

# How Medical Apology Programs Harm Patients

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## INTRODUCTION

From President Barack Obama and Secretary of State Hillary Clinton to *The New York Times*, the popular perception of medical apology programs is that they are wonderful things.<sup>1</sup> These programs call on doctors who have committed an error to meet with their injured patient, explain why the mistakes happened and apologize accordingly. Taken in isolation, the concept of a doctor admitting his or her unintended error to a harmed patient seems appropriate, humanitarian, and fair. This Article explains, however, why their perceived nobility is based on a myth.<sup>2</sup> In reality, the design of medical apology programs allows for the manipulation of injured patients as a means to persuade them not to pursue money damages.

A phenomenon called “cooling the mark out” that was first noted in 1952 by the famed sociologist Erving Goffman, explains how apology programs work.<sup>3</sup> Goffman observed that “confidence men” use a tried-and-true set of techniques to convince (or “cool out”) their victim (or “mark”) not to complain after realizing that he or she had been swindled.<sup>4</sup> Goffman wrote that cooling the mark out also has uses in contexts beyond criminal enterprises.<sup>5</sup> When it does happen in law-abiding society, it uses similar processes in which a person in a position of power uses persuasive methods to control the emotional state of a mark.<sup>6</sup> The intended effect remains to diffuse the mark’s righteous anger to the con’s benefit.<sup>7</sup> This Article argues that medical apology

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<sup>1</sup> See Hillary Rodham Clinton & Barack Obama, *Making Patient Safety the Centerpiece of Medical Liability Reform*, 354 NEW ENG. J. MED. 2205, 2207 (2006); Kevin Sack, *Doctors Start to Say ‘I’m Sorry’ Long Before ‘See You in Court.’* N.Y. TIMES, May 18, 2008, at A1.

<sup>2</sup> The sources on this topic use the terms “disclosure program” and “apology program” interchangeably. Ultimately, disclosure programs—where a medical provider simply discloses that an error occurred—do not necessarily have to include an apology. However, for strategic reasons, doctors are nearly universally counseled to apologize for acts of negligence at the time of their disclosure. As a reason for doing so, CRICO/RMF (the insurer that covers physicians at Harvard’s hospitals) explained that the disclosure should include an apology “because an apology is often equated with the showing of empathy, a communication that lacks this basic ‘human touch’ may actually make a situation much worse.” CRICO/RMF, *Disclosure and Apology: CRICO’s Perspective*, CRICO/RMF (last visited July 1, 2011), <http://www.rmhf.harvard.edu/files/documents/2003WhitePaper--DisclosureApology.pdf> [hereinafter *CRICO’s Perspective*]. For the sake of ease, this paper will refer to these programs as “apology programs” except in the context of quotations from other sources that use the term “disclosure” with identical intention.

<sup>3</sup> Erving Goffman, *On Cooling the Mark Out: Some Aspects of Adaptation to Failure*, 15 PSYCHIATRY 451, 452 (1952).

<sup>4</sup> *Id.*

<sup>5</sup> *Id.* at 455.

<sup>6</sup> *Id.*

<sup>7</sup> *Id.*

programs engage in cooling the mark out. The goal of hospitals that use them is, of course, not to prevent a victim from reporting a crooked game of dice or three-card monte to the police. Instead, modern apology programs appear to cool their marks out as a means of preventing them from speaking to a lawyer and becoming educated about their legal rights.

This Article unfolds in five parts. Part I presents a brief history of apology programs, including their genesis as a calculated attempt to soften the blow from regulatory requirements that forced physicians and institutions to report events of malpractice. Part II develops a typology of the different forms of disclosure programs that have evolved, each of which has become more efficiently designed to restrict a malpractice victim's ability to recover. Part III demonstrates how the current application of medical apology programs is consistent with Goffman's sociological work on cooling the mark out, as well as psychological research on methods of influencing decisions through apologies. Part IV of the Article explains how apology programs create outcomes that are inconsistent with the tort system by influencing patients to receive less compensation than the law entitles them. Part V suggests remedies for the problems created by those who have designed medical apology programs.

### I. THE STORY OF DISCLOSURE PROGRAMS

While proponents of apology programs typically claim that they exist to fulfill an ethical necessity, their creation was far more practical: they were formed as a response to regulatory requirements.<sup>8</sup> The impetus occurred in 1999, when researchers at the Institute of Medicine determined that as many as 98,000 Americans die every year as a result of preventable medical errors.<sup>9</sup> Before that time, apology programs were virtually

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<sup>8</sup> See *CRICO's Perspective*, *supra* note 2, (advocating disclosure because it is the "right thing to do"); ECRI Inst., *Disclosure of Unanticipated Outcomes*, INCIDENT & REPORTING MGMT. 5, at 2 (Jan. 2008), available at [https://www.ecri.org/Documents/Patient\\_Safety\\_Center/HRC\\_Disclosure\\_Unanticipated\\_Events\\_0108.pdf](https://www.ecri.org/Documents/Patient_Safety_Center/HRC_Disclosure_Unanticipated_Events_0108.pdf) (describing disclosure as "appropriate," "ethical," and "the right thing to do").

<sup>9</sup> INST. OF MED., *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* 31 (2000). Subsequent research indicates this figure just scratches the surface of the amount of malpractice that actually occurs. For example, one study found that about 15 million incidents of medical harm—unintended physical injury resulting from medical care—occur annually in the United States. C. Joseph McCannon et al., *Miles to Go: An Introduction to the 5 Million Lives Campaign*, 33 JOINT COMMISSION J. ON QUALITY & PATIENT SAFETY 477, 479 (Aug. 2007). A 2011 study funded by the Institute for Healthcare Improvement found that as many as thirty-three percent of all inpatient stays involve malpractice. David C. Classen et al., *'Global Trigger Tool' Shows that Adverse Events in Hospitals May Be Ten Times Greater than Previously Measured*, 30 HEALTH AFF. 581, 584 (2011). This result is consistent with research results from a federally sponsored United States Department of Health and Human Services study and may, even

unheard of in hospitals.<sup>10</sup> However, the shocking figures catalyzed medical regulators to seek ways to improve patient safety. One effect was that, in 2001, the nation's largest hospital accrediting organization, the Joint Commission on Accreditation of Healthcare Organizations,<sup>11</sup> published a new set of patient safety standards.<sup>12</sup> These standards required medical practitioners to disclose all "unanticipated outcomes," including malpractice, to patients.<sup>13</sup> The cost for failing to disclose errors was steep; facilities whose practitioners did not comply could lose Joint Commission accreditation, effectively putting them out of business.<sup>14</sup>

The Joint Commission's transparency rules caused fear among physicians, risk managers at hospital facilities and insurance executives.<sup>15</sup> They were concerned that, if patients learned of acts of malpractice they would not otherwise know about, they would then have a basis to seek compensation for their injuries.<sup>16</sup>

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still, underrate the amount of malpractice because it is based only on record review and experience has proven that "not all adverse events are documented in the patient record." *Id.* at 586.

<sup>10</sup> See ROBERT D. TRUOG ET AL., TALKING WITH PATIENTS AND FAMILIES ABOUT MEDICAL ERROR 52–56 (2011) (explaining the rise of apology programs in the United States); Nancy Lamo, *Disclosure of Medical Errors: The Right Thing to Do, but What is the Cost?*, LOCKTON COS., LLC 2 (Winter 2011), available at [http://www.lockton.com/Resource/\\_PageResource/MKT/disclosure%20of%20medical%20errors.pdf](http://www.lockton.com/Resource/_PageResource/MKT/disclosure%20of%20medical%20errors.pdf) (describing the cultural shift from deny-and-defend to disclosure at some healthcare organizations). See also Richard C. Boothman et al., *A Better Approach to Medical Malpractice Claims? The University of Michigan Experience*, 2 J. HEALTH & LIFE SCI. L. 125, 131 (2009) (recounting shift from "deny and defend" to transparency after medical errors).

<sup>11</sup> Formerly referred to as "JCAHO," this Article will refer to the organization by its current commonly used moniker, the "Joint Commission."

<sup>12</sup> See JOINT COMM'N, REVISIONS TO JOINT COMMISSION STANDARDS IN SUPPORT OF PATIENT SAFETY AND MEDICAL/HEALTH CARE ERROR REDUCTION (2001).

<sup>13</sup> *Id.* The American Medical Association articulated a similar position, stating that a physician is ethically required to inform the patient when faced with "significant medical complications that may have resulted from the physician's mistake or judgment." AM. MED. ASS'N COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS (1997), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion812.page>.

<sup>14</sup> The Joint Commission is the nation's largest hospital accreditor, certifying more than 19,000 United States medical facilities. *About The Joint Commission*, JOINTCOMMISSION.ORG (last visited July 27, 2011), [http://www.jointcommission.org/about\\_us/about\\_the\\_joint\\_commission\\_main.aspx](http://www.jointcommission.org/about_us/about_the_joint_commission_main.aspx). Accreditation by the Joint Commission or other certifying body is a necessary step before a medical provider can receive payments from Medicare. See 42 C.F.R. § 482 (2010).

<sup>15</sup> Ed Lovern, *JCAHO's New Tell-All; Standards Require that Patients Know About Below-Par Care*, MOD. HEALTHCARE, Jan. 1, 2001, at 2 ("The challenge, of course, will be what liabilities [the Joint Commission's disclosure requirement] may place upon the hospitals and practitioners" given our litigious society, said Greg Wise, M.D., Vice President of Medical Integration at 410-bed Kettering (Ohio) Medical Center).

<sup>16</sup> See Rae M. Lamb et al., *Hospital Disclosure Practices: Results of a National Survey*, 22 HEALTH AFF. 73, 76 (2003) (finding physicians' primary concern about disclosing errors is increased litigation); Albert Wu, *Handling Hospital Errors: Is*

With these changes hanging over them, the medical-insurance industry began using its resources to try to protect itself from being held financially accountable for medical errors. Industry lobbyists exerted influence on lawmakers to create special medical apology shield laws: if a patient chooses not to accept an apology in lieu of money damages, the doctor's apology can never be mentioned in court and the doctor can behave as if he never made the mistake to which he or she admitted.<sup>17</sup> With few legislators or members of the public stopping to ask how these laws will affect injured patients, medical apology shield laws have taken hold in thirty-four states and the District of Columbia.<sup>18</sup>

The apology shield laws come in a variety of forms. Some protect a doctor from allowing a jury to learn about only the apology itself, some protect the doctor from a jury learning that the doctor has admitted fault, and some protect both.<sup>19</sup> Ultimately, however, each of the versions mean that a doctor can make statements related to malpractice and if the patient still wishes to pursue money damages in court, the jury would not be able to learn about it. Financially, they mean that as long as patients do not ask for money, doctors are willing to take responsibility; but when a malpractice victim seeks a legal remedy, the doctor is then free to deny responsibility. As one commentator noted, the rationale for these types of laws exposes the motivations of those that push for them:

One might wonder why physicians and hospitals would seek special protection under the law for being honest with their patients about errors and mistakes. One obvious answer to this question is money, in particular insurance company money. Every doctor and hospital in Massachusetts is insured for damage done by their mistakes. Some

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*Disclosure the Best Defense*, 131 ANNALS INTERNAL MED. 970, 971 (1999) ("Full disclosure could certainly provide an otherwise uninformed patient with a basis for litigation.").

<sup>17</sup> Insurance companies often either employ or foster close ties with lobbyists to sway court rules in their favor. *See, e.g., Affiliations*, GALLAGHER HEALTHCARE (July 12, 2011, 8:35 AM), <http://www.gallaghermalpractice.com/affiliations-endorsements.aspx> (listing seven lobbyist affiliates); *Endorsements*, GALLAGHER HEALTHCARE (July 12, 2011, 8:35 AM), <http://www.gallaghermalpractice.com/affiliations-endorsements.aspx> (listing three lobbyist groups that endorse Gallagher Healthcare insurance agency); MED. LIABILITY MUTUAL INS. COMPANY, <http://www.mlmic.com/portal> (last visited July 12, 2011) ("MLMIC is a respected voice in the State legislature and advocates on behalf of its policyholders on liability insurance and tort reform matters."); *Political Advocacy*, THE DOCTORS COMPANY (July 12, 2011, 8:09 AM), <http://www.thedoctors.com/KnowledgeCenter/PoliticalAdvocacy/index.htm> (explaining The Doctors Company's use of political action committees to advocate and defend tort reform).

<sup>18</sup> Anna C. Mastroianni et al., *The Flaws in State 'Apology' and 'Disclosure' Laws Dilute Their Intended Impact on Malpractice Suits*, 29 HEALTH AFF. 1611, 1612 (2010) (reporting thirty-four states and the District of Columbia have medical apology shield laws).

<sup>19</sup> *Id.* at 1611 (describing different forms of apology shield laws).

insurance companies and risk managers believe, based on studies, that if there are more apologies and admissions of mistakes by health care providers, fewer people will pursue their legal rights, and insurers will have to pay fewer claims. Thus, [apology shield laws] allow medical providers to apologize and admit mistakes so long as they do not have to admit those mistakes when it costs their insurer money. [Apology shield laws] are bad policy, unnecessary and should not be enacted as they tend to hide the truth from the judicial system, while giving health care and providers a free pass to “admit” to mistakes without taking any responsibility for them.<sup>20</sup>

But apology shield laws are not the only measure hospitals employ that lessen the potential financial exposure created by disclosure requirements. More significantly, many insurers and hospital risk management departments have created protocols for doctors to make apologies designed to prevent a case from ever getting to a jury, or even to a lawyer.<sup>21</sup>

The discovery that apology programs could be financially beneficial to the average insurer or hospital was serendipitous. Long before the Joint Commission guidelines changed, the Department of Veterans Affairs hospital at Lexington, Kentucky (“Lexington VAMC”) created their own apology program based on changes to the VA’s internal guidelines.<sup>22</sup> In a subsequent study, data indicated that disclosing errors in specific ways may not result in an increase in the number of malpractice claims or in the amount paid per claim.<sup>23</sup> Its authors did not take too seriously the idea that its principles would be welcomed by

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<sup>20</sup> Benjamin Zimmermann, *When Medical Malpractice Occurs, Sorry Seems to be the Hardest Word*, SUGARMAN L. BLOG (Oct. 20, 2010), <http://www.sugarman.com/blog/2010/10/when-medical-malpractice-occurs-sorry-seems-to-be-the-hardest-word/>.

<sup>21</sup> See *infra* Part II (describing apology programs instituted at hospitals). Even though many American hospitals are nominally “non-profit,” their risk management departments are akin to for-profit insurance companies. The job of hospital’s “bottom-line oriented” risk management team is “to protect the financial assets of the hospital from claims asserted through the tort system.” Stephan Landsman, *The Risk of Risk Management*, 78 *FORDHAM L. REV.* 2315, 2316 (2010). A hospital’s risk managers are, by contractual requirement, in league with the malpractice insurers that represent its doctors. Their mission is to “oversee the institution’s relationship with those providing insurance coverage to pay awards made against the hospital for medical malpractice.” *Id.* at 2317. In fact, this cooperation is contractually required and, as a result, the “required cooperation has serious implications for the care provided to patients after they have suffered injury at the hands of the medical staff. The chief goal shifts from providing treatment to ‘paying as little money in settlements as possible . . .’” *Id.* As a result, it makes no difference whether the information about apology programs comes from risk managers in a hospital or from the insurance company itself. Both are focused on legal liability and money, not the actual provision of medical care.

<sup>22</sup> See *infra* notes 28–33 and accompanying text (discussing the VA’s guidelines for disclosure of unanticipated medical outcomes).

<sup>23</sup> See *infra* notes 34–41 and accompanying text (discussing the results of a study of Lexington VAMC disclosure program).

hospitals outside of the VA system.<sup>24</sup> However, once the Joint Commission ruled, all hospitals subject to their authority had little choice but to consider it.

Subsequent studies supported the idea that many patients were willing to accept a fraction of the amount of money they would get in a malpractice suit if the doctor simply apologized.<sup>25</sup> In response, risk managers began to get serious about examining apology programs much more closely and, once convinced of their pecuniary benefits, began telling the public that they were a moral imperative.<sup>26</sup>

## II. REPRESENTATIVE MODELS FOR APOLOGY PROGRAMS

This part of the Article explains the workings of representative apology programs in the United States. It begins with a discussion of the Lexington VAMC's early experience, which disclosed errors to patients and also took measures to expressly advise the patient to seek legal counsel for what has become both a medical and legal issue.

The Lexington VAMC program is important because it is the precursor to the models of apology programs currently employed in the United States. It is also perhaps the last widely publicized program in the United States that included in its published protocol the need to advise unrepresented patients to seek legal counsel before confronting them with an apology and a set of decisions that would have legal consequences for them.

Once the Joint Commission mandated that facilities disclose acts of malpractice, insurers had no choice but to admit acts of malpractice. The VA program, having already created a path, became a model for others, which made subsequent adaptations to further tilt the process of admitting an act of malpractice in their financial favor. This sub-section then goes on to explore the workings of two of these modern programs, the COPIC 3Rs program and the University of Michigan Health Services ("UMHS") model.

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<sup>24</sup> See Steven S. Kraman & Ginny Hamm, *Risk Management: Extreme Honesty May Be the Best Policy*, 131 ANNALS OF INTERNAL MED. 963, 966 (1999), available at <http://www.annals.org/content/131/12/963.full.pdf> ("If there is a barrier to the adoption of a humanistic risk management policy by nongovernmental hospitals, it may be the involvement of many private malpractice insurers, each of which is interested in paying as little money as possible. We believe that these insurers would have to be convinced of the economical benefits of such a policy before they would consider adopting it.")

<sup>25</sup> See *infra* Part III (discussing how apologies affect victims' willingness to settle).

<sup>26</sup> See *infra* Part III (discussing psychological effects of apology programs). See also note 8 (quoting sources regarding ethical necessity of apology programs).

### A. Lexington, Kentucky VA Hospital

Prior to the Joint Commission's disclosure mandate, only one study had evaluated the effectiveness of an American medical malpractice apology program.<sup>27</sup> In 1995, the Department of Veterans Affairs rewrote its policy manual to mandate disclosure to patients who had suffered an unanticipated outcome.<sup>28</sup> In the event of an unanticipated outcome, the rules required that the medical center inform the patient and/or the family, as appropriate, of the event, and assure them that medical measures have been implemented and that additional steps are being taken to minimize disability, death, inconvenience, or financial loss to the patient or family.<sup>29</sup>

In response, the Lexington VAMC created a protocol so that when the hospital's risk management committee found that a doctor had committed malpractice, they would invite the injured patient to the hospital.<sup>30</sup> When doing so, they would tell the patient that he or she was welcome to bring an attorney.<sup>31</sup> When the patient arrived, the physician would explain what happened, express regret, answer any questions and "make an offer of restitution, which can involve subsequent corrective medical or surgical treatment, [and] assistance with filing for [disability] or monetary compensation."<sup>32</sup> The hospital would negotiate with the patient and, in the event the patient had not retained a lawyer and needed claims assistance, the hospital would help get forms to file and once again advise the patient to seek independent counsel.<sup>33</sup>

Researchers tracked the Lexington VAMC's data to test the impact of its apology policy.<sup>34</sup> They determined that during a seven-year period (1990–1996) of studying the Lexington VAMC's apology program, the facility's payments were "moderate" and "comparable to those of similar facilities."<sup>35</sup> Thus, when injured patients were invited to bring legal counsel to discuss the doctor's error and potential financial resolutions, the study suggested

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<sup>27</sup> See Benjamin Ho & Elaine Liu, *Does Sorry Work? The Impact of Apology Laws on Medical Malpractice* 3 (Johnson Sch. Research Paper Series, Paper No. 04-2011), available at <http://ssrn.com/abstract=1744225>.

<sup>28</sup> Kraman & Hamm, *supra* note 24, at 964.

<sup>29</sup> *Id.*

<sup>30</sup> *Id.* at 967.

<sup>31</sup> *Id.*

<sup>32</sup> *Id.*

<sup>33</sup> *Id.*

<sup>34</sup> *Id.* at 964.

<sup>35</sup> *Id.* at 964, 966.



that the injured patients' claim received roughly the same amount of money as in a traditional deny/defend situation.<sup>36</sup>

The program also provided other benefits, like diminishing the injured patient's anger and allowing for a continuing positive relationship between doctor and patient.<sup>37</sup> The study's authors also noted that their approach provided dramatic pecuniary benefits by avoiding unnecessary litigation expenses.<sup>38</sup> They estimated that it costs the government \$250,000 to litigate a single malpractice case (for medical experts, travel, appeal, incidental expenses). By contrast, their new apology procedures required only an attorney, a paralegal to assist, and a few other hospital employees.<sup>39</sup>

The Lexington VAMC research suggests that patients who are malpractice victims and who are invited to bring an attorney to negotiate on their behalf fare equally as well economically as those that pursue more traditional litigation methods. The added benefit is that the process happens more quickly, with lower litigation costs and a legitimately ethical exchange that is focused on the patient. The Lexington VAMC study's authors predicted that it would take much more proof of an economic benefit before nongovernmental facilities would participate.<sup>40</sup> The barrier they identified is the involvement of private malpractice insurers, "each of which," as the authors put it, "is interested in paying as little money in settlement as possible."<sup>41</sup>

The Lexington VAMC representatives' prediction that their policy would be met with skepticism proved true. For example, after the Joint Commission's disclosure requirement came into effect, ECRI, a non-profit think-tank, expressed skepticism that other facilities would voluntarily use an apology program: "There are many who believe the experience of a VA hospital cannot be replicated in the private sector because the VA, unlike the private sector, has federal tort protections."<sup>42</sup>

Reflecting the profit motivation of nongovernmental insurers, the Lexington VAMC program is the last one for which there has been published research that specifically recommended that patients seek counsel before filing a claim. The newer generation of apology programs includes some protections that

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<sup>36</sup> *See id.* at 965–66.

<sup>37</sup> *Id.* at 966.

<sup>38</sup> *Id.*

<sup>39</sup> *Id.*

<sup>40</sup> *Id.*

<sup>41</sup> *Id.*

<sup>42</sup> ECRI Inst., *supra* note 8, at 12.

appear patient-friendly on their face, but remain adversarial at their core.

## B. Two Examples of Current Apology Programs

Since the finding that apology programs can be used as a money-saving strategy, various insurance companies and hospitals have instituted them. This section focuses on two examples that represent common practices in the medical field today: COPIC and UMHS. While they operate separately, common concerns are ultimately raised by each model as they both include mechanisms that appear designed to pay injured patients as little money as possible. Further, they both encourage collaborative interpersonal behavior, but treat the financial aspect of claims handling as adversarial.

### i. COPIC

One of the models that apology advocates most commonly cite is COPIC's 3Rs program ("Recognize, Respond, Resolve").<sup>43</sup> COPIC is the primary insurer for Colorado physicians and, under the 3Rs program, patients who suffer from an "unanticipated outcome" can be offered up to \$100 a day (capped at \$5000) for their absence from work and reimbursement for out-of-pocket medical expenses of up to \$25,000.<sup>44</sup> COPIC defines their program as a "no-fault" program, meaning that they consider patients eligible regardless of whether there is clear malpractice.<sup>45</sup> Cases involving "never events," which are acts of clear malpractice (e.g., amputating the wrong leg), do not qualify for the 3Rs program.<sup>46</sup> Instead, the program leaves open the

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<sup>43</sup> Thomas H. Gallagher, David Studdert & Wendy Levinson, *Disclosing Harmful Medical Errors to Patients*, 356 NEW ENG. J. MED. 2713, 2716 (2007) ("The best-known private-sector disclosure program is the '3Rs' program at COPIC."). See also *Medical Liability: New Ideas for Making the System Work Better for Patients: Hearing Before the S. Comm. on Health, Educ., Labor and Pensions*, 109th Cong. 25 (2006) [hereinafter *Medical Liability*] (statement of David Studdert, Associate Professor of Law and Public Health, Harvard University Sch. of Public Health) (offering a health court proposal with the first level of review "proceed[ing] along the lines developed by the insurer COPIC (the '3-R's' program)").

<sup>44</sup> Press Release, COPIC, Clarke Joins Colo. Health Found. Bd. (Jan. 7, 2011), available at <http://www.callcopic.com/who-we-are/press-room/press-room-detail?id=16>; *3Rs Program*, COPIC (last visited May 18, 2011), <http://www.callcopic.com/home/what-we-offer/coverages/medical-professional-liability-insurance-co/physicians-medical-practices/special-programs/3rs-program/>.

<sup>45</sup> Even champions of apology programs question the viability of a no-fault program like COPIC's. For example, the UMHS program's architect and leader, Attorney Richard Boothman, testified before Congress that: "Alternatives loosely characterized as 'no fault' systems will not work. The medical and insurance communities will not be fairly served by creating an entitlement not based on the reasonableness of care." *Medical Liability*, *supra* note 43 (statement of Richard C. Boothman, Chief Risk Officer, UMHS).

<sup>46</sup> See Richard E. Quinn & Mary C. Eichler, *The 3Rs Program: The Colorado Experience*, 51 CLINICAL OBSTETRICS & GYNECOLOGY 709, 710 (2008) (recounting COPIC history and the exclusion of NQF's "never events").

ability for COPIC to quickly resolve murkier cases that may or may not have been the result of malpractice.

The rules of program eligibility indicate that the program seems intended to avoid reporting insured doctors' malpractice to regulatory authorities. For example, under the 3Rs program, there can be no payments made for non-economic damages.<sup>47</sup> Another rule specifically prevents a patient from involving an attorney, and yet another rule disqualifies any patient who asks for money in writing.<sup>48</sup> Any of these events would require reporting to the National Practitioners Data Bank.<sup>49</sup> Thus, by precluding anyone from participation who would otherwise seek a lawyer or write a demand letter, COPIC can skirt reporting malpractice.

The advocates for 3Rs might defend their program by claiming that if patients participate in the COPIC program, they may still theoretically pursue a malpractice claim because COPIC does not require patients to sign a release.<sup>50</sup> However, the data indicates that not forcing a release is nearly irrelevant because COPIC's research has shown that even without a release, fewer than twenty-four out of every twenty-five participants do not pursue a claim after going through their program.<sup>51</sup> Even more troubling, the decision not to require a release from patients appears motivated by selfish reasons, as requiring a release would force COPIC to report the settlement to state and federal regulators, which they are able to avoid by calling it a "no-fault" program.<sup>52</sup>

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<sup>47</sup> *Id.* Payment for non-economic damages may also force COPIC to admit the incident was a result of negligence, thus preventing the carrying-on of the fiction that they make payments regardless of whether negligence was involved.

<sup>48</sup> See *A Success Story*, 1 COPIC'S 3RS PROGRAM (COPIC Ins. Co., Denver, Colo.), Mar. 2004 (listing exclusions from participation to include patients who have sent a "[d]emand letter" and stating that "payments are not reported to the National Practitioner Data Bank because they are not made in response to a written demand for monetary compensation"). See also Carol Anne Tarrant, Dir., Facility Patient Safety and Risk Mgmt., *COPIC's 3Rs Program: Recognize, Respond to and Resolve Patient Injury*, COPIC 18 (Apr. 30, 2010), <http://www.capsac.org/documents/Tarrant.CA.pdf> (stating that among the incentives for doctors to participate in 3Rs is no reporting to NPDB (National Practitioners Data Bank) or CBME (Colorado Board of Medical Examiners)).

<sup>49</sup> See *Tarrant*, *supra* note 48, at 18.

<sup>50</sup> Quinn & Eichler, *supra* note 46, at 710.

<sup>51</sup> *Case Studies: Focus on Disclosure*, 3RS PROGRAM (COPIC Tr., Denver, Colo.), May 2011, at 1, available at [www.callcopic.com/resources/custom/PDF/3rs-newsletter/3rs-may-2011.pdf](http://www.callcopic.com/resources/custom/PDF/3rs-newsletter/3rs-may-2011.pdf) ("Our continuing experience is that only 3.4 percent of 3Rs cases with reimbursements to patients subsequently result in malpractice claims or lawsuits. Also, only 0.5 percent of such reimbursed 3Rs cases receive additional payments via malpractice claims or lawsuits.").

<sup>52</sup> Bruce D. Gehle, *A Quick Check on the Impact of Apology Laws on Claims and Costs of Medical Malpractice*, 11 HEALTHCARE LIABILITY & LITIG., May 2009, at 1, 2.

The idea that 3Rs is only for “minor” cases is also misleading. They purport to be a “limited program designed to handle outcomes that are unlikely to involve serious negligence or injury”; the facts suggest that this claim is misleading.<sup>53</sup> While the 3Rs program does exclude death claims and “never events,” the evidence suggests that COPIC still uses the 3Rs program on cases involving very serious claims.<sup>54</sup> In one account, which COPIC fictionalized, but was of the magnitude “often dealt with in COPIC’s 3Rs Program,” a 41-year-old patient underwent a colonoscopy and suffered a perforation to his colon as a result.<sup>55</sup> After the colonoscopy, the patient had severe abdominal pain due to “free air” (indicating the doctor punctured the patient’s colon during the colonoscopy).<sup>56</sup> As a result, the surgical team then had to perform additional surgery to repair the hole in the man’s colon.<sup>57</sup> This resulted in the patient being hospitalized for four additional days and missing “approximately six weeks of work.”<sup>58</sup> Despite their rhetoric, additional surgery, four days as an inpatient, and six weeks of missed work cannot reasonably be considered “not serious.”

Despite the ethical problems it poses, the 3Rs program has been effective in dissuading patients from seeking the damages they would be entitled to under more traditional litigation channels. For example, in 2003, the payments to patients under the 3Rs Program averaged \$1820, as opposed to an average cost of more than \$250,000 for traditionally-handled claims handled by the same insurer.<sup>59</sup>

Beyond under-compensating malpractice victims, the broader impact of the 3Rs program has not been studied. Specifically, the rules under which the program operates—from not allowing attorney involvement to refusing to allow a patient who has written a letter from participating—seem designed to

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<sup>53</sup> *Id.*

<sup>54</sup> See, e.g., *Success Story*, 3 COPIC’S 3RS PROGRAM (COPIC Ins. Co., Denver, Colo.), June 2006, available at <http://www.callcopic.com/resources/custom/PDF/3rs-newsletter/vol-3-issue-1-jun-2006.pdf> (recounting a potentially grave injury addressed by the 3Rs program).

<sup>55</sup> *Id.*

<sup>56</sup> *Id.*

<sup>57</sup> *Id.*

<sup>58</sup> *Id.*

<sup>59</sup> *Will Apologies to Patients Drive Malpractice Lawyers Out of Business?*, MED LEGAL NEWS (Med League Support Servs., N.J.), June 2006, at 2, available at <http://www.medleague.com/Articles/Newsletters/newsletter26.pdf>. This approach has apparently been similarly effective in dissuading patients from seeking damages in other years. For example, a 2005 article quotes a COPIC representative who states that “the average payment in 3Rs cases is \$5586, while the average outside the program is about \$284,000.” Deroy Murdock, “Sorry” Works, NAT’L REV. ONLINE (Aug. 29, 2005, 8:03 AM), <http://www.nationalreview.com/articles/215270/sorry-works/deroy-murdock>.

discourage responsible reporting. In turn, this weakens practitioner accountability and potentially harms patients who subsequently are treated by doctors that have committed malpractice but have not been investigated by the appropriate agencies as a result.

ii. UMHS

The most commonly referenced apology program today is the University of Michigan Healthcare Services' model. UMHS purports to provide quick compensation for viable claims, defend claims they view as non-meritorious and "[r]educ[e] patient injuries . . . by learning from patients' experiences."<sup>60</sup> The architect of the UMHS program is Attorney Richard Boothman, who spent two decades as a medical malpractice defense lawyer before assuming his risk management post at UMHS.<sup>61</sup> Attorney Boothman has become one of the most prominent proponents of apology programs in the United States.<sup>62</sup>

UMHS's philosophy is consistent with the concept of "cooling the mark out."<sup>63</sup> The underlying basis for the program is their belief that people pursue malpractice claims because they seek an explanation for their injury and have a desire to hold the responsible person accountable.<sup>64</sup> To respond to that, UMHS created a system "more directly aimed at what drives a patient to call a lawyer [which] would better address the root cause of the problem."<sup>65</sup> Unlike COPIC, UMHS does allow patients to seek legal advice, although the organization does not do so routinely.<sup>66</sup> UMHS is a self-insured facility, which they state allows for "consistency and alignment of ethical and financial motivation[s] between the hospital, care provider, and insurer" which they consider an "important advantage."<sup>67</sup> However, their program does not have any built-in protection for patients against the conflict of interest this creates. Instead, one must take it on faith that UMHS's risk management department is capable of acting against the facility's own financial interests and fully and fairly compensating injured patients.

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<sup>60</sup> Boothman et al., *supra* note 10, at 139.

<sup>61</sup> *Biography*, U. MICH. HEALTH SYS. (last visited Sept. 25, 2011), <http://surgery.med.umich.edu/portal/research/faculty/boothman.shtml>.

<sup>62</sup> *Biography*, *supra* note 61.

<sup>63</sup> See *infra* Part III(A) (explaining the concept of "cooling the mark out" and how UMHS's model squares with it).

<sup>64</sup> Boothman et al., *supra* note 10, at 134.

<sup>65</sup> *Id.*

<sup>66</sup> E-mail from Richard C. Boothman, Chief Risk Officer, UMHS, to author (Aug. 10, 2011, 14:16 EDT) (on file with author) ("We have overtly advised patients to have lawyers . . . but we do not routinely advise them to get a lawyer.")

<sup>67</sup> Boothman et al., *supra* note 10, at 137.

UMHS does not publish their strategy for approaching the negotiations with the patients to whom they apologize. However, a vignette UMHS uses to explain the mechanisms of their program suggests that an adversarial mindset underlies the program.<sup>68</sup> In its literature, UMHS tells the story of JW, a thirty-six year-old mother of two.<sup>69</sup> In 2003, she presented to her primary care physician's office that she had found a lump in her breast.<sup>70</sup> No follow-up was ordered by the doctor.<sup>71</sup> Two years later, JW was diagnosed with breast cancer.<sup>72</sup> It was treated with a complete mastectomy and radiation therapy.<sup>73</sup> Her primary care doctor, one year later, "described her as disabled due to chronic fatigue syndrome, depressed, suffering chronic shoulder pain, and plagued by anxiety," because of a perceived increased likelihood of recurrence of cancer.<sup>74</sup>

The UMHS internal investigation committee found that the care JW received was sub-par for many reasons.<sup>75</sup> Three of its reviewers said that the decisions her primary care doctor made were below the standard of care.<sup>76</sup> Some reviewers believed there were ways to defend the case (including blaming JW for not returning for care more aggressively), but admitted "they would have handled it differently and [they] expected more of their colleagues under the same or similar circumstances."<sup>77</sup>

By its own estimate, UMHS believed that the case had a value of somewhere between \$3.1 and \$3.7 million if JW won.<sup>78</sup> Factoring in the chance of a plaintiff's verdict at trial, which UMHS believed was likely, they determined that the case should settle for somewhere between \$2,635,000 and \$3,145,000.<sup>79</sup>

UMHS met with JW, along with her husband and their attorney.<sup>80</sup> UMHS brought one of its risk management

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<sup>68</sup> *Medical Malpractice and Patient Safety at UMHS*, U. MICH. HEALTH SYS. (last visited Sept. 20, 2011), <http://www.med.umich.edu/news/newsroom/mm.htm#summary> ("Our approach can be summarized as: 'Apologize and learn when we're wrong, explain and vigorously defend when we're right, and view court as a last resort.'").

<sup>69</sup> Boothman et al., *supra* note 10, at 151.

<sup>70</sup> *Id.*

<sup>71</sup> *Id.*

<sup>72</sup> *Id.*

<sup>73</sup> *Id.*

<sup>74</sup> *Id.* at 152, 157.

<sup>75</sup> *Id.* at 152 ("All reviewers agreed the covering doctor's care . . . was below expectations for UMHS faculty. Three reviewers said that the decision not to follow up on JW's concerns with mammography and referral to a surgeon was a violation of the standard of care.").

<sup>76</sup> *Id.*

<sup>77</sup> *Id.*

<sup>78</sup> *Id.* at 155.

<sup>79</sup> *Id.*

<sup>80</sup> *Id.* at 157. That JW was allowed to have an attorney participate is a positive

consultants (most of whom are trained mediators).<sup>81</sup> At the outset of the meeting, UMHS apologized to JW.<sup>82</sup> JW's emotions warmed because of UMHS's collaborative demeanor.<sup>83</sup> JW asked if UMHS would settle the case for \$2 million, a figure considerably less than UMHS's projected settlement value.<sup>84</sup> In response, UMHS accused JW of being "unreasonable" and inflating the value of her claim.<sup>85</sup> JW reduced her settlement demand to \$1.2 million, less than half of UMHS's original estimate, but UMHS again refused.<sup>86</sup> Eventually, UMHS's tactics prevailed, with JW electing to accept UMHS's \$400,000 settlement offer.<sup>87</sup>

As a result, the apology program made it so that a case that UMHS initially believed had a value of between \$2.6 and \$3.1 million, settled for only \$400,000.<sup>88</sup> This amount would cover the cost of JW's children's college expenses, about which JW expressed concern when she learned that her doctor's malpractice might result in her death.<sup>89</sup> By UMHS's initial estimate, the \$400,000 for which JW settled did not cover her future medical costs, lost wages/benefits caused by their doctor's negligence, nor any non-economic damages for the emotional impact for JW's ordeal.<sup>90</sup>

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advance beyond COPIC's 3Rs program, which would disqualify the patient if she hired counsel. *See* Quinn & Eichler, *supra* note 46, at 710 ("If there was any attorney involvement, 3Rs benefits and involvement would cease."). The point of including this vignette is to demonstrate that UMHS's procedures remain fundamentally adversarial, not to accuse UMHS of refusing to allow JW to seek representation. Although the legal advice JW's attorney provided seems sub-par (as discussed below, JW ultimately settled the case for pennies on the dollar prior to discovery), that is hardly UMHS's fault.

<sup>81</sup> Boothman et al., *supra* note 10, at 157.

<sup>82</sup> *Id.*

<sup>83</sup> *Id.* at 158 ("After that night (of the meeting), I left there like I was on a mountaintop. I felt like I had finally been heard, they listened.").

<sup>84</sup> *Id.* at 156.

<sup>85</sup> *Id.* ("The plaintiff's lawyer's economic assessment was critically reviewed by an economist expert retained by UMHS and a contra-assessment was prepared, pointing out unreasonable assumptions and inflated calculations.").

<sup>86</sup> *Id.* at 157.

<sup>87</sup> *Id.*

<sup>88</sup> *Id.* at 155, 157.

<sup>89</sup> *Id.* at 156, 157.

<sup>90</sup> *Id.* at 155. UMHS also claimed that JW, because of UMHS's disclosure and approach to resolution, did not suffer pain and suffering that she would have if they had used the traditional "deny and defend" approach to her claim. Although emotional stress resulting from the litigation process is not compensable in the civil justice system, UMHS's claim that avoiding the stress of litigation benefited JW is certainly a good thing, although it would have no impact on the value of her case at trial. *See, e.g., Ortega v. Pajaro Valley Unified Sch. Dist.*, 75 Cal. Rptr. 2d 777, 800 (1998) (holding that damages may not be awarded for "litigation stress").

This outcome was a good result in the sense that JW was pleased with it.<sup>91</sup> However, the vignette leaves open several questions that should be vitally important to consider:

- In whose interest was UMHS acting when it paid JW \$400,000 in a settlement it viewed as being worth more than seven times that amount?
- If JW is unable to pay her future medical costs (which UMHS estimated to be \$250,000–\$400,000) as a result of accepting this settlement, who will do so?
- How will JW and her family be compensated for the \$2,350,000–\$2,750,000 in lost wages and benefits that UMHS estimated she suffered as a result of its doctor's negligence if she becomes unable to work?

Because UMHS selectively releases data on their program, it is unclear whether JW's experience in the apology program was representative. Even the statistics that UMHS publishes makes it difficult to see what happens to individual claims with merit. For example, a recent article written by Attorney Boothman and others reported some aspects of the financial effects of UMHS's apology program.<sup>92</sup> They reported that after UMHS implemented the apology program, the overall number of claims dropped, as did the amount of money spent both defending claims and compensating patients.<sup>93</sup> The study did not report, however, statistics explaining whether individual patients that made claims were compensated less after the program was implemented. In other words, it has not been made public whether patients with valid claims for malpractice are giving up some compensation to which they are entitled in exchange for the warm discussions UMHS provides. If the small glimpse provided by JW's case is a representative of what UMHS does, then the organization derives significant financial benefits by paying less money to patients injured by medical errors.<sup>94</sup>

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<sup>91</sup> Boothman et al., *supra* note 10, at 158 ("I was perfectly satisfied after that night. What that apology meant to me was that they had listened finally and I had been heard."). UMHS also seems to indicate that the act of taking part in the apology process had a positive medical outcome on JW and drove her damages down. *Id.* at 156–58. The basis for this is that JW's position during negotiation was that her malpractice-related injuries were disabling. *Id.* at 152. However, after the negotiations were completed, she returned to work. *Id.* at 158. The idea that this negotiation single-handedly transformed JW from being totally and permanently disabled to someone who could immediately resume her prior life is simply unsupported by any evidence other than UMHS's say-so.

<sup>92</sup> Allen Kachalia et al., *Liability Claims and Costs Before and After Implementation of a Medical Error Disclosure Program*, 153 ANNALS INTERNAL MED. 213, 213 (2010).

<sup>93</sup> *Id.* at 215, 217–19.

<sup>94</sup> See Boothman et al., *supra* note 10, at 151–58.



When Attorney Boothman testified before the United States Senate in 2006, he cited the dramatic successes of the UMHS program in lowering costs and reducing the time of claim-completion.<sup>95</sup> He noted that physicians need to ask, “Why would my patient feel the need for an advocate?”<sup>96</sup> Although this question was undoubtedly meant to be rhetorical, it requires an actual answer: Patients need an advocate because programs like UMHS have attorneys whose primary obligation is to protect the assets of their organization. This dynamic results in what is, in actuality, an adversarial environment that simply uses collaborative language. Without legal advice of their own, patients who take part in apology programs must trust that risk managers would violate their obligation to their own employer (of keeping overall costs low), in order to give them an appropriate settlement. There is simply no evidence that this has, or will, occur and no program has released any data to that effect.

Yet, it should not be lost that the UMHS model does most of the things a good disclosure program should do (including many things COPIC would refuse to allow): it advises the patient of what happened, allows the patient to seek legal counsel (although it does not necessarily advise it), increases the speed of settlement negotiations to keep costs low, and so on.<sup>97</sup> Ultimately, though, stories like that of JW also expose its underlying adversarial nature.

### III. CONVINCING PATIENTS THAT LESS MONEY IS BETTER

Because program administrators will not admit to it, it cannot be said with absolute certainty that medical apology programs are specifically designed to exploit the research on influencing patients to accept less compensation for valid injuries caused by malpractice. However, what can be said with accuracy is that what apology programs are willing to publish about their approach makes their behavior at least appear to be consistent with the research on how to influence people to control an outcome in a negotiation.

#### A. Cooling the Mark Out

In 1952, Erving Goffman explained that when con men “cool the mark out,” as a method of preventing their dissatisfied victim from complaining to the authorities, they use a variety of

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<sup>95</sup> *Medical Justice*, *supra* note 43, at 4.

<sup>96</sup> *Id.* at 7.

<sup>97</sup> *See generally* Boothman et al., *supra* note 10, at 137–50.

methods.<sup>98</sup> In its most basic form, cooling the mark out requires that “one of the operators stays with the mark and makes an effort to keep the anger of the mark within manageable and sensible proportions . . . and exercises upon the mark the art of consolation.”<sup>99</sup> In other words, the primary function of the “cooler”—the person tasked with consoling the mark—is “to define the situation for the mark in a way that makes it easy for him to accept the inevitable” and quietly move on without causing unwanted negative attention for the con men.<sup>100</sup>

Goffman envisioned cooling the mark out as being applied in all sorts of social relationships.<sup>101</sup> Even legitimate organizations, according to Goffman, have a need to cool out customers.<sup>102</sup> In the medical industry, Goffman noted that doctors frequently serve as coolers to break bad news to patients as a way to control their response.<sup>103</sup> The doctor is often the one to do this because it is advisable to “give the task to someone whose status relative to the mark will serve to ease the situation in some way.”<sup>104</sup> The doctor-patient relationship involves just this sort of disparate social status. As a result, it should come as no surprise that apology programs frequently use a doctor to have a discussion with the patient.<sup>105</sup>

Goffman said that the effectiveness of cooling the mark out rests in creating a system that allows the mark, “under suitable guidance, to give full vent to his initial shock.”<sup>106</sup> In other words,

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<sup>98</sup> See Goffman, *supra* note 5, at 452.

<sup>99</sup> *Id.*

<sup>100</sup> *Id.*

<sup>101</sup> *Id.* at 456. Others have applied the concept of cooling the mark out to different contexts. For example, some see the role of junior/community college administrators to be coolers for students who are not “college material.” Burton R. Clark, *The “Cooling-Out” Function in Higher Education*, 65 AM. J. SOC. 569, 569 (1960). Others have studied the process of women who cool out undesirable male suitors at singles bars. See, e.g., David A. Snow et al., *“Cooling Out” Men in Singles Bars and Nightclubs: Observations on the Interpersonal Survival Strategies of Women in Public Places*, 19 J. CONTEMP. ETHNOGRAPHY 423, 423 (1991). The process of cooling out has been studied in legal contexts, including the role of criminal defense attorneys who must prepare their clients to accept a jail sentence. Abraham S. Blumberg, *The Practice of Law as Confidence Game: Organizational Cooptation of a Profession*, 1 L. & SOC’Y REV. 15, 27 (1967). Cooling out has even subtly been employed in popular entertainment. In the hit 1989 film, *Road House*, Dalton (played by Patrick Swayze) is a professional “cooler” who uses his expertise in psychology and New York University philosophy degree to combat a group of violent nightclub patrons who are disrupting a small town bar, the “Double Deuce,” and the surrounding community. *ROAD HOUSE* (United Artists 1989).

<sup>102</sup> Goffman, *supra* note 5, at 455.

<sup>103</sup> *Id.* at 457.

<sup>104</sup> *Id.*

<sup>105</sup> See, e.g., Boothman et al., *supra* note 10, at 142 (describing physician-delivered disclosure and apology at UMHS); Quinn & Eichler, *supra* note 46, at 713 (describing the value of direct physician/patient disclosure and apology at COPIC).

<sup>106</sup> Goffman, *supra* note 5, at 458.

the mark is encouraged to articulate their righteous anger and move beyond the situation at hand. This part of the process is specifically spelled out in various apology protocols. For example, in the *SorryWorks!*<sup>107</sup> model, diffusion of answer is defined as the first thing that a doctor should understand about effective apologies: “The key is anger . . . disclosure [sic] and apology keep a lid on anger, whereas traditional deny and defend risk management strategies increase anger felt by patients & families, and increase the likelihood of costly litigation.”<sup>108</sup> When they provide this advice, *SorryWorks!* recognizes that its function is not to increase a patient’s knowledge or the doctor-patient relationship. Instead, their reason is financial: “An enormous & growing body of data is showing that disclosure coupled with apology (when appropriate) actually reduces lawsuits, litigation expenses, and settlements/judgments.”<sup>109</sup> In other words, allowing the patient to vent is a money-saver for hospitals and insurers at patients’ expense.

One specific technique Goffman notes is that the cooler can effectuate the process by assigning a new role to the mark.<sup>110</sup> Medical apology programs do this as well, at times asking patients who have been cooled out to tell their story and encourage others to do the same. For example, JW, the cancer survivor about whom UMHS wrote, was enlisted to film a video extolling UMHS’s apology program and her satisfaction with it.<sup>111</sup>

Coolers themselves sometimes need to be convinced to follow their role because of internal conflict about what they are doing to the mark. To be able to participate in cooling out, Goffman found that the cooler “protects himself from feelings of guilt by arguing that the customer is not really in need of the service he expected to receive . . . and complaints are a sign of bile, not a sign of injury.”<sup>112</sup> The apology literature is replete with rationalizations that the pursuit of damages for malpractice is often based upon an injured patient’s anger.<sup>113</sup> Likewise, the

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<sup>107</sup> *SorryWorks!* is an “advocacy organization for disclosure, apology (when appropriate), and upfront compensation (when necessary) after adverse medical events.” *About Us*, SORRYWORKS! (last visited Sept. 25, 2011), <http://www.sorryworks.net/about.phtml>.

<sup>108</sup> *5 Things Every Doctor Should Know About Disclosure!*, SORRYWORKS! (last visited Aug. 10, 2011), <http://sorryworks.net/fivethings.phtml> [hereinafter *5 Things*].

<sup>109</sup> *5 Things*, *supra* note 108.

<sup>110</sup> Goffman, *supra* note 5, at 456–57.

<sup>111</sup> Boothman et al., *supra* note 10, at 157.

<sup>112</sup> Goffman, *supra* note 5, at 455.

<sup>113</sup> See, e.g., Boothman et al., *supra* note 10, at 133 (explaining patients file suit when they feel lied to or misled); Kraman & Hamm, *supra* note 24, at 963 (illustrating reasons patients file suit, including breakdowns in the doctor/patient relationship due to physicians’ failure to disclose errors).

literature on apologies is filled with rhetoric about patients and lawyers injured by malpractice seeking “big bucks,” presumably for injuries that do not justify it.<sup>114</sup> This language used by apology programs supports Goffman’s theory that those involved from the medical perspective seek justifications that allow them to inoculate themselves from the guilt associated with the process.

### B. The Psychology of Apology

Not only does Goffman’s explanation of cooling the mark out appear consistent with the strategy of medical apology programs, psychologists have also explained how apologies affect individuals’ interpretations of an incident that gave rise to their legal claim, as well as their decision to seek legal advice for it.<sup>115</sup> In summary, the findings show that not only is a person less likely to pursue litigation following a doctor’s apology, but even if a patient does still pursue money damages, the patient is likely to adopt a more pliant negotiating position.<sup>116</sup> This generalized research squares with the research performed by apology programs themselves. For example, UMHS’s research found that of the patients that participate, “71% admitted that they accepted less in settlement than they would have had they litigated the case.”<sup>117</sup>

A leading scholar on the role of apology in the law, Professor Jennifer Robbennolt of the University of Illinois, has written a series of works exploring the role of apologies in litigation.<sup>118</sup>

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<sup>114</sup> See, e.g., Quinn & Eichler, *supra* note 46, at 709–10 (“Only one third of dollars actually reach injured parties. At the same time, it seemed truly substandard care was not reliably identified by the legal system. Furthermore, this system was inherently adversarial almost always destroying the physician/patient relationship.”).

<sup>115</sup> See Jennifer K. Robbennolt, *Apologies and Civil Justice*, in CIVIL JURIES AND CIVIL JUSTICE: PSYCHOLOGICAL AND LEGAL PERSPECTIVES 195, 197 (Brian H. Bornstein et al. eds., 2008) [hereinafter Robbennolt, *Civil Justice*]. “A growing body of studies suggests that apologies do influence claimant decision making in a number of ways, including decisions to consult attorneys for advice, decisions about whether or not to file suit, judgments about negotiating positions, and ultimate decisions about settlement.” *Id.* at 209.

<sup>116</sup> See Jennifer K. Robbennolt, *Apologies and Settlement Levers*, 3 J. EMPIRICAL L. STUD. 333, 333 (2006) [hereinafter Robbennolt, *Settlement Levers*].

<sup>117</sup> J. Sybil Biermann & Richard Boothman, *There Is Another Approach to Medical Malpractice Disputes*, 4 J. ONCOLOGY PRAC. 148, 148 (2006).

<sup>118</sup> See, e.g., Jennifer K. Robbennolt, *Apologies and Legal Settlement: An Empirical Examination*, 102 MICH. L. REV. 460, 460 (2003) [hereinafter Robbennolt, *Legal Settlement*] (examining empirical evidence of the effect of apology on perception and decision-making); Jennifer K. Robbennolt, *Apologies and Medical Error*, 467 CLINICAL ORTHOPAEDICS & RELATED RES. 376, 376 (2009) [hereinafter Robbennolt, *Apologies and Med. Error*]; 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, 1009 (2005) [hereinafter Robbennolt, *What We Know*].

While apology programs do not publish the psychological mechanisms they employ when dealing with patients, Professor Robbennolt's findings about what effectively persuades a person square very well with what the literature indicates happens in apology programs.<sup>119</sup>

First, apologies appear to work when they lessen the degree of anger patients feel toward their physicians.<sup>120</sup> In fact, the "types of injurious actions that are often at issue in civil litigation—violation of the victim's autonomy—have been specifically linked to anger responses."<sup>121</sup> The way a physician apologizes influences the patient's attitude toward the physician and the prospects of settlement.<sup>122</sup> In fact, an inadequate or poorly delivered apology may cause a person to file suit.<sup>123</sup> This is known by those that create apology protocols, with some programs reminding doctors that although the Joint Disclosure rules do not require an apology, failing to do so will likely make the situation worse because the communication will lack "human touch."<sup>124</sup> Apology advocates also know the medical institution's relationship with the patient is strained after they harm patients, and counsel physicians to "bring the patient and family closer and embrace them" by making the patient "their best friend."<sup>125</sup> This appears to match the finding that there is a correlation between anger and litigation, and plays out in apology programs when programs recommend specific strategies for diffusing that anger:

Any effective, meaningful apology has four basic elements: (1) Empathy or "sorry"; (2) Admission of fault . . . [;] (3) Explanation of what happened and how it will be prevented from happening again; (4) As necessary, an offer of compensation or some sort of fix to the problem that has been created. These elements, in the right cases, eliminate anger felt by the aggrieved party . . . . It is important to explain what happened and how it will be prevented from happening again. . . . Patients want to know what happened.<sup>126</sup>

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<sup>119</sup> See, e.g., Robbennolt, *Legal Settlement*, *supra* note 118, at 487.

<sup>120</sup> Robbennolt, *Civil Justice*, *supra* note 115, at 202; Robbennolt, *Legal Settlement*, *supra* note 118, at 488. This, of course, is also consistent with the observation Goffman made about the role of a cooler in allowing a mark to vent. Goffman, *supra* note 4, at 457 ("Another standard method of cooling the mark out—one which is frequently employed in conjunction with other methods—is to allow the mark to explode, to break down, to cause a scene, to give full vent to his reactions and feelings, to 'blow his top.' If this release of emotions does not find a target, then it at least serves a cathartic function.").

<sup>121</sup> Robbennolt, *Civil Justice*, *supra* note 115, at 202.

<sup>122</sup> Robbennolt, *Settlement Levers*, *supra* note 116, at 363.

<sup>123</sup> Robbennolt, *What We Know*, *supra* note 118, at 1024.

<sup>124</sup> *CRICO's Perspective*, *supra* note 2.

<sup>125</sup> DOUG WOJCIESZAK ET AL., SORRY WORKS! DISCLOSURE, APOLOGY, AND RELATIONSHIPS PREVENT MEDICAL MALPRACTICE CLAIMS 60–61 (2d ed. 2010).

<sup>126</sup> *Id.* at 62–63.

In terms of timing, patients are more impacted by apologies delivered soon after the negligence occurred, as opposed to later apologies, which are more easily recognizable as ploys to avoid litigation.<sup>127</sup> To avoid this, apology advocates tell physicians to initiate an apology as soon as possible.<sup>128</sup>

In terms of content of the apology, psychologists have found that patients are most influenced when physicians offer “full” apologies under which they take total responsibility for causing the harm.<sup>129</sup> A “partial” apology—when the physician simply expresses sympathy—has less of an effect on a patient’s attitude, but still influences patients to settle for less than if the physician offered no apology at all.<sup>130</sup> Apology advocates have recognized that even these partial measures have benefits: when physicians are unwilling to take responsibility for adverse outcomes (or when, for example, that expression of responsibility might not be covered under the jurisdiction’s apology shield law), apology advocates still encourage them to make this partial apology: “Convey compassion and empathy for [the] patient’s and family’s suffering . . . [Words like] ‘I’m sorry that you. . .’ [or] ‘I am sorry for you,’” etc., can assist in re-building trust between the doctor and patient.

Psychologists have also determined several factors that affect patients’ subconscious attitudes towards their physicians.<sup>131</sup> For example, the way a physician dresses has a demonstrable effect upon patients’ perceptions, establishing authority and credibility. Anecdotal evidence suggests that those in the medical field are well aware of this. One commentator reported that a doctor told her:

[L]uckily for us, most patients will accept an apology, but it matters a lot how you give it. If you apologize in the hospital or in your office, you’ve got it made. It’s really important to have the white coat on and a stethoscope around your neck, though. If you go in there dressed as any Joe, it won’t work.<sup>132</sup>

Apology experts encourage physicians to carefully control the conditions of the disclosure session. Each possible variable, including the apologizer’s manner of dress<sup>133</sup> and the location of

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<sup>127</sup> MICHAEL S. WOODS, HEALING WORDS: THE POWER OF APOLOGY IN MEDICINE 45 (2004) (“Delays in communication make patients and families suspicious.”).

<sup>128</sup> *Id.*

<sup>129</sup> Robbenolt, *Settlement Levers*, *supra* note 116, at 368.

<sup>130</sup> *Id.*

<sup>131</sup> John E. Ware & Mary K. Snyder, *Dimensions of Patient Attitudes Regarding Doctors and Medical Care Services*, 13 MED. CARE 669, 670 (1975).

<sup>132</sup> Erin Ann O’Hara, *Apology and Thick Trust: What Spouse Abusers and Negligent Doctors Might Have in Common*, 79 CHI.-KENT L. REV. 1055, 1079–80 (2004).

<sup>133</sup> Shakaib U. Rehman et al., *What to Wear Today? Effect of Doctor’s Attire on the*

the session<sup>134</sup> have been studied by the medical industry and have the ability to influence the patient's reaction to the benefit of the hospital or insurer.

On its own, there is nothing wrong with physicians using psychology to maintain their relationships with patients after adverse effects—in some respects, these strategies are simply good customer service. The problem, however, is when these strategies are used to influence legal decisions as opposed to medical ones.<sup>135</sup>

#### IV. IF EVERYONE IS HAPPY, WHAT'S WRONG?<sup>136</sup>

The literature on apology programs is replete with anecdotes conveying the happiness of patients who gladly agreed to resolve a case as a result of an apology, even if they did so for little or no compensation.<sup>137</sup> The underlying argument seems to be that if a patient is happy, then it is a good result. The literature, however, never makes clear what percentage of patients are ignorant about what they are giving up when they take a partial payment instead of full compensation. The programs leave open the possibility of short-changing patients on economic damages, and (especially) non-economic damages, which apology programs seem fixated on washing away altogether. The literature also never considers the long-term effect of this partial compensation on the patient and society as a whole. This part addresses that issue.

The tort system addresses the challenge of compensating victims for their damages—making them whole—by calculating values for each type of harm suffered.<sup>138</sup> The value of many types of harm is simple to determine because there are market rates

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*Trust and Confidence of Patients*, 118 AM. J. MED. 1279, 1280 (2005). Research indicates patients overwhelmingly *want* physicians to display that authority, and meeting that expectation builds trust. *Id.* at 1283.

<sup>134</sup> See TRUOG ET AL., *supra* note 10, at 81 (encouraging physicians to disclose errors at the bedside or a quiet location where everyone can be comfortably seated).

<sup>135</sup> See, e.g., Robbennolt, *Settlement Levers*, *supra* note 116, at 363 (discussing the effect of apologies on the settlement of potential medical malpractice legal claims).

<sup>136</sup> I give particular thanks and recognition to my research assistant extraordinaire, Christopher J. Fiorentino, who took the lead in drafting this part of the Article.

<sup>137</sup> See MASS. COAL. FOR THE PREVENTION OF MED. ERRORS, WHEN THINGS GO WRONG: RESPONDING TO ADVERSE EVENTS 28–29 (2006), *available at* <http://www.macoalition.org/documents/respondingToAdverseEvents.pdf> (recounting patient's "positive" experience after she received an apology and "token" compensation after negligence in her cancer treatments); Quinn & Eichler, *supra* note 46, at 715 (reporting patient "expressed sincere appreciation" after COPIC reimbursed her \$3898 for a damaged ureter that required an extra surgery and extended recovery).

<sup>138</sup> 1 JEROME H. NATES ET AL., DAMAGES IN TORT ACTIONS § 1.01 (2011).

for the jury to reference.<sup>139</sup> However, non-economic harms are more difficult because:

There is no direct correspondence between money and harm to the body, feelings or reputation. There is no market price for a scar or for loss of hearing since the damages are not measured by the amount for which one would be willing to suffer the harm. The discretion of the judge or jury determines the amount of recovery, the only standard being such an amount as a reasonable person would estimate as fair compensation.<sup>140</sup>

That pain and suffering can be difficult to calculate, however, is not an appropriate reason to downplay its significance. As Professor Neil Komesar of the University of Wisconsin Law School has noted:

The importance of these nonpecuniary losses can be seen by asking yourself whether you would be indifferent or even nearly indifferent between an uninjured state and a severely injured state, such as paraplegia, blindness, or severe brain damage, so long as your income and wealth remained constant.<sup>141</sup>

For this reason, the courts have long recognized the importance of compensating plaintiffs for their suffering.<sup>142</sup>

By contrast, apology programs only offer a small portion of the total range of damages. COPIC only compensates victims for a maximum of \$30,000 of out-of-pocket expenses, and does not compensate victims for their pain and suffering.<sup>143</sup> It is unclear—because they have not released the data—as to how UMHS tabulates damages. However, in JW's case, the settlement value was tied to the projected cost of her children's college education, as opposed to the value of the damages she sustained.<sup>144</sup> Nothing was paid to her for non-economic damages.<sup>145</sup>

Tort reformers have argued that non-economic damage awards are unfair because juries tend to unreasonably calculate them in favor of a plaintiff.<sup>146</sup> Seizing upon this notion, the

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<sup>139</sup> *Id.* at § 1.02.

<sup>140</sup> RESTATEMENT (SECOND) OF TORTS § 912 cmt. b (1979).

<sup>141</sup> Neil K. Komesar, *Injuries and Institutions: Tort Reform, Tort Theory, and Beyond*, 65 N.Y.U. L. REV. 23, 58 (1990).

<sup>142</sup> *See, e.g.*, *Random v. N.Y. & Erie R.R. Co.*, 15 N.Y. 415, 424 (1857) (awarding a negligently injured railroad passenger damages for “bodily pain and suffering, without reference to the time when endured”).

<sup>143</sup> Quinn & Eichler, *supra* note 46, at 710.

<sup>144</sup> Boothman et al., *supra* note 10, at 156.

<sup>145</sup> *Id.*

<sup>146</sup> *See, e.g.*, Joseph H. King, Jr., *Pain and Suffering, Noneconomic Damages, and the Goals of Tort Law*, 57 SMU L. REV. 163, 164–65 (2004) (arguing that pain and suffering damages are inconsistent with the goals of tort law—to “return the injured person to his pre-injury position”—because the only damages that “can genuinely nullify some of the



insurance industry has waged a lengthy campaign to limit malpractice damages (and thus to limit their own exposure).<sup>147</sup> Their lobbyists have convinced over half of state legislatures to implement tort reforms and place arbitrary caps on how much plaintiffs in medical malpractice suits can recover, regardless of how badly the victim is injured.<sup>148</sup> As a result, legislatures have somewhat skewed tort litigation in favor of the injurers rather than the injured.

Nevertheless, unlike apology programs involving unrepresented injured patients, the traditional litigation system is administered by impartial judges, essentially requiring that each party be represented by legal counsel, and utilizing disinterested juries to calculate damages. By contrast, in apology programs, part of the goal seems to be keeping plaintiffs away from the tort system altogether. The result is that, when patients—particularly unrepresented patients—are compensated, there is no third party considering the itemized damages. Instead, the calculation seems to be based on the smallest figure that will mollify the patient.

By playing on psychology and the dynamic of an injured patients' interaction with a physician coached by an insurance company, those that would otherwise be required to pay the

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pain are economic damages for medical expenses to cover pain management and rehabilitation, not noneconomic damages for pain and suffering"). "The tacit assumption [made by opponents of noneconomic damages] is that pain and suffering damages are frivolous and too often granted for phantom or imaginary pain." Michael L. Rustad, *Neglecting the Neglected: The Impact of Noneconomic Damage Caps on Meritorious Nursing Home Lawsuits*, 14 *ELDER L.J.* 331, 379–80 (2006).

<sup>147</sup> See Michael Rustad, *The Jurisprudence of Hope: Preserving Humanism in Tort Law*, 28 *SUFFOLK U. L. REV.* 1099, 1128 (1994) (noting that in 1994 insurance companies had lobbied for fifteen years to limit medical malpractice liability).

<sup>148</sup> See Catherine M. Sharkey, *Unintended Consequences of Medical Malpractice Damages Caps*, 80 *N.Y.U. L. REV.* 391, 396 (2005) (noting that a majority of states have imposed some kind of limitation on the amount of damages available to a plaintiff in a medical malpractice claim). For example, in Massachusetts, damages for noneconomic losses are limited to \$500,000 unless there are "special circumstances" that justify raising the award above the cap. *MASS. GEN. LAWS ANN. ch. 231, § 60H* (West 2000). In California, noneconomic losses are capped at \$250,000 regardless of extenuating circumstances. *CAL. CIV. CODE § 3333.2* (West 1997). In Colorado, home of COPIC insurance, all damages in medical malpractice cases are limited to \$1,000,000 (of which only \$250,000 may be for noneconomic damages) unless the court grants special leave. *COLO. REV. STAT. ANN. § 13-64-302(1)(b)* (West 2005). The theoretical purpose of capping damages is to lower physicians' insurance premiums, but the data does not support that conclusion. Katherine Baicker & Amitabh Chandra, *The Effect of Malpractice Liability on the Delivery of Health Care*, 8 *F. FOR HEALTH ECON. & POL'Y* 1, 13 (2005), available at [http://www.hks.harvard.edu/fs/achandr/FHPR\\_EffectofMalpracticeHealthCareDelivery\\_2005.pdf](http://www.hks.harvard.edu/fs/achandr/FHPR_EffectofMalpracticeHealthCareDelivery_2005.pdf). Further, early advocates of caps contended they had no negative effect on patient care, but these caps may actually make medical care more dangerous. See Janet Currie & W. Bentley MacLeod, *First Do No Harm?: Tort Reform and Birth Outcomes* 36 (Nat'l Bureau of Econ. Research, Working Paper No. 12478, 2006) (finding damage caps increase complications of childbirth).

traditional damages have discovered value in disclosure and apology.

While protecting profits is an understandable goal for an insurance company, it comes at a cost: every extra dollar of profit realized by the insurer resulting from a medical apology is a dollar taken from an injured patient. On its own, convincing an individual not to sue is no different than any other “bad” settlement. What makes this different is the appearance of a system of methods designed to dissuade patients from actually considering their rights before settling for short money. It also creates a secondary problem; that plaintiffs who accept settlements for less money than their claim is worth may become a drain on society. With no damages to cover future lost wages or future medical expenses, the taxpayers may be left footing the bill for the negligence of others.

By ignoring the measures of damages applied by American courts and steering patients from a neutral venue to redress innocent victims’ injuries, these programs stack the deck in favor of the insurance companies who administer them. The result is that others bear the long-term costs of going uncompensated for their physicians’ mistakes.

#### V. THE CURE: “MALPRACTICE *MIRANDA*” AND OTHER FIXES

Apology programs, if run properly, are worth saving. This is because, despite all of the potential for abuse, they still have positive attributes: insurers and injured patients alike benefit from lower litigation costs (both with respect to attorneys’ fees on both sides, as well as reducing the costs of discovery, experts, and other expenses); they promote faster resolutions; they allow for an ongoing doctor-patient relationship (assuming the patient is comfortable with it); and, most importantly, they aid the patient’s subjective sense of satisfaction with the resolution and outlook for future treatment. There is no reason that these goals could not still be met while reforming what requires repair. This part of the Article suggests necessary changes to do so.

##### A. Assuring Injured Patients Understand Their Rights

The primary problem with current apology programs is that injured patients are put in a position in which they might easily confuse the willingness of a provider to communicate with the willingness of a provider to compensate them fully. Therefore, the first and most important step is to require apology programs to allow their patients a real opportunity to educate themselves on their rights before being influenced to settle.

To prevent a patient's potential confusion, apology programs should be required to advise patients in any case that has more than a nominal value that they will not resolve the matter with the patient unless and until the patient is educated on his or her legal rights.<sup>149</sup> This should involve advising patients to speak to an attorney. Patients who, after being so advised, choose not to seek counsel should be given a reasonable period of time thereafter to make a sober decision. This "Malpractice *Miranda*" would help patients understand their rights and give them an opportunity to make a sober, intelligent decision about their needs as a result of the malpractice.

Providing information about the possible need to seek an attorney is a rarity among apology programs, with ninety-six percent not doing so.<sup>150</sup> Involving attorneys is recommended by the *SorryWorks!* organization: "Patients and families should never feel like the hospital/insurer is trying to pull a fast one on them, and by encouraging involvement of [personal injury] attorneys you remove those fears and make your disclosure program credible."<sup>151</sup> Yet, neither COPIC (which expressly forbids it) nor UMHS (which allows attorney involvement, but does not expressly recommend it) accept the view that patients are entitled to know their legal rights before negotiation. One possible reason for this discrepancy is that *SorryWorks!* is an advocacy group that has no financial stake in the resolution of claims. By contrast, self-insured hospitals like UMHS and insurers like COPIC are obligated to pay the cost of a settlement and may believe that educating patients about legal decisions could result in more expenses for their organizations.

Because apology programs influence legal decisions, the ethical rules that require a doctor to recommend to malpractice victims that they seek legal counsel should be parallel to that of a similarly situated attorney who suspects he or she has committed malpractice. When a lawyer abuses a client's trust in order to avoid a malpractice suit, the lawyer is violating his or her

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<sup>149</sup> Not every error that merits an apology, of course, should go down the legal path. Minor errors that could never realistically result in a claim being brought should be handled informally (e.g., an overly-rough phlebotomist causing bruising). However, once risk management becomes involved, it would follow that because the hospital is evaluating the matter from a legal angle, the injured patient should be afforded the same opportunity.

<sup>150</sup> See Lamb et al., *supra* note 16, at 77 (stating that only four percent of hospitals with disclosure programs provide information about lawyers).

<sup>151</sup> *September 13, 2006 Newsletter*, SORRYWORKS! (last visited Sept. 10, 2011, 11:23 PM), <http://sorryworks.net/newsletter20060913.phtml>.

responsibility to the client.<sup>152</sup> The American Bar Association's ethical rules state:

A lawyer shall not . . . settle a claim or potential claim for . . . liability with an unrepresented client or former client unless that person is advised in writing of the desirability of seeking and is given a reasonable opportunity to seek the advice of independent legal counsel in connection therewith.<sup>153</sup>

The legal community has accepted that this is of vital importance. As a result, lawyers failing to disclose this conflict of interest before settling a claim are subject to steep penalties, and may lose their licenses.<sup>154</sup>

The reason given to lawyers for this ethical obligation is as applicable to the doctors that ask their injured patients to make a legally significant decision about settlement: "By seeking to settle his own liability, a lawyer places himself in direct conflict with a client. Requiring lawyers to advise clients to consult independent counsel before settling a malpractice dispute helps ensure that clients are well informed before they give up important rights."<sup>155</sup>

Many of the programs outlining disclosure measures suggest language for doctors to use to show empathy, respect, and understanding of the gravity of the situation. Under the concept of the "Malpractice *Miranda*," this language could be supplemented with language about the legal aspects of the malpractice apology program. The doctor could say:

My goal is to make you better. In addition to promising to do my best to fix your injuries, I want you to understand that because of this error, you have legal rights. I tell you this because I do not just accept responsibility for what happened to you medically, but because I also accept the consequences of that. Therefore, you have to know that I do not take it personally if you pursue your legal rights. In fact, I buy insurance for just this reason and, although I am sad that it is needed, my goal is to make you whole again, including getting fair compensation. I am not a lawyer, and just like you would not want a lawyer to give medical advice, a physician should not give legal advice—especially when there is potentially a conflict of interest.

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<sup>152</sup> MODEL RULES OF PROF'L CONDUCT R. 1.8(h) (2011) (discussing conflicts of interest in client-lawyer relationships).

<sup>153</sup> *Id.*

<sup>154</sup> See, e.g., *In re Carson*, 991 P.2d 896, 903, 905 (Kan. 1999) (censuring publicly a lawyer who attempted to settle an unrepresented former client's malpractice case); *In re Henderson*, 819 So. 2d 296, 301–02 (La. 2002) (disbarring a lawyer for failing to disclose malpractice and seeking a release from his client without advising him to seek third-party legal advice); *In re Tallon*, 447 N.Y.S.2d 50, 51 (App. Div. 1982) (suspending a lawyer from practice for six months for failure to disclose advisability of independent counsel while negotiating a malpractice release).

<sup>155</sup> ABA/BNA LAWYERS' MANUAL ON PROF'L CONDUCT § 51:1112 (2011).

Therefore, before we agree to any amount of compensation, or any other way we agree is fair to make you whole, I want you to speak to a lawyer. It is up to you if you choose to do so, but my advice is that you should do so. I will not allow you to sign any release<sup>156</sup> before you have spoken to a lawyer or you have had some time to think about it. This is because I feel badly about this situation and I want the best for you, even if it means that my insurance company has to pay you money for this accident.

The industry's advocates would likely argue that patients who participate in apology programs are satisfied with having done so, thus they are, by definition, successful.<sup>157</sup> That misses the point: blissful ignorance is not something for which the medical community, or society as a whole, should strive. To date, the medical-insurance industry's research does not make clear if apology program participants are ever even aware of what it is that they are giving up when they settle their cases as part of an apology program. If apology programs were willing to provide this education, it would set the stage for a fair result. By contrast, if insurance companies feel obligated to try to pay the minimum possible amount of money to patients who have been the victims of malpractice, they should, at the least, not make the doctors who pay premiums complicit in doing so. Doctors can, and should, be free to tell patients that legal advice is the best route to help them get the compensation they need to care for themselves and their loved ones as a result of an unfortunate medical event.

#### B. Processing Claims Quickly and Fairly

UMHS and the Lexington VAMC both identify the ability to resolve claims quickly as a benefit to apology programs.<sup>158</sup> It would follow that prompt resolution would also potentially benefit patients, as long as they have an opportunity to fully consider their options before choosing whether to pursue litigation.

To accomplish fast claims-processing, as well as fairness to allow patients to consider their options, one solution is to allow

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<sup>156</sup> Of course, some disclosure programs, like COPIC's 3Rs program, do not require a release. In that case, the doctor should tell the patient that they should consider pursuing a claim and that the disclosure program will not offer them any money until they do so.

<sup>157</sup> See Boothman et al., *supra* note 10, at 158 (publicizing the happiness JW stated she felt after participating in their apology program).

<sup>158</sup> See Kachalia et al., *supra* note 92, at 220 (attributing a substantial proportion of reduced litigation costs at UMHS to reduced claims processing times); Kraman & Hamm, *supra* note 24, at 966 (explaining how local settlement allows the VA to avoid the "hidden expenses of litigation").

for immediate settlement following an apology, as long as the patient certifies they have spoken with an attorney about their legal rights. If the patient chooses not to seek counsel, they should be required to have a cooling off period of six months before settling any claim. Use of this type of time period has been approved by the UMHS when the six months is a hiatus that prevents a patient from suing.<sup>159</sup> Using the same reasoning as UMHS, it follows that one who wishes to accept a settlement as part of a disclosure program should likewise be given six months to think through their decision before making a permanent decision with potentially lifelong consequences on the patient and family.

Another step to make claims processing faster, cheaper and more efficient would be for hospitals and insurers whose insured have committed a negligent error to provide injured patients with a simple, one page "Stipulation of Liability." This stipulation could be provided as soon as the initial meeting post-incident between doctor and patient (and patient's attorney, if desired by the patient). The effect of the stipulation would be that the medical provider would be admitting to being at fault and having caused the patient's damages. The stipulation would be accompanied by a request for either a jury trial on the limited issue of the patient's damages, or an assessment of damages hearing in which a judge determines the patient's damages.

The stipulation would benefit the medical provider's insurer because it would save the expense of pre-trial litigation (attorney fees, expert opinions on the issue of liability, deposition transcript costs, etc.), and would allow for a more efficient processing of the case, with the only issue requiring determination being the amount of the patient's damages. It would also be ethically sound: it would be a recognition of responsibility and a willingness to participate in our society's mechanism for deciding how to determine the cost to accompany that responsibility.

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<sup>159</sup> Among the reasons stated by the UMHS hospital's website for the success of their disclosure program are:

We're fortunate to be located in Michigan, a state that passed sensible medical malpractice reform in the 1990s and is not having some of the same crisis situations as other states. Our state law, among other things, builds a six-month "cooling off" period into the malpractice lawsuit process. If a patient is thinking about bringing suit against a doctor or hospital for medical malpractice, the patient must first alert prospective defendants of their complaints with a "notice of intent," and both parties then have six months to consider their cases before going to court.

*Medical Malpractice and Patient Safety at UMHS*, U. MICH. HEALTH SYS. (last visited July 25, 2011), <http://www.med.umich.edu/news/newsroom/mm.htm> [hereinafter U. OF MICH. HEALTH SYS.].

### C. Closing COPIC-Style Loopholes

Any time a patient resolves a case as part of an apology/disclosure process, even if it's framed as a "no-fault" program like COPIC's 3Rs program, the provider should still be required to report the act of malpractice. The databases associated with malpractice claims serve a critical public safety purpose to inform patients (and licensing authorities) of whether providers are negligent in their care. That a doctor could escape this because he or she was able to convince a patient not to litigate an otherwise viable malpractice claim not only is a disservice to the public in general, but serves as motivation for the negligent medical provider to inappropriately press the harmed patient into settling.

### D. Repealing Apology Shield Laws

Finally, medical apology shield laws should be repealed. Although the anecdotal evidence indicates that for an attorney to actually attempt to use an admission of fault against a physician at trial would be detrimental to a case against that doctor,<sup>160</sup> that does not change the fact that doctors should play by the same set of rules as all other people.<sup>161</sup> This change would mean that a doctor's apology or admission against interest, as a norm, is admissible. This is simply the same default standard as exists for an attorney who admits malpractice to a client or a driver that admits negligent driving to the person he hit.

## CONCLUSION

In concluding this Article, it is important to point out three things that it did *not* argue. First, it did not argue that patients must, or even should, pursue a malpractice claim against a doctor that has treated them carelessly and caused them injury. Adults can, and should, be expected to make responsible decisions about the benefits and disadvantages of pursuing a

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<sup>160</sup> TRUOG ET AL., *supra* note 10, at 46 (citations omitted) ("As the president of the South Carolina Trial Association stated in testimony before the South Carolina Senate, 'I would never introduce a doctor's apology in court. It is my job to make a doctor look bad in front of a jury, and telling the jury the doctor apologized and tried to do the right thing kills my case.'").

<sup>161</sup> See generally Mark Bennett & Christopher Dewberry, "I've Said I'm Sorry, Haven't I?" *A Study of the Identity Implications and Constraints that Apologies Create for their Recipients*, 13 CURRENT PSYCHOL. 10, 15 (2004) (demonstrating victims who reject apologies are viewed less sympathetically by third parties). Advocates justify tort reforms, such as apology laws, by claiming those laws will reduce the cost of medical malpractice insurance, but the laws have not had that effect; instead, they appear more closely linked to helping insurance companies cover losses sustained in stock market speculation. See June Smith Tyler, *Medical Malpractice Statutes: Special Protection for a Privileged Few?*, 12 N. KY. L. REV 295, 299-303 (1985).

legal course of action, just as they should make educated, informed medical decisions. The problem, this Article argues, is that the current model for apology programs is designed to make it harder for patients to reach these reasonable, informed decisions. This need not be the situation; there are simple, fair fixes to the problem created by apology programs to prevent parties responsible to pay for the damages caused by malpractice to victimize patients by convincing them not to pursue claims that their insurers would have to pay. To correct this problem, this Article argued that malpractice victims require simple protections that even the playing field.

Second, this Article did not accept the insurance industry's invented definitions of "fair" and "reasonable" compensation. The medical insurance literature on apology programs is replete with examples of what those who have to pay claims believe to be "fair," followed by language indicating that their definitions simply do not correspond with what our legal system has defined as the appropriate measure of damages, assuming a plaintiff can prove malpractice.<sup>162</sup> Instead, the literature reflects an imagined system of tort damages that delegitimizes the availability of non-economic damages, and perhaps, even more expensive measures of economic damages. This is not an article that argues about whether the legal system currently assesses damages the "right" way. Instead, it accepts that full and fair damages are as defined by courts and applied by juries.<sup>163</sup> Therefore, this article accepts the commonly accepted and current *legal* definition of "fair" and "reasonable" compensation, which requires that tort victims be compensated with all of the economic and non-economic damages sufficient to make the injured plaintiff "whole."

Third, and finally, this Article did not argue that doctors are the "bad guys." Just the opposite: it is intended to expose the actual motivation behind medical disclosure policies—insurers' desire to keep more money for themselves and give less to

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<sup>162</sup> See, e.g., Steve S. Kraman, *Proactive Reporting, Investigation, Disclosure, and Remediating of Medical Errors Leads to Similar or Lower than Average Malpractice Claim Costs*, AHRQ HEALTH CARE INNOVATIONS EXCHANGE (last visited July 25, 2011), <http://innovations.ahrq.gov/content.aspx?id=2731> ("[After disclosure, Kentucky VA] hospital representatives offer to provide corrective medical or surgical treatment, assist the patient/family in filing for needed services associated with any disability resulting from medical care, and/or present an offer of monetary compensation. The respective attorneys negotiate to reach a fair settlement based on a reasonable calculation of loss."); U. OF MICH. HEALTH SYS., *supra* note 159 ("If we have concluded that our care was unreasonable, we say so—and we apologize. If our care caused an injury, we work with the patient and his/her counsel to reach mutual agreement about a resolution. This doesn't always mean a settlement, but if it does, we compensate quickly and fairly.")

<sup>163</sup> See *supra* notes 138–148 and accompanying text (describing full and fair compensation under the tort system).



patients—and to suggest ways to reform the process to meet the needs of improving doctor-patient communication while providing injured patients with an appropriate, compassionate, and fair opportunity to receive compensation in the event of an unwanted outcome. Rather than demonize doctors, it is hoped that medical providers will read this Article, recognize the disservice that their insurers are asking them to commit against their patients, and revolt against it. By allowing the legal process to go forward after an apology, doctors can then know that they are putting patients in the best position possible to recover from a medical error.

Disclosure programs put in place by insurance companies and self-insured hospitals put their own interests in front of both patients and providers alike. For example, consider the guidelines provided to doctors by CRICO/RMF to its physicians when an error occurs:

In cases that are clear-cut and where an objectively visible error has occurred, apologies should be made. Some institutions refer to these as “The Wrongs”: wrong patient; wrong digit/limb/organ; wrong drug/dose/method of administration; wrong procedure, etc. If a doctor, assisted by the institutional risk manager, can clearly determine that the unanticipated outcome has been caused by one of these “wrongs”, [sic] an immediate apology should be made. However, it should be emphasized that physicians should not make this determination on their own. They should immediately contact their risk manager, lay out every known fact, and then let the risk manager serve as their expert.<sup>164</sup>

The assertions are both remarkable and insulting to the physicians expected to carry them out: it is CRICO/RMF's position that *even if a doctor accidentally cuts off the wrong limb of a patient*, that doctor cannot determine if his or her act was an error. Can one seriously believe that CRICO/RMF's risk managers believe that they know better than a provider if they have made an error? Instead, language like the above suggests what insurers really want when dealing with their physicians: control. When a doctor submits to the insurer's control, in turn, it allows the insurer to instruct the doctor on how to talk to their patients to steer them away from seeking compensation for their injuries. While no doctor wants a malpractice claim on his or her record, it is also hard to imagine any doctor that pays for malpractice insurance would want his or her injured patient to be shortchanged by the insurer to whom they pay premiums (let alone that the doctor that made the error would want to be the

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<sup>164</sup> CRICO's *Perspective*, *supra* note 2.

insurance company's tool to convince the patient that their injury should not be compensated).

Those that have to pay malpractice claims have a conflict of interest with physicians: the risk manager's obligation is to the insurance company, whereas the physician's obligation is to the patient. Even those who have written strongly in favor of apology programs, like Dr. Steve Kraman and Ginny Hamm, note that this phenomenon is inherent to risk management. By their definition, "risk management usually refers to self-protective activities meant to prevent real or potential threats of financial loss due to accident, injury, or medical malpractice. When a malpractice claim is made against an institution in the private sector, risk managers coordinate the defense against patients, their dependents, and their attorneys."<sup>165</sup>

When insurance companies, or the internal risk managers at a hospital who are in league with the insurers, use their influence over physicians to encourage apology as a means of maximizing their own profits, they taint the physician's responsibility to the patient. Without corporate concerns about compensating patients, insurance companies and risk managers would not publish elaborate guidance to their doctors explaining sophisticated policies about how to apologize.<sup>166</sup> Doctors would not need to seek approval of a risk manager before admitting an error to a patient that has just suffered from a "never event" at their hands.<sup>167</sup> This Article seeks to cut doctors out of the hypocrisy by allowing them to offer a sincere, no-strings-attached apology after an act of malpractice that leaves the legal effects of

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<sup>165</sup> Kraman & Hamm, *supra* note 24, at 963 (emphasis omitted).

<sup>166</sup> See, e.g., *CRICO's Perspective*, *supra* note 2. See also MASS. COAL. FOR THE PREVENTION OF MED. ERRORS, WHEN THINGS GO WRONG: RESPONDING TO ADVERSE EVENTS 1 (2006), available at <http://www.macoalition.org/documents/respondingToAdverseEvents.pdf> (providing advice regarding "The Patient and Family Experience"; "The Caregiver Experience"; and "Management of the Event"); Am. Soc'y for Healthcare Risk Mgmt., *Disclosure: What Works Now & What Can Work Even Better*, 24 J. HEALTHCARE RISK MGMT. 19 (2004) ("The next step in better communication with patients"; "Creating an effective patient communication polity"; and "What works now and what can work even better."). Furthermore, a cottage industry of private companies has sprung up offering guidance and seminars to physicians instructing exactly what to say, when to say it, under what circumstances, and in what setting. These programs are designed to minimize the possibility the disclosure might instigate, rather than prevent, litigation. See, e.g., TRUOG ET AL., *supra* note 10; WOJCIESZAK, *supra* note 125; WOODS, *supra* note 127.

<sup>167</sup> Doctors deliver apologies, but they are trained to carefully plan their words in concert with their risk manager. See, e.g., *Disclosure*, CRICO/RMF (last visited Sept. 27, 2011), <http://www.rmfm.harvard.edu/education-interventions/materials-for-instructors/disclosure/disclosure-support-materials.aspx>. A "never event" is a term used by the National Quality Forum (NQF) to describe particularly shocking medical errors (such as wrong-site surgery) that should never occur. *Never Events*, U.S. DEPT HEALTH & HUM. SERVS. (July 13, 2011), <http://psnet.ahrq.gov/primer.aspx?primerID=3>.

that to the insurance company to whom the doctor pays premiums for just such a purpose.

The shame is that medical apology programs *could be* a positive thing. Saving on psychological stress and anguish of the patient and physician, lowering attorneys' fees and litigation costs, and lightening burdens on already overwhelmed court systems are all laudable goals. Using power differentials and taking advantage of harmed patients to increase profits are not. Some commentators have argued that doctors are fiduciaries of their patients, thus owing them the highest possible duty to protect their interests.<sup>168</sup> Some courts have even ruled as such.<sup>169</sup> We should take seriously the idea that doctors owe their primary allegiance to their patients; not just in making medical decisions, but in any and all decisions relating to their relationship. In their White Paper on disclosing malpractice, the Massachusetts Coalition for the Protection of Medical Errors suggested that, when approaching these issues, it should be done from the patient's point of view.<sup>170</sup> They asked, "What would I want if I were harmed by my treatment?" and "[W]hat is the right thing to do?"<sup>171</sup>

This Article stands for that idea that doing the "right thing" for patients requires something more than convincing them not to seek compensation through litigation for injuries caused by negligent errors. Adults can, and should, be expected to make serious decisions about whether to pursue legal claims that they are entitled to make. If an injured patient, after soberly considering the options, decides not to pursue a claim, then that is a perfectly acceptable result. However, in situations where a

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<sup>168</sup> See Thomas L. Hafemeister & Sarah P. Bryan, *Beware Those Bearing Gifts: Physicians' Fiduciary Duty to Avoid Pharmaceutical Marketing*, 57 U. KAN. L. REV. 491, 526 (2009) (suggesting physicians' fiduciary duties obligate them to avoid effects of medical manufacturers' marketing). See also Thomas L. Hafemeister & Richard M. Gulbrandsen, Jr., *The Fiduciary Obligation of Physicians to "Just Say No" if an "Informed" Patient Demands Services that Are Not Medically Indicated*, 39 SETON HALL L. REV. 335, 374 (2009) (suggesting physicians' fiduciary duty includes obligation to deny patients' requests for medically unnecessary services). As one commentator noted, "[s]o long as doctors continue to claim the mantle of professional and not mere business contractor, they are privileged by the trust invested in them by patients, and also burdened by the duty of loyalty and devotion to patient welfare above their own that their status as fiduciaries entails." Charity Scott, *Doctors as Advocates, Lawyers as Healers*, 29 HAMLINE J. PUB. L. & POL'Y 331, 350-51 (2008).

<sup>169</sup> See, e.g., *Emmet v. E. Dispensary and Cas. Hosp.*, 396 F.2d 931, 937 (D.C. Cir. 1967) (finding a fiduciary relationship exists between physicians and patients); *Hahn v. Mirda*, 54 Cal. Rptr. 3d 527, 532 (2007) (recognizing California courts have "repeatedly" recognized the physician/patient relationship as a fiduciary one); *Nixdorf v. Hicken*, 612 P.2d 348, 354 (Utah 1980) (explaining that the doctrine of informed consent springs from the fiduciary relationship between physician and patient).

<sup>170</sup> MASS. COAL. FOR THE PREVENTION OF MED. ERRORS, *supra* note 137, at 3.

<sup>171</sup> *Id.*

person is injured and scared, the medical industry should find ways to give them an opportunity to make educated decisions and not take advantage of their weakened state.