging their mistakes. In this respect, apology laws illustrate the limits of the law in changing human behavior.

Acknowledgments

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3. Ibid., 2715-16.

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7. D. Studdert et al., "Disclosure: The Authors Respond," *Health Affairs* 26 (2007): 904-5.

8. Wojcieszak, Banda, and Houk, "The Sorry Works! Coalition," 348.

9. Ibid., 349.

10. M. Wei, "Doctors, Apologies, and the Law: An Analysis and Critique of Apology Laws," *Journal of Health Law* 40 (2007): 107-159.

11. A. Lazare, "Apology in Medical Practice: An Emerging Clinical Skill," *Journal of the American Medical Association* 296 (2006): 1401-4.

12. A. Wu, "Medical Error: The Second Victim," *British Medical Journal* 320 (2000): 726-27.

13. Gallagher, Studdert, and Levinson, 2716.