

Toward Candor after Medical Error: The First Apology Law

Jonathan R. Cohen, JD, PhD

A pivotal development in American legal and medical practices may have occurred quietly in Colorado last year. It took the form of a change in Colorado's evidence code. Largely unnoticed by the national press, in April, 2003 Colorado enacted a law providing in part:

In any civil action brought by an alleged victim of an unanticipated outcome of medical care[...]any and all statements, affirmations, gestures or conduct expressing apology, fault, sympathy, commiseration, condolence, compassion, or a general sense of benevolence which are made by a health care provider or an employee of a health care provider to the alleged victim [or the victim's relatives or representatives] which relate to the discomfort, pain, suffering, injury, or death of the alleged victim as the result of the unanticipated outcome of medical care shall

be inadmissible as evidence of an admission of liability.¹

In Colorado when medical errors occur, medical providers, such as a doctor or nurse or the hospital, can apologize to the patient, including not just words of sympathy but a full admission of fault, and that apology cannot be used against them in a medical malpractice action.

It must be recognized how significant a change this law is from the legal perspective.² The general backdrop of the Anglo-American legal tradition provides that statements by parties to cases are virtually automatically admitted in suits against them, commonly called the "admission by a party opponent" doctrine.³ In recent years, six states [viz., Massachusetts (1986), Texas (1999), California (2000), Florida (2001), Washington (2002) and Tennessee (2003)] have enacted laws excluding expressions of sympathy (e.g., "I'm sorry that you are hurt") after accidents as proof of liability.⁴

.....

Jonathan R. Cohen is Associate Professor of Law and Associate Director of the Institute for Dispute Resolution at the University of Florida Levin College of Law. He received his AB, JD and PhD in Economics from Harvard University. The central theme of Cohen's research is ethical dispute resolution. His recent publications address the use of apology in legal disputes, the need for respect in negotiation and facing rather than denying responsibility for one's actions.

Yet, before the Colorado law none had excluded full, fault-admitting apologies (e.g., “I’m sorry that I hurt you”).⁵ In essence, the Colorado law attempts to create an exception that exists virtually nowhere else in American law for Colorado medical providers: the ability to apologize without the fear that the apology will come back against them in court.⁶

Valid concerns both support and oppose such laws. Some might argue that they help avoid conflict through fostering open and direct communication, thereby speeding settlement and preventing litigation. Others might argue that these laws promote insincere, strategic apologies.⁷ This is clearly a complicated issue that I will not fully address in this article. Rather I will highlight here some of this law’s most salient implications for medical error.

First and foremost, this law has potential to change how Colorado medical providers respond to actual cases of error. While the case for full disclosure to patients of errors resulting in adverse outcomes is exceedingly strong from the viewpoint of medical ethics, the reality in practice is quite different.⁸⁻¹² (In response, several states have recently enacted laws requiring disclosure to patients of serious adverse medical events.¹³) Often, whether advised by their attorneys or by their hospital’s risk management board, or motivated by the shame of the mistake, physicians remain silent in the face of error. Colorado’s law seeks to promote an open, trusting and care-giving relationship following medical error. The patient may benefit from learning information about the specific medical error and from feeling that he is being dealt with honestly. The medical provider may benefit as well, finding a psycho-ethical release from the guilt

attached to a concealed mistake.

Laws such as the one instated in Colorado may also decrease the incidence of medical malpractice suits. As discussed, under existing laws medical providers frequently remain silent once a medical error resulting in an adverse event has occurred. Yet it is precisely that silence – that failure to admit a mistake and apologize for it – that can prompt a lawsuit. There are three important aspects to highlight. First is in regard to information. Patients who experience adverse medical events almost inevitably, and quite rightly, desire to know what happened. If the medical provider does not offer that information, some patients or their families will sue to get it.¹⁴ Apologies qua information vehicles may prevent these suits. Observe too that many patients are concerned that the error they experienced not be repeated on future patients, and until acknowledgement occurs, their concern may persist. Second is the issue of betrayed trust. To be effective, the physician-patient relationship must be rooted in trust. Many patients quite literally entrust their medical providers with their lives. Hence, the anger prompted when a trusted medical caregiver becomes silent can be tremendous. Third is simply the matter of dignity. When a person injures another, whether on purpose or by accident, the respectful course is for the injurer to apologize. Failing to apologize after injury can itself be a second form of injury. It is difficult to know precisely what percentage of medical malpractice claimants would not have sued had only they received an apology, and what limited evidence exists is to some extent conflicting. Yet this percentage may well be sizable, perhaps in the range of ten to thirty percent.¹⁵⁻²⁰ To a startling degree, medical

malpractice suits are prompted not simply by underlying medical negligence, but by a relational breakdown between the patient and the medical provider.²¹⁻²³ By removing the specter of liability from the physician-patient dialogue, such a law can help to maintain trust and quality care within the physician-patient relationship after an error occurs.

It is important to observe, however, that an apology – even one that is accepted – does not imply that no compensation need be made. Rather, if after having received the apology the patient still wants compensation, the process of determining that compensation is likely to be far less adversarial.²⁴⁻²⁵ Conflict is not the inevitable result of medical error. The critical issue is how the parties respond to that event: by open communication and settlement, or by silence and litigation. Particularly where medical errors are severe, the critical issue is usually not whether an apology will prevent all legal recourse, but rather how it will influence the character of that recourse – whether compensation will be determined by a relatively cooperative and speedy settlement process or through more lengthy, costly and often unpredictable litigation.²⁶


Colorado's law may also have a significant long-run impact on error prevention. A key component of preventing future medical errors is gathering information about errors that have occurred.²⁷⁻²⁹ No doubt one of the greatest barriers to gathering information on medical error is the fear that it will be "used against one," that it will come back to haunt the medical practitioner in court. By stating in effect that it is "safe" for a physician to apologize to a patient for medical error, the Colorado law may help break the silence that so

often shrouds medical mistakes. As that silence breaks, preventing future medical errors becomes more hopeful.

I do not mean to suggest that Colorado's law is a panacea for addressing medical errors. There may well be challenges in its application. Suppose, for example, that following the physician's fault-admitting apology, a suit nevertheless ensues. Imagine how maddened a patient might be if at trial he could not prove the physician's fault despite the fact that the physician had admitted it to him directly. Further, by no means does such a law alone remove all barriers to disclosure of medical errors. This law excludes from evidence statements made to the patient, but not statements made, for example, to one's colleagues. It will be important to watch how Colorado's law plays out in practice. Further, by way of caution, I offer here the type of warning often attached to medical products: medical providers considering apologizing, even in Colorado, who are concerned about the potential legal ramifications should consult with an attorney in their jurisdiction before so doing. Observe, however, that even in states where apologies can be used as evidence, pecuniary risks attach both to apologizing (e.g., the risk the apology will be used against the medical provider in court) and not apologizing (e.g., the risk that the lack of an apology will inhibit the settlement process and/or trigger a lawsuit).³⁰

Colorado's new law has the potential to produce profound changes in both responding to and preventing medical errors. Such changes will not happen overnight, but they may well happen in time. Further, one "bonus" of such a law should not be overlooked: cost. In an age where economic forces so often drive health pol-

icy choices, how often do we encounter a potential reform with so much potential and with such little cost? What, after all, does it cost to enact a law that excludes a healthcare provider's apology from admissibility into evidence? Virtually nothing. Yet that legal evidentiary reform may profoundly change how medical providers respond to and attempt to prevent medical errors.

Some level of medical error is beyond our control, despite our best efforts. In contrast, how we as a society respond to medical error is very much within our control. In enacting a law to exclude medical apologies from admissibility into evidence, Colorado has taken a pioneering step. Colorado has sought to replace a pattern of denial-by-silence and subsequent litigation with one of apology and reconciliation between physician and patient. As we look toward the future, will other states follow Colorado's lead?³¹ 

References

1. See Colo Rev Stat § 13.25 (2003).
2. Cohen JR. Legislating Apology: The Pros and Cons. *University of Cincinnati Law Rev.* 2002;70:819-895.
3. See generally Federal Rules of Evidence, Rule 801(d)(2); Charles Tilford McCormick, McCormick on Evidence, at 254 et seq. (John W. Strong et al. eds., 5th ed. 1999).
4. See respectively Mass Gen Laws Ann ch.233,23D; Tex Civ Prac and Rem Code Ann § 18.061; Cal Evid Code 1160; Fla Stat § 90.4026; Rev Code Wash § 5.66.010; Tenn Evid Rule § 409.1.
5. See 2003 Bill Text MI S.B. 528; 2003 Bill Text HI H.B. 2387.
Bills are currently pending in Michigan and Hawaii to exclude such full, fault-admitting apologies as proof of liability not merely in medical malpractice cases but in civil cases generally.
6. Cohen JR. Advising Clients to Apologize. *Southern California Law Review.* 1999;72(4):1009.
7. Cohen JR. 2002.
8. Finkelstein et al. When a Physician Harms a Patient by Medical Error: Ethical, Legal and Risk Management Considerations. *Journal of Clinical Ethics.* 1997;8:330.
9. Wu et al. To Tell the Truth: Ethical and Practical Issues in Disclosing Medical Mistakes to Patients. *Journal of General Internal Medicine.* 1997;12:770
10. Cohen JR. 1999.
11. Smith ML, Foster HP. Morally Managing Medical Mistakes. *Cambridge Quarterly of Healthcare Ethics.* 2000;9(1):38-53.
12. Cohen JR. 2002.
13. 40 Fla Stat §395.1051; Pa Stat §1303.308; Nev Rev Stat §439.835.
14. Gilbert, Sandra. *Wrongful Death: A Medical Tragedy.* New York: W.W. Norton & Co., 1997.
15. Hickson et al. Factors That Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries. *JAMA.* 1992;267(10):1359-1363.
16. Vincent et al. Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action. *Lancet.* 1994;343(8913):1609-1613.
17. Witman et al. How Do Patients Want Physicians to Handle Mistakes? A Survey of Internal Medicine Patients in an Academic Setting. *Archives of Internal Medicine.* 1996;156(22):2565-2569.
18. Cohen JR. Apology and Organizations: Exploring an Example from Medical Practice. *Fordham Urban Law Journal.* 2000;27:1447.
19. Cohen JR. 2002.
20. Mazor et al. Health Plan Members' Views about Disclosure of Medical Errors. *Annals of Internal Medicine* 2004;140(6):409-418.
21. Localio et al. Relation Between Malpractice Claims and Adverse Events Due to Negligence: Results of the Harvard Medical Malpractice Study III. *New England Journal of Medicine.* 1991;325(4):245-251.
22. Weiler et al. A Measure of Malpractice: Medical Injury, Malpractice Litigation and Patient Compensation. Cambridge: Harvard University Press, 1993.
23. Levinson W et al. Physician-Patient Communication: The Relationship with Malpractice Claims Among Primary Care Physicians and Surgeons. *JAMA* 1997; 277; 553-9.
24. Cohen JR. 1999.
25. Cohen JR. 2000.
26. Frenkel DN, Liebman CB. Words that Heal. *Annals of Internal Medicine* 2004;140(6):482-3.
27. Wu et al. Do House Officers Learn from Their Mistakes? *JAMA.* 1991;265(16):2089-94.
28. Kohn et al., eds. *To Err is Human: Building a Safer Health System.* Washington: National Academy Press, 2000.
29. Liang BA. Error in Medicine: Legal Impediments to U.S. Reform. *Journal of Health Politics, Policy and Law.* 1999;24:27.
30. Cohen JR. 1999.
31. In June, 2003, Oregon enacted a medical apology law similar, though not identical, to Colorado's. Ore H.B. 3361 (2003). As of April, 2004, similar bills are pending in North Carolina, Oklahoma, and Washington. NC S.B. 802 (2003); Okla H.B. 2661 (2003); Wash S.B. 6645 (2003).