WHAT WE KNOW AND DON'T KNOW ABOUT THE ROLE OF APOLOGIES IN RESOLVING HEALTH CARE DISPUTES

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Introduction

The role of apologies in resolving all types of civil disputes has received growing attention. While apologies may well play a role in resolving civil disputes generally, they may be particularly relevant in the health care setting—a setting in which the parties are in a relationship that necessitates a high degree of trust and intimacy. Apology is, after all, consistent with a professional ethic that cares for and respects patients. In addition, there is evidence that patients desire apologies after medical errors and that physicians desire to give apologies. Physicians, however, are apprehensive that disclosing errors and apologizing for them will result in lawsuits and loss of respect and trust by patients and peers. Perhaps it is not surprising that the issue of whether or not health care providers should consider apologizing in the wake of a medical error is increasingly being explored and debated in the medical literature, the legal literature, and the popular press.

I. Legislative Developments

Whether and how to communicate with patients about medical error has drawn much recent interest. Several states now require that hospitals or physicians disclose to patients that an adverse outcome has occurred. For example, Pennsylvania requires that "[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." Florida requires facilities to "inform each patient . . . in person about adverse incidents that result in serious harm to the patient." Using different terminology, Nevada provides that a representative of the medical facility "shall, not later than 7 days after discovering or becoming aware of a sentinel event that occurred at the medical facility, provide notice of that fact to each patient who was involved in that sentinel event." In addition, New Jersey requires that a patient be informed of "a serious preventable adverse event or an adverse event specifically related to an allergic reaction" in a "timely fashion."

These disclosure provisions are consistent with ethical standards articulated by a number of professional medical organizations. For example, the American College of Physicians’ Ethics Manual provides that "physicians should disclose to patients information about procedural or judgment errors made in the course of care if such information is material to the patient's well-being. Errors do not necessarily constitute improper, negligent, or unethical behavior, but failure to disclose them may." Similarly, the American Medical Association (AMA) instructs physicians that when "a patient suffers significant medical complications that may have resulted from the physician's mistake or judgment, . . . the physician is ethically required to inform the patient of all the facts necessary to ensure understanding of what has occurred." Moreover, the AMA counsels that "[c]oncern regarding the legal liability which might result following truthful disclosure should not affect the physician's honesty with a patient."

However, neither the ethical guidelines nor the statutory disclosure requirements themselves equip providers with guidance about how the disclosure ought to be made. Health care providers have received varied advice, compounding the uncertainty. Consistent with providers' fears of litigation, risk managers, insurance companies, and others have advised providers against disclosure or apology. Alternately, providers sometimes are advised to acknowledge the outcome and express sympathy, but to avoid any discussion of responsibility. Others, often suggesting that an approach that fails to acknowledge responsibility can make matters worse, advise providers to discuss errors with patients, offer apologies, and make compensation. Not surprisingly, a recent survey of hospital risk managers found "marked variation" among hospitals in disclosure practices. While most risk managers reported that when they make a
disclosure they include an explanation (92%) and would initiate an investigation into the occurrence (87%), fewer reported that they include an apology (68%), that they accept responsibility for the harm (33%), or that they pay compensation (36%). Moreover, risk managers' intuitions varied about whether disclosure would increase or decrease the risk of litigation.

Of particular interest for the purposes of this Article is the role of apology in these disclosure conversations. Indeed, at the same time that there has been growing interest in disclosure requirements, a number of states have enacted statutes designed to encourage apologies by preventing parties from using them as evidence at trial. For example, an Oregon statute provides that "any expression of regret or apology made by or on behalf of [a licensed medical provider] . . . does not constitute an admission of liability for any purpose" and may not be the subject of examination "by deposition or otherwise." Oklahoma recently enacted a statute that protects some apologetic statements from being admissible in medical malpractice cases. The Oklahoma statute provides:

A. In any medical liability action, any and all statements, affirmations, gestures, or conduct expressing apology, 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 plaintiff, a relative of the plaintiff, or a representative of the plaintiff and which relate solely to discomfort, pain, suffering, injury, or death as the result of the unanticipated outcome of the medical care shall be inadmissible as evidence of an admission of liability or as evidence of an admission against interest.

Statutes in Ohio and Wyoming contain similar provisions. Colorado has chosen to explicitly protect statements that acknowledge fault, providing protection in medical malpractice suits, to "any and all statements, affirmations, gestures, or conduct expressing apology, fault, sympathy, commiseration, condolence, compassion, or a general sense of benevolence" offered by health care providers. Similarly, Georgia provides protection to "any and all statements affirmations, gestures, activities or conduct expressing benevolence, regret, apology, sympathy, commiseration, condolence, compassion, mistake, error, or a general sense of benevolence which are made by a health care provider."

Proponents of these statutes suggest that if the law protects apologetic expressions from admissibility, health care providers and other defendants will be more likely to offer them. It is further anticipated that apologies, if offered, will lead to a variety of legal and non-legal benefits to disputants. Specifically, proponents suggest that apologies play a role in repairing relationships, have positive emotional and physiological benefits, fulfill a need to make reparations and restore equity, make forgiveness possible, and facilitate psychological growth. Accordingly, apologies may facilitate settlement by making possible better, faster, more satisfying negotiations. In the health care context, proponents hope that apologies will also lead to better relationships and increased trust between patients and health care providers, the alleviation of suffering for both patients and providers, and an increased ability to learn from mistakes and prevent future errors.

While there is a body of research spanning several disciplines suggesting positive impacts of apologizing more generally, only recently has there been systematic research examining the role of apology in litigation and, more specifically, the role of disclosure and apology in cases of adverse medical outcomes.

II. What We Know: Empirical Research

A. Survey Research

Several studies have examined the reasons that litigants in medical malpractice cases cite for why they brought a lawsuit. Patients, it turns out, report a variety of motivations for filing suit after an injury, several of which indicate the potential importance of disclosure and apology. In particular, many patients say that they file lawsuits to get information about and understand their injury and the circumstances surrounding it, to determine accountability, and to prevent future injuries.

In a similar study of medical claims, Charles Vincent and his colleagues asked claimants about any
explanation they had received following the injury, why they brought the claim, and what could have prevented their claim. Although the need for communication and an explanation was one of the key reasons claimants gave for filing suit, receiving an explanation for the adverse event was not the norm—over one-third (37%) of claimants received no explanation, and only 21% received an explanation within a few days. Of those who did receive an explanation, fewer than 40% felt that the provider gave the explanation in a sympathetic manner. Medical care providers accepted responsibility for the adverse outcome, either wholly or in part, in only 13% of cases. Nearly 40% of claimants who thought that something could have been done to prevent litigation indicated that litigation would not have been necessary if the medical provider had offered an explanation and apologized.

Using a different methodology, Thomas Gallagher and his colleagues conducted focus groups with patients and physicians to discuss medical error and found interesting differences in how patients and physicians viewed medical error. Patients desired full disclosure (including "what happened, the implications of the error for their health, why it happened, how the problem will be corrected, and how future errors will be prevented"), desired apologies, and wanted information to "be provided to them rather than having to ask their physician numerous questions." Patients expressed a desire for reassurance that the provider felt regret and that the provider would make the appropriate changes to prevent recurrence of the error. Physicians reported a desire to apologize but also reported concern that disclosure increased the possibility for legal liability. As a result, they reported choosing their words carefully and a belief that, if patients wanted more information or an explanation, they "would ask follow-up questions." This basic disconnect between patients and physicians can be counter-productive. Patients in the study reported that "they would be less upset if the physician disclosed the error honestly and compassionately and apologized . . . [and] . . . that explanations of the error that were incomplete or evasive would increase their distress."

B. Experiments

Experimental studies have also explored the effects of disclosure or apology in the context of litigation—several of them in the medical malpractice context.

C. Case Study

Finally, there are case studies of institutions that have adopted policies of disclosure or apology. The Veterans Affairs (VA) Medical Center in Lexington, Kentucky ("Lexington VA") has implemented the most widely described policy of this nature. As described by Jonathan Cohen:

The policy involved multiple steps. The hospital encouraged workers to report mistakes to its risk management committee. . . . Once a mistake was reported, a 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. In some cases, the patient was not aware nor likely would have become aware of the mistake absent the hospital volunteering the information. The risk management committee then brainstormed 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 chief of staff and chair of the risk management committee] apologized to the patient at that meeting, including admitting fault verbally and, if the patient desired, subsequently in writing. Members of the committee then discussed further steps the hospital could take to aid the patient medically and any disability benefits to which the patient might be entitled. 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.

The hospital has reported that with the policy in place, patients are less angry and continue to have a good relationship with the hospital, cases settle more quickly, self-reporting of errors by the medical professionals has increased, the hospital has received positive publicity, and litigation costs have declined. In addition, the hospital compared itself to 35 comparable VA hospitals for a seven-year period following
implementation of the policy. The Lexington hospital was in the top 20% of facilities in terms of the number of claims against it (possibly reflecting the fact that more patients learn of errors) but was among the lowest 25% of facilities in terms of the amount of total payments.

There are a number of factors that make it difficult to generalize from the experience in Lexington to health care settings more generally. For example, the VA is not subject to punitive damages, the providers' personal liability exposure in the system differs from that of providers in the private sector, and the patients are not representative of the broader population and may have access to additional sources of compensation. Moreover, it is difficult to disentangle the effects of portions of the policy, such as disclosing, apologizing, or offering compensation, from the effects of the policy as a whole. Nonetheless, the Lexington VA experience stands as one example of the potential effects of implementing a policy of disclosure that includes apology.

III. Unanswered Questions

The research reviewed here suggests that apology has a role to play in the resolution of health care disputes. Survey research finds that patients report that they desire apologies, and that they may have been less likely to litigate if the other party had apologized. Experimental studies indicate that litigants may be more likely to make favorable attributions, less likely to seek legal counsel, and more likely to settle when they receive apologies. Researchers continue to explore the boundaries on these effects. The experiences of individual facilities seem to suggest that providers can incorporate disclosure and apology in policies addressing adverse events without ill effects. There is, however, still much to be learned.

It is clear that the role of apologies in resolving health care disputes is complex. There are risks to apologizing—the patient may sue anyway, and an apology (particularly one that accepts responsibility) may make the patient's case easier to prove. Moreover, an inadequate or poorly delivered apology may incite the patient's ire by adding insult to injury and, itself, lead to litigation. Providers must balance these risks against the potential for an apology to help repair relationships, to smooth the resolution of the dispute, or to make it harder to portray the provider as a villain if a lawsuit does go forward. On the other hand, there are also risks to not apologizing; failure to apologize and take responsibility when appropriate may be unsatisfying to the provider, may result in increased anger and blame, and may provide the patient with a reason to sue. We know very little about how most of these possibilities are likely to play out; a few examples are highlighted below.

First, while the research suggests that apologies are likely to result in generally positive effects, there is much we do not know about how different personal and situational factors may impact these effects. For example, one might draw a distinction between medical errors and adverse outcomes that are not attributable to error. This distinction may have important implications for how patients respond to apologies. In particular, the existing research seems to suggest that the degree of responsibility attributed to the other party moderates how injured parties respond to expressions of sympathy. Thus, it may be that when there has been a medical error, a responsibility accepting apology is most powerful but that an expression of sympathy is helpful when an adverse outcome occurs but is not the result of an error. Complicating this relationship, moreover, are a host of factors that may influence how patients and providers may attribute responsibility for an adverse outcome. Understanding how patients and providers distinguish between adverse outcomes that are and are not attributable to error may help us to better understand the role of apologies in resolving these disputes.

Third, some have expressed concerns that an apology may induce injured parties to settle for too little compensation. Arguments that health care providers offering insincere apologies can manipulate injured parties into agreeing to inadequate settlements magnify these concerns. In this vein, Erin O'Hara has argued that the "dependency and trust" attendant to the patient-physician relationship predisposes patients to accept apologies from physicians too easily. Additional research should examine the ways in which injured patients respond to apologies of different types and how those responses influence settlement outcomes.

Finally, health care providers cite fear of litigation as a major barrier to disclosing and apologizing for medical error. Statutes that prevent apologies from being admissible at trial speak to this fear and are
premised and promoted on the notion that apologies will be more forthcoming if the law provides this protection. However, whether these apology statutes will result in more apologies is an open empirical question. These statutes provide opportunities to explore the influences on providers' willingness to offer apologies and on insurance companies, risk managers, and defense attorneys' willingness to advise clients to consider apologizing. Research might also explore how these statutes may influence perceptions of the risks and benefits of apologizing—these perceptions may well be more important than the realities in influencing behavior. Beyond this, however, it seems clear that part of the fear of litigation stems from concern about how jurors will react to a case in which a provider has disclosed error and apologized. While some initial steps have been taken in exploring the influences of apologies on the behavior of claimants, few steps have been taken toward understanding the effects of disclosure and apologies on jury decision making.

**Conclusion**

The increased attention to the role of apologies in the resolution of health care disputes is a positive step in the development of new approaches for dispute resolution in this area. Given the nature of the physician-patient relationship and the nature of disputes that result when there is an adverse medical outcome, consideration of the role of apologies in this area of law seems particularly appropriate. There is an emerging body of empirical research that uses a variety of methodologies to examine a range of questions related to disclosure and apology. This research suggests that apologies have the potential to facilitate the settlement of health care disputes. The effects of apologies, however, are likely to be complex and dependent on a variety of factors including the nature of the apology, the situation, and the parties involved. Thus, continuing to examine the potential role of apologies in resolving health care disputes will likely yield benefits that will redound to health care providers and patients alike.