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Santa Clara Law Review

Volume 48 | Number 2 Article 4

1-1-2008

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FULL DISCLOSURE: AN ALTERNATIVE TO LITIGATION

Rebecca Rubel-Seider*

I. INTRODUCTION

Patients in the United States health care system are dying.[1] They are leaving hospitals with medical problems that will affect them for the rest of their lives, having to remain in the hospital for longer periods of time than necessary, and suffering unnecessary physical and mental pain.[2] Many of these unfortunate outcomes are preventable, but the medical community needs to reform its approach to medical errors.[3]

The safety of patients in hospitals, doctor's offices, and other medical institutions is questionable.[4] A recent study by the Institute of Medicine of the National Academies (IOM)[5] found that, in the United States, there are between 44,000 and 98,000 preventable deaths per year due to medical error.[6] There is debate as to the exact numbers, but the IOM study leaves no doubt that the number of deaths due to medical

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1. *See* INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 1 (1999), *available at* http://www.iom.edu/Object.file/master/4/117/0.pdf.
2. *See id.*
3. *See id.*
4. *See id.*
5. The Institute of Medicine of the National Academies (IOM) is a non-profit organization created to provide science-based advice on matters of biomedical science, medicine, and health. About the Institute of Medicine of the National Academies, http://www.iom.edu/CMS/AboutIOM.aspx (last visited Nov. 11, 2007). The IOM works outside the government to ensure independence. *Id.*
6. INST. OF MED., *supra* note 1, at 1.

malpractice is considerable.[7] While these numbers are daunting, the IOM also found that "more than ninety percent of these deaths are the result of failed systems and procedures, not negligence of physicians."[8]

Besides the immense loss of life, significant economic loss and societal harm are also attributable to preventable medical errors.[9] The economic costs of medical errors are astronomic with the estimates ranging between $17 billion and $29 billion.[10] Other losses exist that are not as easily quantifiable, but are nonetheless important to the health care system and the American public.[11] Medical errors lead to decreased trust in the health care system generally.[12] Patients bear the cost of medical errors with physical and psychological suffering.[13] Preventable medical errors reach outside of the health care setting to harm society as a whole by inhibiting productivity and reducing the population's health status.[14]

Victims of medical errors look to the legal profession and often the courts to provide them with information about how the medical error occurred and to provide compensation.[15] However, the traditional litigation system is no longer effective.[16] Since 1975, medical malpractice costs have increased at a steady rate of almost twelve percent annually.[17] Even though few cases go to trial and fewer cases

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7. Lee Taft, *Apology and Medical Mistakes: Opportunity or Foil?*, 14 ANNALS HEALTH L. 55, 56 (2005). Medical Error is defined as "the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim." INST. OF MED., *supra* note 1, at 1.

8. Hillary Rodham Clinton & Barack Obama, *Making Patient Safety the Centerpiece of Medical Liability Reform*, 354 NEW ENG. J. MED. 2205, 2205 (2006).

9. INST. OF MED., *supra* note 1, at 1.

10. Taft, *supra* note 7, at 56.

11. *See generally* INST. OF MED., *supra* note 1, at 1.

12. *Id.*

13. *Id.* "Patients who experience a long hospital stay or disability as a result of [medical] errors pay with physical and psychological discomfort." *Id.*

14. *Id.*

15. *See generally* COPIC 3Rs PowerPoint Presentation, http://sorryworks.net/files/3rsaosreq.ppt (last visited Nov. 11, 2007).

16. *Id.* The litigation system is often adversarial, drawn out, expensive, provides unfair compensation, and shatters the physician-patient relationship. *Id.*

17. TOWERS PERRIN, TILLINGHAST, U.S. TORT COSTS AND CROSS-BORDER PERSPECTIVES: 2005 UPDATE, (2006), http://www.towersperrin.com/tp/getwebcachedoc?webc=TILL/USA/2006/200603/

win large verdicts, a recent surge in large jury awards is driving medical costs up and encouraging lawyers and plaintiffs to pursue litigation.[18] In 1994, the average medical malpractice award was $1.1 million.[19] By 2002, the average had shot up to $3.5 million.[20] This rise in large verdicts also influences every settlement negotiation.[21]

Unfortunately for many patients, litigation also has limits as a dispute resolution mechanism.[22] Litigation cannot always provide all the relief plaintiffs desire.[23] The litigation system is often adversarial, drawn out, and expensive.[24] If successful, litigation provides the patient and family with monetary compensation for the harm that they have encountered.[25] However, in most cases monetary

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2005_Tort.pdf. Tillinghast-Towers Perrin is an interested party in the politics of tort reform with its operations as a major consultant to the insurance industry. Lawrence Chimerine & Ross Eisenbrey, Econ. Policy Inst., *The Frivilous Case for Tort Law Change* (2005), http://www.epi.org/content.cfm/bp157. The Economic Policy Institute has previously criticized studies by Tillinghast-Towers Perrin as unverifiable. *Id.* The Economic Policy Institute stated, "although [Tillinghast-Towers Perrin]'s estimate is widely cited by journalists, politicians, and business lobbyists, it is impossible to know what the company is actually measuring in its calculation of tort costs, and impossible to verify its figures, because [Tillinghast-Towers Perrin] will not share its data or its methodology, which it claims are 'proprietary.'" *Id.*

18. *See* OFFICE OF DISABILITY, AGING AND LONG-TERM CARE POLICY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, UPDATE ON THE MEDICAL LITIGATION CRISIS: NOT THE RESULT OF THE "INSURANCE CYCLE" (2002), http://aspe.hhs.gov/daltcp/reports/mlupd2.htm. The median jury award has more than doubled from $475,000 in 1996 to $1,000,000 in 2000. *Id.*

19. ROBERT H. LEBOW, M.D., HEALTH CARE MELTDOWN: CONFRONTING THE MYTHS AND FIXING OUR FAILING SYSTEM 80 (2004).

20. *Id.*

21. OFFICE OF DISABILITY, AGING AND LONG-TERM CARE POLICY, *supra* note 18.

22. *See* ROSEMARY GIBSON & JANARDAN PARASAD SINGH, WALL OF SILENCE 212 (2003). Some patients, as a result of disabling and painful injuries, do not have the energy to pursue litigation. *Id.* Others do not wish to go through a long legal battle only to have an uncertain outcome or are fearful of talking publicly about the medical mistake. *Id.*

23. *See infra* notes 26-29 and accompanying text.

24. COPIC 3Rs PowerPoint Presentation, *supra* note 15; *see also* Bryan A. Liang & LiLan Ren, *Medical Liability Insurance and Damage Caps: Getting Beyond Band Aids to Substantive Systems Treatment to Improve Quality and Safety in Healthcare*, 30 AM. J.L. & MED. 501, 503 (2004).

25. *See* STEVEN L. EMANUEL, TORTS 1 (7th ed. 2005) ("The overall purpose of tort law is to compensate plaintiffs for unreasonable harm which they have sustained.").

compensation is not the patient's first desire.[26] Patients who experience medical errors seek litigation as a way to hold the hospital responsible for its mistake or out of a feeling of obligation to prevent future patients from becoming victims of a similar medical error.[27] Furthermore, patients believe it is important for a physician to admit fault.[28] In fact, research suggests that frequently tort plaintiffs bring lawsuits only when the responsible party offers no apology and that when an apology is received it "was the most valuable part of the settlement."[29]

An apology can play an important role in both satisfying the patient's desires and avoiding exorbitant medical and insurance costs.[30] Coupled with other elements of honest disclosure, an apology can work as an alternative to litigation.[31] American culture has accepted and utilized apology.[32] Yet, the American legal culture discourages apology.[33] In some areas of law, apologies are discouraged because of the belief that jurors will interpret an apology admitted into evidence as a statement of responsibility.[34]

Doctors and hospitals currently face increasing malpractice insurance costs, partially because of the increased costs of preventable medical error.[35] For a solution to the increasing malpractice insurance costs, legislatures

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26. *See* GIBSON & SINGH, *supra* note 22, at 184-85.

27. Ashley A. Davenport, Article, *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, 82 (2006).

28. *Id.*

29. Daniel W. Shuman, *The Role of Apology in Tort Law*, 83 JUDICATURE 180, 180 (2000) (quoting Betsy Blaney & Tara Dooley, *Diocese Apologizes in Kos Case, 23.4 Million Deal Reached with Plaintiffs*, FORT WORTH STAR TELEGRAM, July 11, 1998, at 1).

30. *See* discussion *infra* Part II.C.

31. *See* discussion *infra* Part II.B-C.

32. *See generally* Brent T. White, *Say You're Sorry: Court-Ordered Apologies as a Civil Rights Remedy*, 91 CORNELL L. REV. 1261, 1265-71 (2006). To show American culture's acceptance of apology, one can look to a Google search on apology that in June 2005 returned more than 11,200 articles containing the word apology. *Id.* at 1265. Another example is that under the Federal Sentencing Guidelines, defendants who refuse to apologize routinely serve sentences that are up to thirty-five percent longer than those who do apologize. *Id.* at 1269.

33. Jennifer K. Robbennolt, *Apologies and Legal Settlement: An Empirical Examination*, 102 MICH. L. REV. 460, 461 (2003).

34. *Id.*

35. *See* Clinton & Obama, *supra* note 8, at 2205.

across the country have looked to medical malpractice caps on damages awarded to patients.[36] Medical malpractice caps are an area of intense disagreement[37] because they restrict patients' rights and have not clearly proven to be effective.[38]

The role of apologies can help to reduce insurance premiums while improving patient safety and leaving the patients feeling more positive about their hospital experience.[39] An apology offered along with an admission of fault, explanation of what occurred, an assurance that the mistake will not occur again, and up-front compensation is a powerful tool.[40] While full disclosure programs with these five elements are desirable, there are barriers to the widespread adoption of such programs.[41]

This comment discusses how full disclosure programs can benefit the medical community and the patient[42] while exploring the barriers faced by the medical community when implementing full disclosure programs.[43] Part II sets out general background information to provide a base for understanding full disclosure programs.[44] Part III discusses the problem this comment identifies, namely the barriers inhibiting full disclosure programs from broad implementation by medical institutions.[45] Part IV analyzes the barriers to widespread adoption of full disclosure programs.[46] This section identifies the culture of hospitals, physicians' fear of admitting liability, physicians' fear of losing respect and trust by patients and peers, concern that a physician's apology may coerce a patient into settling for an inadequate amount of compensation, and an attorney's self-interest as the barriers to the widespread adoption of full disclosure programs.[47] In Part V, this comment proposes that

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36. *See* Liang & Ren, *supra* note 24, at 505-16.
37. *See* Clinton & Obama, *supra* note 8, at 2205.
38. *See generally* U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES 41-43 (2003).
39. *See* discussion *infra* Part II.C.2-3.
40. *See* discussion *infra* Parts II.B., II.C.2.
41. *See* discussion *infra* Part IV.
42. *See* discussion *infra* Part V.
43. *See* discussion *infra* Part IV.
44. *See* discussion *infra* Part II.
45. *See* discussion *infra* Part III.
46. *See* discussion *infra* Part IV.
47. *See* discussion *infra* Part IV.

both hospitals and patients will experience benefits from implementing full disclosure programs.[48] Furthermore, it proposes medical institutions can overcome the barriers to full disclosure through mandatory disclosure policies, education, and government involvement.[49]

II. THE CASE FOR APOLOGY AND FULL DISCLOSURE

To aid in understanding the importance of full disclosure programs, this comment takes a brief look at the medical malpractice crisis and its causes.[50] Next, the discussion focuses on the role apologies play after the occurrence of a preventable medical error, and studies that develop the background of how apologies work, and elements that make an apology successful.[51] Finally, there is a discussion of full disclosure programs, medical institutions that have successfully implemented them, and recent developments moving the medical community towards full disclosure.[52]

A. *The Medical Malpractice Crisis*[53]

Many people consider the United States to be in a medical malpractice crisis.[54] Two factors contribute to this crisis: 1) rising medical malpractice insurance premiums, and 2) a reduction in the number of firms offering medical malpractice coverage.[55] While the increase in premiums varies by specialty and state, the median increase ranges from fifteen to thirty percent.[56] Further, as much as fourteen percent of the national medical malpractice insurance market has withdrawn from offering medical insurance coverage.[57]

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48. *See* discussion *infra* Part V.
49. *See* discussion *infra* Part V.
50. *See* discussion *infra* Part II.A.
51. *See* discussion *infra* Part II.B.
52. *See* discussion *infra* Part II.C.
53. "By many accounts, the United States is in the midst of its third medical malpractice 'crisis.'" Kenneth E. Thorpe, *The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms*, HEALTH AFFAIRS, Jan. 21, 2004, http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.20v1/DC1. While there are varying ideas on what exactly defines the current medical malpractice crisis, most agree it is characterized by rising insurance premiums and a reduction in the number of firms offering coverage. *Id.*
54. Thorpe, *supra* note 53.
55. *Id.*
56. *Id.*
57. *Id.* This statistic looks only at large regional insurance carriers that

The medical malpractice crisis is large, covering much of the United States and it has varying effects.[58] In 2003, the American Medical Association (AMA)[59] found that forty-four states were either in crisis or showing signs of crisis.[60] Physician strikes, work slow downs, and temporary shut downs of hospitals are just some of the effects felt by the medical community and the public.[61] Some doctors are even reluctant to perform high-risk procedures,[62] leaving patients without a complete set of treatment options. The medical malpractice crisis has also led some physicians to demand "tort reform" from their state legislatures.[63]

Both individual states and medical institutions have moved to address the malpractice crisis by looking to caps on damages, insurance reform, or focusing on stricter discipline of doctors.[64] At the federal level, President George W. Bush supports efforts to limit payments for medical malpractice suits.[65] In 2003, the House of Representatives passed the Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2003.[66] It would provide limits on

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have exited the market. *Id.* In some states, carriers exiting the market account for up to a forty percent share of the premiums written. *Id.*

58. *See id.*

59. The American Medical Association's (AMA) mission is "[t]o promote the art and science of medicine and the betterment of public health." AMA Mission, http://www.ama-assn.org/ama/pub/category/1815.html (last visited Nov. 11, 2007). The AMA "helps doctors help patients by uniting physicians nationwide to work on the most important professional and public health issues." *Id.*

60. Liang & Ren, *supra* note 24, at 504. Similarly, a 2002 analysis showed twelve states with a crisis in their medical liability systems and another thirty states showing signs of heading towards a problem. Thorpe, *supra* note 53. There does not appear to be a crisis in the remaining states. *Id.*

61. Thorpe, *supra* note 53.

62. *Id.*

63. *Id.*

64. Doug Wojcieszak, John Banja, & Carole Houk, *The Sorry Works! Coalition: Making the Case for Full Disclosure*, 32 J. ON QUALITY & PATIENT SAFETY 344, 344 (2006). The Sorry Works! Coalition is "an organization of doctors, lawyers, insurers, and patient advocates that is dedicated to promoting full disclosure and apologies for medical errors as a 'middle-ground solution' to the medical malpractice crisis." *Id.* The goals of the coalition are to "(1) educate all stakeholders in the medical liability debate, (2) serve as an organizing force for the full-disclosure movement, and (3) advocate for legislative incentives, including pilot programs." *Id.*

65. Thorpe, *supra* note 53.

66. *Id.*; *see also* Help Efficient, Accessible, Low-Cost, Timely Healthcare Act, H.R. 5, 108th Cong. (2003).

payments for medical malpractice claims.[67] However, the Senate has yet to pass similar legislation.[68]

In addressing the medical malpractice debate, the focus needs to be on the underlying cause of the recent rise in medical malpractice premiums.[69] While there are numerous reasons for the increase in premiums, the primary one is due to losses incurred by insurance companies in medical malpractice litigation.[70] For example, between 1990 and 2001, median malpractice awards, including both jury awards and settlements, have doubled.[71] Full disclosure programs can aid in reducing the losses incurred in litigation, solving the current medical malpractice crisis, and creating a more effective healthcare system in the United States.[72]

B. *The Role of Apology in Medical Error*

Apologies, when used effectively, can play a role in fixing the medical system by reducing a patient's desire to pursue litigation thereby reducing any costs associated with litigation of a claim.[73] When a physician offers an apology, the physician reduces the anger of patients, as well as their families, leaving them less likely to pursue litigation.[74]

There is no clear definition of what constitutes an authentic apology.[75] One concept of apology is that "[t]o apologize is to declare voluntarily that one has *no* excuse,

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67. Thorpe, *supra* note 53.
68. *Id.*
69. *Id.*
70. U.S. GEN. ACCOUNTING OFFICE, *supra* note 38, at 3-4, 15-16; *see also* Thorpe, *supra* note 53. Other important reasons for increased premiums include an increase in the frequency of claims per physician and lower returns on the investments made by medical malpractice insurance carriers. *Id.*
71. Thorpe, *supra* note 53. The calculation of "doubled" is in real terms. *Id.* The factors that have contributed to the doubling of medical malpractice awards include: (1) future wage loss and future medical expenses rising more quickly than indemnity payments, (2) a rise in the severity of the injury per paid claim, (3) a great increase in payment for grave injury, and (4) a rise in defense and administrative costs per paid claim. *Id.*
72. *See infra* Part II.B-C.
73. *See* Wojcieszak et al., *supra* note 64, at 344; *see* discussion *infra* Part II.B.1.
74. *See* Wojcieszak et al., *supra* note 64, at 344.
75. *Compare* Taft, *supra* note 7, at 63-65 (discussing various elements necessary to an apology), and MARTHA MINOW, BETWEEN VENGEANCE AND FORGIVENESS: FACING HISTORY AFTER GENOCIDE AND MASS VIOLENCE 114 (1998) (quoting NICOLAS TAVUCHIS, MEA CULPA: A SOCIOLOGY OF APOLOGY AND RECONCILIATION (1991)).

defense, justification, or explanation for an action (or inaction)."[76] Due to the nature of the adversarial system, full acceptance of responsibility is something that a trial or monetary compensation simply may not offer.[77]

There are at least three elements to an effective apology.[78] An apology must include "an *expression of sympathy* for the pain or difficulty the patient is experiencing."[79] The two other essential elements are an *admission of fault* and *expression of remorse or regret*.[80] To give the victim power, another element that experts often consider part of an effective apology is the ability of the victim to accept or refuse the apology.[81] Aside from the elements of the actual apology, its effectiveness may also depend on an immediate action accompanying it.[82]

1. Apologies as Effective Dispute Resolution Tools

Why is an apology highly effective in resolving a dispute, especially when it cannot undo what has been done? The simplest answer is that forgiveness often depends on the apology.[83] An apology becomes more than just words because it strengthens a social relationship.[84] Further, an apology reminds the parties of social norms by admitting that a violation of the norms occurred.[85]

There are varied theories as to why apologies are beneficial.[86] One view is that an apology helps a person recover from harm because the apology acts as a vehicle "to adjust an imbalance of power in a relationship that occurs when a wrong is committed by a party to the relationship."[87]

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76. MINOW, *supra* note 75, at 115 (quoting NICOLAS TAVUCHIS, MEA CULPA: A SOCIOLOGY OF APOLOGY AND RECONCILIATION (1991)).

77. *See* Liang & Ren, *supra* note 24, at 503. The adversarial legal system in the United States leads to manipulation of the facts and discourages open and honest communication. *Id.*

78. HEALTH LAW HANDBOOK 727 (Alice G. Gosfield ed., 2004).

79. *Id.*

80. *Id.*

81. MINOW, *supra* note 75, at 115.

82. *Id.* at 116.

83. *See id.*

84. *Id.*

85. *Id.*

86. *See* Shuman, *supra* note 29, at 183.

87. *Id.*

In an apology, there is an exchange of shame and power.[88] The "imbalance of power" is adjusted because the party who committed the wrong seeks to take the shame for the wrong while the wronged person receives the power to accept the apology.[89] Other theories as to why apologies are beneficial include: 1) they attribute responsibility for the harm, and 2) they reduce the victim's anger or desire to see the wrongdoer punished.[90]

2. *Studies: Patients Desire Disclosure and Apology*

Various studies are instructive in the nature of apologies, the role they play in a dispute, when they are successful, and the effects of disclosure on patients and physicians.[91] To begin, a 1992 study looked at interviews with family members who filed claims against medical providers for injuries to fetuses and infants that occurred from five months prior to birth to one month after the birth.[92] The study found that many of the participants filed suit for reasons related to disclosure and apology.[93] For example, twenty-four percent of the family members interviewed said "they chose to file suit 'when they realized that physicians had failed to be completely honest with them about what happened, allowed them to believe things that were not true, or intentionally misled them.'"[94] Twenty percent filed suit "when they decided that the courtroom was the only forum in which they could find out what happened from the physicians who provided care,"[95] and nineteen percent of participants "indicated that a motivation for filing was the need to achieve deterrence or retribution, including not wanting the physician to continue

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88. *Id.*

89. *Id.*

90. *Id.*

91. *See* Shuman, *supra* note 29, at 184-85. The seriousness of the harm is the most important factor in determining whether an apology would dissipate anger. *Id.*; *see also* Jennifer K. Robbennolt, *What We Know and Don't Know About the Role of Apologies in Resolving Health Care Disputes,* 21 GA. ST. U.L. REV. 1009, 1016-25 (2005)(citing various studies on the role of apology).

92. Robbennolt, *supra* note 91, at 1016. For the study, Gerald Hickson and his colleagues interviewed 127 family members. *Id.*

93. *Id.*

94. *Id.* (quoting Hickson et al., *Factors That Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries*, 267 JAMA 1359, 1361 (1992)).

95. *Id.* (quoting Hickson et al., *supra* note 94).

to provide substandard care."[96]

Research also shows a divergence in views between patients and physicians.[97] Patients desire full disclosure including an explanation of what occurred and what effect the medical error will have on their health.[98] Patients also express a desire to know that the physician felt regret and that the medical institution will implement appropriate changes to ensure the same medical error is not repeated.[99]

Physicians report a desire to apologize, but express concern over whether disclosure will increase the possibility of legal liability.[100] Physicians also express a belief that patients desiring more information will ask follow-up questions.[101] Interestingly, patients in the study also stated, "they would be less upset if the physician disclosed the error honestly and compassionately and apologized . . . [and] . . . that [if the] explanation of the error . . . were incomplete or evasive [it] would increase their distress."[102]

It is evident that consideration of the patient's desire for an apology and disclosure are not always a primary factor in attempting to avoid medical malpractice litigation.[103] While hospital disclosure programs vary, a 2003 national survey on hospital disclosure found that only thirty-three percent of risk managers actually accepted responsibility for harm to the patient and thirty-six percent of risk managers stated that they pay compensation.[104] Further, only sixty-eight percent of risk managers included an apology when making a disclosure.[105]

C. *Full Disclosure Programs*

While a culture of cover-up exists in the medical profession, the profession will benefit if it can reach past this

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96. *Id.*

97. *Id.* at 1018; *see also* Thomas H. Gallagher, et al., *Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors*, 289 JAMA 1001, 1003 (2003).

98. Robbennolt, *supra* note 91, at 1018.

99. *Id.*

100. *Id.*

101. *Id.*

102. *Id.* (quoting Gallagher et al., *supra* note 97, at 1005).

103. *See* discussion *infra* Part IV.

104. Robbennolt, *supra* note 91, at 1013.

105. *Id.*

culture to apply effective disclosure programs.[106] Medical institutions that have successful disclosure programs have seen major benefits.[107] Those medical institutions wishing to reduce medical errors can look to other institutions that have successful disclosure programs, using them as an illustrative example.[108] Local governments, the federal government, and national organizations have seen the successes of such programs and have made recommendations to move towards full disclosure in medical institutions.[109]

1. *The Culture of Cover-up in the Medical Profession*

Since ancient times, an aspect of the medical profession has been to avoid disclosure of medical errors to patients.[111] Today, this tradition of nondisclosure and cover-up remains an aspect of the medical profession's culture.[112] Many doctors, either willingly or passively, participate in this cover-up by not reporting doctors who practice medicine below the accepted standard of care.[113] When a physician tries to bring concerns about medical errors to the attention of peers or superiors, others in the medical profession may accuse the physician of not being a "team player."[114] From the hospital's point of view, that physician becomes a liability to them as he or she is willing to report at least some medical errors.[115]

The medical profession's reliance on peer review to ensure that its members meet the standard of care is one aspect of the continuing culture of cover-up.[116] The system of peer review is a distinguishing feature of the medical profession and "is a self-regulating function in which physicians evaluate their colleagues and hold them accountable."[117] Peer review is a problem because the accepted culture of cover-up silences many conscientious

106. *See* discussion *infra* Parts II.C.2 and II.C.3.
107. *See* discussion *infra* Part II.C.3.
108. *See* discussion *infra* Part II.C.3.
109. *See* discussion *infra* Part II.C.4.
111. *See* GIBSON & SINGH, *supra* note 22, at 135.
112. *See id.* at 136.
113. *See id.*
114. *See id.* at 137.
115. *Id.*
116. *Id.* at 137-38.
117. *See* GIBSON & SINGH, *supra* note 22, at 137.

physicians and leaves the patients living with the results of substandard medical services.[118]

2. *Effective Full Disclosure Leads to Benefits for the Medical Institution and the Patient*

Medical institutions base full disclosure programs on the idea that an apology for medical errors, along with up-front compensation, will reduce the anger felt by patients and families.[119] A patient is less likely to file a medical malpractice lawsuit when the patient feels less anger towards the physician.[120] As a result, both sides receive a substantial benefit.[121] The hospital benefits by seeing a decrease in legal expenses,[122] and the patient receives honest explanations and fair compensation in an expedient manner.[123]

While there are many different ways to disclose a medical error, to effectively reduce the chance of litigation and leave the patient with less anger toward the medical provider, the medical institution must take a multi-step approach.[124] For a full disclosure program to be effective,[125] at least four elements must be present in every disclosure.[126] First, the

118. *Id.* at 138. One example of physicians remaining silent is a physician in New York who, after several charges of gross negligence, had his license revoked. *Id.* Prior to the revocation, the physician's problems were well known by other physicians at the hospital where they practiced. *Id.* The other physicians even discouraged training doctors from practicing with him. *Id.*

119. *See* Wojcieszak et al., *supra* note 64, at 344.

120. *Id.*

121. *Id.*

122. *Id.*

123. *Id.* at 344-45.

124. *See generally* MINOW, *supra* note 75, at 114-15. The hospital must take a specific approach because a simple apology, without more, will not reach the result of reducing litigation. *See generally id.* The apology must be accompanied by an expression of remorse and acceptance of responsibility. *See generally id.*

125. Discussed in this section are the elements that will create the most effective disclosure program. This is referred to as "full disclosure."

126. *Compare* Albert W. Wu, *Removing Insult from Injury – Disclosing Adverse Events*, AHRQ WEB M&M, Feb. 2006, http://sorryworks.net/article28.phtml (suggesting a four-step approach to full disclosure that includes "(i) tell the patient what happened, using plain language; (ii) accept responsibility on behalf of the institution or yourself, as appropriate; (iii) apologize; and (iv) describe the next steps, including what will be done for the patient, and what will be done to prevent similar events in the future"), *and* Doug Wojcieszak, John Banja, & Carole Houk, *The Sorry Works! Coalition: Making the Case for Full Disclosure*, 32 J. ON QUALITY AND PATIENT SAFETY 345 (2006) (suggesting that the elements of full disclosure are

patient and family must receive an explanation of what occurred and an assurance that the hospital will make efforts to prevent reoccurrence of the error.[127] Second, full disclosure requires the appropriate party to accept responsibility for the adverse outcome.[128] The acceptance of responsibility may come from either the doctor or the institution.[129] Third, if an investigation shows the physician did not meet the standard of care, the medical professionals involved should apologize to the patient and family.[130] Fourth, the hospital offers fair compensation to the appropriate party, generally the patient and the patient's family.[131] The amount considered to be fair is offered up-front, and while the dollar amount is negotiable, an actuary or other qualified party should aid in establishing the amount.[132]

The benefits of full disclosure programs are numerous.[133] The medical community receives improved communication between the physician and the patient.[134] Additionally, full disclosure helps to restore the physician-patient relationship after a medical error has occurred because it improves communication and trust between the parties.[135] Full disclosure can also work to restore a physician's reputation "by turning them into 'straight shooters' who can be believed when they say a death or injury [was not] their fault."[136]

The patient and family also stand to gain from the use of full disclosure programs.[137] The patients can receive justice more swiftly than pursuing litigation, while simultaneously maintaining their right to sue should negotiations not produce the desired results.[138] Further, addressing the

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apologizing to the patient, admitting fault, providing an explanation of what happened, providing an explanation of how the hospital will prevent reoccurrence, and offering up-front compensation).

127. *See* Wojcieszak et al., *supra* note 64, at 345; Wu, *supra* note 125.

128. *See* Wu, *supra* note 125.

129. *Id.* Whether the doctor or the institution accepts responsibility depends on who is the appropriate agent to do so. *Id.*

130. *Id.*

131. *See* Wojcieszak et al., *supra* note 64, at 345.

132. *Id.*

133. *See generally id.* at 345.

134. *See id.*

135. *Id.*

136. Wojcieszak et al., *supra* note 64, at 345.

137. *See id.* at 344-45.

138. *Id.*

medical mistake honestly creates a dialog regarding the prevention of future mistakes, which results in increased patient safety.[139]

If an investigation proves the physician met the standard of care and there is no medical error, the approach to full disclosure differs.[140] In the situation where an unwanted outcome occurred without medical error, communication remains open, as in all full disclosure situations.[141] The doctors meet with the patient and family to discuss the outcome, explain what occurred, and offer empathy; however they offer no compensation.[142] If the patient and family are not satisfied with any part of the physician's disclosure, whether there was an admitted error or not, they have the option of looking to the judiciary and pursuing litigation.[143]

3. *Examples of Successful Disclosure Programs*

The Veteran's Affairs Medical Center in Lexington, Kentucky ("Lexington VA") takes a different approach to medical errors than most hospitals.[144] The notion that it is prudent for them to accept responsibility when they are at fault guides the hospital.[145] It has adopted a policy that requires the disclosure of all medical errors to patients and families, even in cases where it is unlikely that the patient was aware of the error.[146] They take a proactive approach to medical error, even going so far as to call families after discharge to explain that an error occurred.[147]

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139. *See* Jonathan R. Cohen, *Apology and Organizations: Exploring an Example from Medical Practice*, 27 FORDHAM URB. L.J. 1447, 1464-68 (2000).

140. *See* Wojcieszak et al., *supra* note 64, at 345.

141. *Id.*

142. *Id.*

143. Doug Wojcieszak et al., *Finally, Patient Safety Advocates Can Feel Good About Tort Reform*, PATIENT SAFETY AND QUALITY HEALTHCARE, Jan./Feb. 2006, http://sorryworks.net/media45.phtml.

144. Andrea Gerlin, *Accepting Responsibility, by Policy*, PHILA. INQUIRER, Sept. 14, 1999, at A18, *reprinted in* Jonathan R. Cohen, *Apology and Organizations: Exploring an Example from Medical Practice*, 27 FORDHAM URB. L.J. 1447, 1448-51 (2000). Other health care providers have implemented similar full disclosure programs. *See* Wojcieszak et al., *supra* note 64, at 346. They include the University of Michigan, Stanford University Medical Center, Children's Hospitals and Clinics of Minnesota, and dozens of Kaiser Permanente hospitals. *Id.*

145. Gerlin, *supra* note 144, at 1449.

146. Cohen, *supra* note 139, at 1452.

147. Gerlin, *supra* note 144, at 1448.

The policy has been implemented through a multiple step process. First:

> [T]he hospital encouraged workers to report mistakes to its risk management committee . . . . Once a mistake was reported, [the] typical case proceeded as follows. The committee rapidly investigated the mistake and attempted to determine its root cause. If the root cause was deemed "systemic," efforts at systemic reform were undertaken. If the mistake resulted in harm to the patient, irrespective of whether the patient was aware of it, the patient was informed of the error . . . . The risk management committee then brainstormed [sic] about ways to aid the patient through further medical treatment, disability benefits and compensation. The committee arranged a meeting between itself, the patient and anyone the patient wished to bring, usually family members and an attorney. If the risk management committee believed that the hospital or its employees had been at fault, [the doctor] apologized to the patient at that meeting, including admitting fault verbally . . . . In cases where the risk management committee believed the hospital or its employees had been at fault, the committee made what it believed to be a fair settlement offer.[148]

The approach taken by the Lexington VA uses all of the elements of an effective disclosure.[149]

The hospital's effort to "create a culture in which

148. Cohen, *supra* note 139, at 1452-53 (footnotes omitted). Other organizations such as the Sorry Works! Coalition and the University of Michigan Health System have based their full disclosure protocol off the procedures established by the Lexington VA's full disclosure program. *See* Wojcieszak et al., *supra* note 64, at 345.

149. *See supra* notes 123-32 and accompanying text. For a full disclosure program to be effective at least four elements must be present. Doug Wojcieszak, John Banja, & Carole Houk, *The Sorry Works! Coalition: Making the Case for Full Disclosure*, 32 J. ON QUALITY AND PATIENT SAFETY 344, 345 (2006). First, the patient and family must receive an explanation of what occurred and an assurance that the hospital will make efforts to prevent reoccurrence of the error. *Id.* Second, full disclosure requires the appropriate party to accept responsibility for the adverse outcome. *Id.* Third, if an investigation shows the physician did not met the standard of care, the medical professionals involved should apologize to the patient and family. *Id.* Fourth, the hospital offers fair compensation to the appropriate party who is generally the patient and family. *Id.*

mistakes are acknowledged and [reoccurrences prevented]"[150] has produced beneficial results.[151] The hospital has minimized its legal exposure because families are not as angry when they learn of a medical error.[152] In 1987, shortly after the Lexington VA paid two malpractice verdicts that together totaled $1.5 million, the hospital implemented its full disclosure policy.[153] The hospital saw results quickly and it reached the lowest quartile of medical malpractice payments when compared with other similar VA hospitals.[154] It also reached the bottom sixth in terms of liability payment per claim in the years 1990 through 1996.[155]

The overall financial gain from the full disclosure policy may be even greater than merely the savings in malpractice payments.[156] The Lexington VA has also saved immensely in litigation costs.[157] With the new policy in place, most cases settle quickly, which undoubtedly reduces expenses related to litigation.[158] The chief-of-staff and a hospital attorney estimate that taking a case to the appellate level, costs the hospital approximately $250,000 in expenses excluding the ultimate settlement or verdict.[159] By leading to rapid settlement, the full disclosure policy helps avoid these costs as well.[160]

Furthermore, insurance companies benefit from the implementation of full disclosure programs.[161] In 2000, COPIC Insurance of Colorado implemented what it calls the "Three Rs" Program.[162] While the program does not have all of the elements of a full disclosure program, it does utilize

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150. Gerlin, *supra* note 144, at 1450.

151. *See* Cohen, *supra* note 139, at 1450-52.

152. *Id.* at 1449.

153. *Id.* at 1451.

154. *Id.* at 1453.

155. *Id.* From 1990 though 1996, $190,113 was the average payment per year in malpractice claims. *Id.* The average (mean) payment was $15,622 per claim. *Id.*

156. *See id.* at 1454.

157. *See* Jonathan R. Cohen, *Apology and Organizations: Explore an Example from Medical Practice*, 27 FORDHAM URB. L.J. 1447, 1454 (2000).

158. *Id.*

159. *Id.*

160. *Id.*

161. COPIC's 3Rs Program: Recognize, Respond, Resolve, http://www.callcopic.com/resources/custom/PDF/3rs-newsletter/vol-3-issue-1-jun-2006.pdf (last visited Nov. 10, 2007).

162. *Id.*

apology and up-front compensation to solve a medical error situation.[163] The Three Rs include: 1) *recognizing* unanticipated events, 2) *responding* soon after the event, and 3) *resolving* related issues.[164] Physicians must enroll to become participants in the program.[165] Once the physician has enrolled, he or she is responsible for reporting incidents to COPIC.[166] After reporting the incident, the physician must explain to the patient and family what occurred, express concern, offer empathy, and apologize.[167] The physician must offer further assistance to the patient and investigate and implement any changes necessary to prevent future error.[168] The patient receives reimbursement of up to $25,000 in medical expenses and $100 per day for up to fifty days for loss of time from normal activities.[169] The patient receives this compensation in a timely fashion.[170]

COPIC insurance has greatly reduced its costs associated with litigation since the implementation of the Three Rs program in 2000.[171] From October 2000 through December 2005, only fifty-two of the 2,174 cases that met the Three Rs criteria have gone on to become traditional, formal claims and no Three Rs case has gone to trial.[172] The insurance company estimates that it has saved $889,642 in indemnity costs

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163. COPIC's 3Rs Program, http://sorryworks.net/article33.phtml (last visited Nov. 10, 2007). COPIC's Three Rs program is different from full disclosure because it excludes plaintiffs involving attorneys in the negotiations and COPIC only uses the Three Rs program in cases with a value of less than $30,000. *Id.* In contrast, a true full disclosure program can cover all medical errors effectively, whether minor or grave. *Id.* Further, the plaintiff in a true full disclosure situation is always encouraged to have counsel present in order to bring accountability to the program. *Id.*; *see* discussion *infra* Part IV.C and accompanying notes.

164. COPIC 3Rs PowerPoint Presentation, *supra* note 15.

165. *See generally* COPIC's 3Rs Program: Recognize, Respond, Resolve, *supra* note 161. Not all physicians are involved in the COPIC Three Rs program. *Id.* As of December 31 2005, only sixty-five percent of proceduralists and twenty-eight percent of nonproceduralists were enrolled in the program. *Id.*

166. COPIC 3Rs PowerPoint Presentation, *supra* note 15.

167. *Id.*

168. *Id.*

169. *Id.*

170. *Id.*

171. COPIC's 3Rs Program: Recognize, Respond, Resolve, *supra* note 161.

172. *Id.* Of the fifty-two cases that have become formal claims, twenty-three have since closed. *Id.* Three of the twenty-three cases that have closed had substantial settlements of $40,000, $75,000, and $300,000. *Id.*

alone.[173] This number does not include what COPIC insurance has saved in legal costs as a result of implementing the Three Rs program.[174] Further, COPIC has seen a twenty-five percent reduction in settlement expenses.[175]

The Lexington VA and COPIC Insurance Company are just two examples of medical institutions that realized benefits as a result of adopting full disclosure programs.[176] Other institutions, including private hospitals, university educational centers, and solo practitioners, have also successfully adopted full disclosure programs,[177] and they too have seen a reduction in patient anger and litigation costs.[178]

4. *Developments Moving Towards Full Disclosure*

Efforts to implement full disclosure programs have occurred on many levels.[179] Both the United States Congress and many state legislatures have addressed requiring disclosure of medical errors.[180] Further, national organizations and health care institutions have begun recommending or requiring full disclosure.[181]

Legislation introduced on the national level discusses various aspects of full disclosure programs.[182] In September 2005, Senators Hilary Clinton and Barack Obama introduced legislation known as the National Medical Error Disclosure and Compensation (MEDiC) Bill.[183] MEDiC's goals are to "promote open communication between patients and providers; reduce rates of preventable medical errors; ensure patient access to fair compensation for medical injury, negligence, or malpractice; and reduce the cost of medical

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173. COPIC 3Rs PowerPoint Presentation, *supra* note 15.

174. *Id.*

175. Wojcieszak et al., *supra* note 64, at 346.

176. *See id.*

177. *Id.* The other organizations include the University of Michigan Health Center, the Stanford University Medical Center, dozens of Kaiser Permanente Hospitals, and at least one individual practitioner, Dr. Rick Van Pelt. *Id.*

178. *Id.*

179. *See generally id.* at 346, 349.

180. *See id.* at 349.

181. *See* Taft, *supra* note 7, at 56; Wojcieszak et al., *supra* note 64, at 344.

182. *See* Wojcieszak et al., *supra* note 64, at 349.

183. Clinton & Obama, *supra* note 8, at 2206-07. In 2005, Senators Enzi and Baucus introduced another bill that supports full disclosure programs, S 1337. *See* Wojcieszak et al., *supra* note 64, at 349. While not as comprehensive as the MEDiC Act, it would provide funds for disclosure pilot programs if made law. *Id.*

liability insurance."[184] The MEDiC program attempts to meet these goals by providing grants "for doctors, hospitals, and health systems that disclose medical errors and problems with patient safety and offer fair compensation for injuries or harm."[185]

Confidentiality is an important aspect of the MEDiC program.[186] Any discussion about compensation and any apology offered by a health care provider during negotiations are confidential.[187] Should negotiations fail and litigation occur, an apology by the physician may not be used in legal proceedings as an admission of guilt.[188] To ensure that the goal of insurance premium reduction is met, insurance companies that participate in the MEDiC program are required to apply a percentage of any savings from lower administrative and legal costs to the reduction of premiums for physicians.[189] Insurance companies are also required to contribute a percent of their savings to improve patient safety and reduce preventable medical errors.[190]

States, national organizations, and health care institutions are also looking to full disclosure programs to help with the medical malpractice problem.[191] Several states now require hospitals or physicians to disclose any adverse outcomes that have occurred with patients.[192] National health care organizations have also moved towards requiring full disclosure in the medical profession.[193] For example, in July of 2001, the Joint Commission on Accreditation of

184. Clinton & Obama, *supra* note 8, at 2206. Beyond grants, the legislation also looks to create an Office of Patient Safety and Health Care Quality within the Department of Health and Human Services. *Id.*

185. *Id.*

186. *Id.*

187. *Id.*

188. *See id.*

189. *Id.*

190. Clinton & Obama, *supra* note 8, at 2206.

191. *See generally* COPIC 3Rs PowerPoint Presentation, *supra* note 15; Wojcieszak et al., *supra* note 64, at 344-49.

192. Robbennolt, *supra* note 91, at 1011. States that require disclosure of adverse outcomes include Pennsylvania which requires, "a medical facility . . . shall provide written notification to a patient affected by a serious event . . . within seven days of the occurrence or discovery of a serious event." *Id.* Other states with similar disclosure laws include Florida, Nevada, and New Jersey. *Id.*

193. Wojcieszak et al., *supra* note 64, at 344.

Healthcare Organizations (JCAHO)[194] published new patient safety standards and now requires disclosure of unanticipated adverse outcomes.[195] The JCAHO regulation reads, "[p]atients and, when appropriate, their families are informed about the outcomes of care, treatment, and services, including unanticipated outcomes."[196] Health care institutions across the country are also asking their committees to create policies for the disclosure of adverse events.[197]

III. IDENTIFICATION OF THE LEGAL PROBLEM

While full disclosure programs result in benefits to the health care provider and the patient, implementation of the programs is not common in the medical community.[198] Both the decision to utilize a full disclosure program and implementation are often difficult because there are substantial barriers to the successful implementation of a full disclosure program.[199] Changes in policy within the medical institution solve some of the barriers to implementation of full disclosure programs.[200] Other, more deeply rooted practices in the medical community, such as the culture of cover-up and physicians' fear of liability, create more substantial barriers to the implementation of full disclosure programs.[201]

The problems presented by a lack of full disclosure in

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194. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is an independent, not-for-profit organization that evaluates and accredits nearly 15,000 healthcare organizations and programs in the United States. Facts About the Joint Commission, http://www.jointcommission.org/AboutUs/joint_commission_facts.htm (last visited Nov. 10, 2007). JCAHO is health care's predominant standard setting and accrediting organization. *Id.*

195. Wojcieszak et al., *supra* note 64, at 344.

196. *See* Taft, *supra* note 7, at 56 (quoting JOINT COMM'N ON THE ACCREDITATION OF HEALTHCARE ORGS., HOSPITAL ACCREDITATION STANDARDS (2001), Standard RI.1.2.90). JCAHO later clarified this statement saying ". . . accredited organizations must tell patients when harms occur to them in the course of treatment." *Id.* (quoting Rae M. Lamb et al., *Hospital Disclosure Practices: Results of a National Survey*, 22 HEALTH AFFAIRS 73, 74 (2003)).

197. *Id.*

198. *See generally* Wojcieszak et al., *supra* note 64, at 346. The article lists six hospitals and one insurance company with successful disclosure programs. *Id.*

199. *See id.* at 344.

200. *See* discussion *infra* Part IV.B-C.

201. *See generally* Wojcieszak et al., *supra* note 64, at 348.

health care settings are of great importance to the legal community. First and foremost, mistakes that injure or even kill patients occur,[202] yet reform designed to avoid recurrence of these mistakes does not follow.[203] At least in part due to the lack of open discussion surrounding mistakes, the medical community has seen no real reform to prevent medical errors.[204] As a result, hospitals face ever-increasing litigation costs.[205] Decreasing or eliminating many of the legal costs can occur by providing up-front, fair compensation.[206] Further, rising insurance costs fuel the "medical malpractice crisis" that the United States is currently experiencing.[207]

IV. ANALYSIS OF THE BARRIERS TO IMPLEMENTING FULL DISCLOSURE PROGRAMS

Barriers to the widespread adoption of full disclosure programs grow from concerns brought by the medical community, physicians, and patients.[208] One very substantial barrier is the current culture in many hospitals of "shame and blame" placed on the physician who last worked with a patient who suffered from an adverse event.[209] Another barrier is the physician's fear that admitting a medical error will increase the likelihood of a subsequent lawsuit.[210] In addition, there is an accompanying fear that the fact finder in a legal proceeding will view the apology as an admission of guilt.[211] Patient rights advocates are concerned that physicians may take advantage of their position relative to the patient.[212] In fact, patients' rights advocates believe that an apology may induce injured parties to settle for inadequate compensation because of the trust that exists between a physician and patient.[213] Finally, there is the concern that an attorney may act solely in his or her self-interest instead of

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202. *See generally* Cohen, *supra* note 139, at 1464-65.
203. *Id.*
204. *See generally id.*
205. *See generally* Thorpe, *supra* note 53.
206. Wojcieszak et al., *supra* note 64, at 344.
207. *See generally* Thorpe, *supra* note 53.
208. *See generally* discussion *infra* Part IV.
209. *See* discussion *infra* Part IV.A.
210. *See* discussion *infra* Part IV.B.
211. *See* discussion *infra* Part IV.B.
212. *See* discussion *infra* Part IV.C.
213. *See* discussion *infra* Part IV.C.

doing what is best for the patient.[214] Though these barriers are substantial, if medical institutions can overcome them, the overall health care system will improve.

A. *Culture of Hospitals: Shame and Blame*

Arguably, the largest obstacle to the successful implementation of a full disclosure program is the current culture of cover-up that is present in many hospitals.[215] Traditionally, hospitals have taken a "shame and blame" approach.[216] This approach blames the physician who last worked on the patient, who suffered from a medical error, for that error.[217]

Society's view of physicians also influences the culture of hospitals.[218] Society expects that physicians can solve any medical problem without causing harm to the patient.[219] Unfortunately, it is impossible for physicians to live up to this standard because the prospect of human error is omnipresent.[220] This idealistic expectation is one reason for the perpetuation of the culture of cover-up.[221]

The medical community's fear of admitting mistakes due to "shame and blame" and the maintenance of the physician's image is a cause for great concern.[222] Open discussion allows the medical community to address medical mistakes more effectively.[223] The "shame and blame" approach is particularly problematic as medical errors are often the result of institutional malfunctions, and not mistakes made solely by professionals.[224] Typically, more than one individual contributed to the error.[225] It is common knowledge that you cannot fix a problem until you admit you have one.[226] If this

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214. *See* discussion *infra* Part IV.D.

215. *See generally* Wojcieszak et al., *supra* note 64, at 348-49; GIBSON & SINGH, *supra* note 22, at 135-38.

216. *See* Davenport, *supra* note 27, at 90-91.

217. *Id.*

218. Telephone Interview with Doug Wojcieszak, Founder, Sorry Works! Coalition (Dec. 20, 2006); *see generally* Taft, *supra* note 7, at 57-58.

219. Telephone Interview with Doug Wojcieszak, *supra* note 218.

220. *Id.*

221. *Id.*

222. *See id.*; Davenport, *supra* note 27, at 90-91.

223. *See generally* Cohen, *supra* note 139, at 1465-66.

224. *See* Davenport, *supra* note 27, at 90-91.

225. *See* Cohen, *supra* note 139, at 1464.

226. *Id.* at 1465.

notion applies to the medical setting, practitioners and facilities alike are "likely to be more prompt in reporting [medical] errors, more honest in investigating them, and more willing to embrace reform" when the error is finally disclosed.[227]

B. Fear of Litigation: Deny and Defend

Another barrier to the implementation of full disclosure programs is the fear among doctors that admitting error will increase the likelihood of a lawsuit.[228] As a result, many hospitals use a "deny and defend" approach to adverse medical outcomes in which the defense attorney tells physicians and medical staff to keep quiet in the event of a medical error.[229] When an adverse outcome occurs, often those involved limit and eventually break off communication with the patient and family.[230] Physicians are accustomed to this approach due to years of risk management education instructing them in this manner.[231]

One way to remove the fear of admitting liability is to look to apology immunity laws.[232] Apology immunity laws prevent the admission of apologies as evidence should the medical error result in litigation.[233] Currently, twenty-nine states have apology immunity laws.[234] The principle animating these laws is that with immunities and the protections they offer in place, physicians will be more

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227. *Id.* (footnote omitted).

228. *See* Davenport, *supra* note 27, at 92.

229. The Sorry Works! Coalition, Sorry Works! Testimony Before the South Carolina Senate, http://www.sorryworks.net/media34.phtml (last visited Nov. 10, 2007).

230. Telephone Interview with Doug Wojcieszak, *supra* note 218. An example of a typical situation is that a family keeps in touch with a patient's doctor regularly throughout a medical situation. *Id.* However, after an adverse outcome occurs and is apparent, the doctor cuts off all communication with the family by no longer discussing the situation or returning calls. *Id.* At this point the family becomes upset and suspicious of the doctor, and the patient and family consider filing a lawsuit. *Id.*

231. Telephone Interview with Doug Wojcieszak, *supra* note 218; *see* GIBSON & SINGH, *supra* note 22, at 185.

232. Robbennolt, *supra* note 91, at 1026.

233. Wojcieszak et al., *supra* note 64, at 347.

234. The Sorry Works! Coalition, Simple Words Can Yield Big Rewards, http://sorryworks.net/article41.phtml (last visited Nov. 10, 2007); Telephone Interview with Doug Wojcieszak, *supra* note 218.

forthcoming with apologies.[235]

In practice, apology immunity laws may not be as effective in removing physicians' fear of liability as they are in theory.[236] Opponents of apology immunity argue that the laws are simply public relations gimmicks that have very little legal significance.[237] While immunity laws may make physicians feel more comfortable with, and therefore be more accepting of, full disclosure programs, in actuality it has always been acceptable for a physician to apologize.[238]

Apology immunity laws are so ineffective in prosecuting a physician, that many attorneys admit that they never have and likely never will use them in the courtroom.[239] The following example demonstrates why attorneys do not often turn to apology immunity laws. A physician offers an apology and fair compensation to an injured patient, but the patient rejects the offer.[240] If the case reaches litigation and there is evidence that the apology and compensation offer occurred, the physician goes into court as a sympathetic defendant because she tried to do the appropriate thing by apologizing and offering compensation.[241] A jury is likely to become angry, not at the doctor, but at the patient who was not willing to accept a reasonable offer.[242] This is a risk that most attorneys are not willing to take.[243]

Despite the example and many studies showing that admitting error does not lead patients to pursue litigation, many physicians still fear that admitting error will lead to liability.[244] It is a "widespread myth" that patients will be more likely to retaliate against a physician by initiating legal action when the physician discloses an error.[245] Physicians must learn to accept what the studies demonstrate through education, support, and encouragement from their

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235. Robbennolt, *supra* note 91, at 1026.

236. *See generally* Robbennolt, *supra* note 91, at 1026

237. Telephone Interview with Doug Wojcieszak, *supra* note 218.

238. *Id.*

239. *Id.*

240. *See* Wojcieszak et al., *supra* note 64, at 347.

241. *See id.*

242. *See id.*

243. *See id.*

244. *See* Davenport, *supra* note 27, at 92.

245. *Id.*; *see also* Armando Hevia & Cherri Hobgood, *Medical Error During Residency: To Tell or Not to Tell*, 42 ANNALS EMERGENCY MED. 565, 566-67 (2003).

institutions to become comfortable with the disclosure process.[246]

C. Concern that Apology may Induce the Patient to Settle for Inadequate Compensation

Patient advocates are concerned that, as a result of the trust-based patient-physician relationship, an apology by the physician may induce a victim of medical error to settle for inadequate compensation.[247] Even beyond a patient's acceptance of compensation, there is the potential for a doctor to manipulate a patient into a settlement by offering an insincere apology.[248]

In order to avoid these types of coercive situations, the medical facility must encourage or even require legal counsel's presence in all situations of full disclosure.[249] The presence of counsel is a necessity for full disclosure programs because it adds credibility to the program.[250] With counsel present, a patient receives more information regarding their available legal options and the likelihood of success as to each.[251]

In addition, an effective full disclosure program always leaves open the option to go to court.[252] If a patient is being unreasonable and asking for too much compensation or a hospital is not disclosing all information about the error, either side can pursue litigation.[253] In fact, if there is a major disagreement as to compensation or another factor, the parties are encouraged to look to the courts.[254] Therefore, no constitutional rights are violated because access to the courts

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246. *See* discussion *infra* Part V and accompanying notes.

247. Robbennolt, *supra* note 91, at 1026; *see also* Erin Ann O'Hara, *Apology and Thick Trust: What Spouse Abusers and Negligent Doctors Might Have in Common*, 79 CHI.-KENT L. REV. 1055, 1077 (2004) (arguing that a negligent doctor is similar to an abusive spouse in that victims too easily accept apologies).

248. *See* Robbennolt, *supra* note 91, at 1026.

249. *See* Wojcieszak et al., *supra* note 64, at 345; Telephone Interview with Doug Wojcieszak, *supra* note 218.

250. Telephone Interview with Doug Wojcieszak, *supra* note 218.

251. *Id.*

252. *See generally* Wojcieszak et al., *supra* note 143.

253. Telephone Interview with Doug Wojcieszak, *supra* note 218. It was discussed during the interview that often if either side is being unreasonable, a jury will tend to "get angry" at the unreasonable party in the event litigation is commenced. *Id.*

254. *Id.*

always remains an option.[255]

D. Attorneys Acting in Their Own Self-Interest

A barrier about which both patients and medical professionals share concern is the attorney acting in their own self-interest during the disclosure process.[256] An attorney may look for ways to gain financially from the medical error.[257] Both patients and medical professionals want to keep legal costs down, and such costs will be lower the sooner a situation is resolved.[258] The concern of attorneys acting in their own financial self-interest arises because of the customs of the legal profession.[259] Many attorneys' jobs depend on billing clients a specified number of hours per year.[260] Therefore, a case that is disposed of quickly does not aid an attorney in meeting their required yearly quota.[261]

Attorneys may also act in their own self-interest out of concern of committing legal malpractice.[262] An attorney may commit malpractice if the attorney provides a client with legal advice, the client takes the advice, and then the client incurs a liability from following the legal advice.[263] It will not be in an attorney's interest if the attorney advises a client to apologize and the apology backfires or is later admissible in court.[264] As a result, "[w]hile the vast majority of attorneys would not outright advise against an option of apology and closure when presented, they may passively neglect to discuss

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255. Wojcieszak et al., *supra* note 143. The constitutional right referred to is the right found in the Sixth Amendment for criminal defendants to have access to the courts. U.S. CONST. Amend. VI. Some forms of tort reform have been subject to claims of constitutional violations. *See, e.g.*, William Glaberson, *Ohio's Top Court Strikes Down Tort Reform Law; Ruling Is a Set Back to Lawmakers Seeking Caps on Damage Suits*, CHI. TRIB., Aug. 17, 1999 § 1, at 9.

256. *See* Jonathan Cohen, *Advising Clients to Apologize*, 72 S. CAL. L. REV. 1009, 1046 (1999). When an attorney acts in their own best interest rather than the client's best interest, questions of professional ethics violations arise. *Id.* at 1046 n.126.

257. *Id.*

258. Telephone Interview with Doug Wojcieszak, *supra* note 218.

259. *See* Cohen, *supra* note 256, at 1046.

260. Telephone Interview with Doug Wojcieszak, *supra* note 218. Medical malpractice defense attorneys in general must bill 2000 hours a year. *Id.*

261. HEALTH LAW HANDBOOK, *supra* note 78, at 730; *see also* Cohen, *supra* note 256 at 1046.

262. *See* Cohen, *supra* note 256, at 1046.

263. *Id.*

264. *Id.*

that option."[265]

V. PROPOSAL

Medical institutions should adopt full disclosure programs. Both patients and the medical community will benefit from the implementation of these programs.[266] Full disclosure programs should be implemented for at least five reasons: 1) medical errors will be reduced through reform of policies and procedures, 2) lawsuits will decrease in number, 3) the health care institution will see economic benefits, 4) patients will receive fair compensation in a timely manner, and 5) it is an ethical approach to medical errors.[267]

Full disclosure programs will help improve patient safety.[268] Such programs, by promoting communication, bring the discussion of medical errors into the open.[269] An honest conversation after a medical error occurs can leave the patient in a better position to understand his or her health status, and to know what to expect in terms of personal health in the future.[270] It can also lead to positive systematic changes in the hospital.[271] Through implementation of full disclosure programs, legal, insurance, and administrative costs are all reduced.[272] The savings from decreased litigation and administrative costs enables hospitals to put more resources towards patient safety and consequently reduce medical malpractice premiums for the hospital's physicians.[273]

In addition, a full disclosure program is positive because it is an ethical approach to medical errors. Human beings inherently make mistakes.[274] When a physician admits a mistake, people can accept the mistake and work towards reconciliation.[275] American society admires physicians and other medical professionals.[276] When a medical professional

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265. HEALTH LAW HANDBOOK, supra note 78, at 730.
266. *See* Wojcieszak et al., *supra* note 64.
267. *See* discussion Part II *supra*.
268. *See* Cohen, *supra* note 139, at 1464-65.
269. *See generally id.*
270. *See generally* Robbennolt, *supra* note 91, at 1022-23.
271. *See id.* at 1022.
272. *See generally* Wojcieszak et al., *supra* note 64, at 344-45.
273. *See generally* Clinton & Obama, *supra* note 8, at 2206.
274. Taft, *supra* note 7, at 56.
275. *See* Shuman, *supra* note 29, at 180.
276. *See generally* GIBSON & SINGH, *supra* note 22, at 161. Physicians are held to a higher standard than people in other professions. *Id.*

can admit their mistake, society as a whole can continue to admire, exemplify, and respect medical professionals who utilize the ethical approach of full disclosure in their practice.

Medical institutions have the ability to adopt full disclosure systems even though they face barriers during the implementation process. Perhaps the largest barrier is the culture of cover-up present in many United States medical institutions.[277] In order to overcome this barrier, health care institutions should make participation in the program and the disclosure mandatory.[278] American society does not rely on voluntary efforts to solve other crises that kill thousands of American citizens, and they should not rely on it to reduce preventable medical errors.[279] People generally have difficulty admitting fault, and admitting fault is even more difficult for medical professionals who are working in environments of "shame and blame."[280]

While mandatory reporting is ideal, other incentives, such as anonymous reporting, may help to break the culture of cover-up. Reporting at the individual hospital level is likely to lead to an increase in reporting of medical errors to national organizations such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).[281] The knowledge gained from national organizations researching why a medical mistake occurred can aid in preventing possible repeat errors.

To work towards removing the culture of cover-up, medical institutions implementing full disclosure must show that they take reporting medical errors seriously.[282] While both voluntary and mandatory disclosure is certainly a step in the right direction, it does not lead to the automatic disclosure of all medical errors.[283] The leadership of the

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277. *See* discussion *supra* Part II.C.1.

278. *See generally* GIBSON & SINGH, *supra* note 22, at 159.

279. *See id.*

280. *Id.* at 160. Medical professionals often have a feeling of "who wants to be the first doctor or nurse to [disclose an error]?" *Id.* Until someone has admitted mistake, medical professionals will not know whether the institution will stand behind them or not. *Id.*

281. *See supra* note 194.

282. *See* GIBSON & SINGH, *supra* note 22, at 162.

283. *Id.* at 161-62. Currently twenty states require health care facilities to report medical errors and several others have voluntary disclosure. *Id.* Yet, only six states have received more than one hundred reports of medical errors. *Id.* One reason for the lack of disclosure in health care facilities is that the

medical institution implementing full disclosure must show its medical professionals that they will no longer tolerate cover-ups.[284] In addition, the medical institution must offer incentives for following the full disclosure.[285]

A change in the culture of cover-up is possible. It is important to remember that this culture has been present for decades and will take many years to alter.[286] Educational efforts are an integral part to changing the hospital culture and ultimately reducing medical errors. Education regarding the benefits of full disclosure must be provided to the health care community. However, for these efforts to be effective, they must go beyond the health care community and involve the legal and insurance communities as well.[287] The economic and ethical benefits that a health care institution will see from the implementation of full disclosure programs will hopefully continue to expand educational efforts.

Congress is considering legislation "to encourage health care organizations to develop their own voluntary reporting systems by giving legal protection to those who report mistakes."[288] This legislation would help remove the culture of cover-up from the medical profession and therefore aid in the adoption of full disclosure programs.

A second barrier to full disclosure is a physician's fear that disclosure will lead to litigation.[289] In many cases, legal action is the only option for a patient or family who either wants to know why they were injured or hold the appropriate person responsible for the medical error.[290] Nevertheless, full disclosure programs provide an alternative to pursuing legal action. Medical institutions that adopt full disclosure programs actually see a reduction in litigation that occurs because the physician takes responsibility for the medical error and apologizes, which is often what the patients and

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consequences of nondisclosure are not severe enough. *Id.*

284. *See* GIBSON & SINGH, *supra* note 22, at 200-01.

285. *See generally id.* at 160. Incentives must be offered because it is difficult for a medical professional to admit to a mistake when working in a hospital where the culture of cover-up is present. *Id.*

286. *See* Wojcieszak et al., *supra* note 64, at 349.

287. *Id.*

288. *See* GIBSON & SINGH, *supra* note 22, at 164.

289. *See* discussion *supra* Part IV.B.

290. *See* GIBSON & SINGH, *supra* note 22, at 185-86.

families desire.[291] With the apology comes a reduction in a patient's disappointment and anger; thus, the potential plaintiff is less likely to pursue legal action.[292] The decrease in the likelihood of litigation has enormous financial benefits to health care institutions.[293] For every case settled through full disclosure, the institution saves resources by avoiding litigation.[294]

Patient advocates often fear that full disclosure programs will lead patients to settle for an inadequate amount of compensation.[295] It is true that as anger towards the institution decreases, full disclosure reduces the average settlement amounts.[296] The reduction in settlement amounts, however, does not mean that the patient settled for "inadequate compensation." The presence of counsel makes the process fair and addresses concerns that the patient-physician trust relationship will induce the patient to settle for inadequate compensation.[297]

Patients and families receive much more in a full disclosure settlement than simply dollars. When full disclosure programs are in place, the patient and family will certainly receive fair compensation.[298] However, the promptness of payment is also important.[299] While a medical malpractice lawsuit can drag on for years, a settlement typically occurs in two to three months in cases of full disclosure.[300] During this time, negotiation between the parties occurs to determine a fair payment.[301] Further, with full disclosure programs patients and families see a reduced risk of losing in litigation and receiving no compensation.[302] With full disclosure programs there is a ninety-five percent

291. *See generally* Wojcieszak et al., *supra* note 64, at 344.
292. *Id.*
293. *See generally* Cohen, *supra* note 139, at 1453-54 (discussing the savings the Lexington VA has received from its disclosure program due to reducing the anger of its patients).
294. *See generally id.*
295. *See* discussion *supra* Part IV.C.
296. *See* discussion *supra* Part II.C.3; Robbennolt, *supra* note 91, at 1022-23.
297. *See* discussion *supra* Part IV.C.
298. Wojcieszak et al., *supra* note 64, at 345.
299. *See id.*
300. The Sorry Works! Coalition, Just the Facts, http://www.sorryworks.net/article6.phtml (last visited Nov. 10, 2007).
301. *See* Wojcieszak et al., *supra* note 64, at 345.
302. *See* Just the Facts, *supra* note 303.

chance of success within six months, compared to a thirty-three percent chance of success in litigating a claim.[303] There is substantial value in an apology, a quick settlement of the dispute, a greater likelihood of reaching a settlement, and even an assurance that steps will be taken so the same error is not repeated. These factors must be considered when deciding what constitutes fair compensation for a medical error.

Full disclosure programs can be successfully adopted despite the concern regarding attorneys acting in their own self-interest.[304] The leadership of the medical institution must contemplate and acknowledge the reasons they desire a full disclosure program in their institution.[305] Medical institutions adopt full disclosure programs because they are in the best interest of both the patient and the hospital, not the attorney.[306] The leadership of the medical institution needs to take control of the situation and if an attorney or firm they are working with sees full disclosure as a threat to their own self-interest, the institution needs to immediately address the situation. The institution may also consider hiring in-house counsel.[307] Through taking this step, the institution can choose to remove the billable hours quota the attorney would have to meet if working for an outside firm.

There is also a concern that attorneys will not advise a client to apologize out of fear that it may result in a legal malpractice claim.[308] While apology laws are not necessary for full disclosure programs to be successful,[309] attorneys may feel more comfortable advising a client to apologize when such laws exist. Further, education of attorney's in the effects of full disclosure programs may convince an attorney to be more accepting of advising a client to apologize.

VI. CONCLUSION

The role of apologies in resolving medical malpractice

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303. *Id.*

304. *See* discussion *supra* Part IV.D.

305. See discussion *supra* Part II.C.2 for a discussion of the benefits enjoyed by medical institutions as a result of implementing a full disclosure program.

306. *See* discussion *supra* Part II.C.2.

307. Telephone Interview with Doug Wojcieszak, Founder, Sorry Works! Coalition. (Sept. 27, 2007).

308. *See* discussion *supra* Part IV.D.

309. *See* discussion *supra* Part IV.B.

cases is complex.[310] Studies show that patients and families can live with mistakes and are generally very accepting of apologies.[311] What people will not tolerate is a cover-up, particularly when it pertains to their own health.[312] It is when a medical professional covers-up a medical error that patients and families feel obligated to look to litigation for answers and compensation.[313]

While the most far-reaching reform in this context would be via national legislation, there is no need to wait for the legislature to act. Full disclosure programs can be implemented effectively in the smallest of settings, including an independent practicing doctor's office.[314] On a larger scale, hospitals or insurance companies can adopt policies to support full disclosure in their organizations.[315] Full disclosure programs have the potential to provide great benefits to all parties involved, regardless of the setting.

The most important benefit of a successful full disclosure program is that the United States health care system will be safer. More patients will recover from medical problems and return to their normal lives without unnecessary physical pain or drawn out litigation. Physicians will be less likely to make a medical error because open discussion will lead to the adoption of preventative measures. However, when a mistake does occur, physicians will feel less pressure to cover it up, and have a greater drive to take an ethical approach.

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310. *See* discussion *supra* Part II.B.

311. *See* GIBSON & SINGH, *supra* note 22, at 186; *see generally* discussion *supra* Part II.B.1.

312. The Watergate Scandal is perhaps the most well known political cover-up. Watergate Scandal, http://en.wikipedia.org/wiki/Watergate_scandal (last visited Nov. 10, 2007). It led to a Senate investigation, the resignation of President Nixon, and eventually voters showed their disgust with the cover-up by replacing many Republican members of Congress. *Id.* Other examples of political cover-ups that have caused outrage in society include the My Lai Massacre, the Roman Catholic sex abuse cases, and the cover-up of incidences of SARS and avian flu in various countries. Cover-up, http://en.wikipedia.org/wiki/Cover-up (last visited Nov. 10, 2007). In sports, Pete Rose was accused of betting on major league games while he was a team manager. Major League Baseball Scandals, http://en.wikipedia.org/wiki/Major_League_Baseball_scandals (last visited Nov. 10, 2007). He was facing a very harsh punishment, but decided to compromise with Major League Baseball and accept a voluntary life ban from baseball. *Id.*

313. *See* GIBSON & SINGH, *supra* note 22, at 185-86.

314. *See* Wojcieszak et al., *supra* note 64, at 346-47.

315. *See* discussion *supra* Part II.C.3.

Most importantly, the medical community can reduce the number of deaths that are attributable to medical error. Ultimately, full disclosure programs create a safer medical environment for everyone.