

ATTORNEYS, TELL YOUR CLIENTS TO SAY THEY'RE SORRY: APOLOGIES IN THE HEALTH CARE INDUSTRY

Robin E. Ebert*

TABLE OF CONTENTS

I. INTRODUCTION.....	338
II. COMMUNICATION IN THE PHYSICIAN-PATIENT RELATIONSHIP	340
III. WHY PHYSICIANS HOLD THEIR TONGUES	341
A. <i>Fear of Litigation</i>	342
B. <i>The Patient</i>	343
1. <i>Expectations</i>	343
2. <i>Misinterpretations</i>	343
3. <i>Disclosing the Error</i>	343
C. <i>Personal Character</i>	344
1. <i>Ego and the Suppression of Apology</i>	344
2. <i>Nature of the Profession</i>	345
IV. IT IS BETTER TO BE SORRY THAN SAFE.....	346
A. <i>State Legislation Regarding Expressions of Sympathy</i>	346
1. <i>The Massachusetts Approach</i>	346
2. <i>Reasoning for Legislation</i>	347
3. <i>Legislative Trends</i>	348
B. <i>In the Courtroom</i>	349
1. <i>Case Law</i>	349
2. <i>Effect of Apologies in Litigation</i>	351
C. <i>Scholarly Studies</i>	351
1. <i>The Robbennolt Study</i>	351
2. <i>The Vincent Study</i>	352
3. <i>The Gallagher Study</i>	352
D. <i>Economic Benefits to Protecting Apologies</i>	353
1. <i>Preventing Litigation</i>	353
2. <i>Encouraging Settlement Discussions</i>	354
E. <i>Case Studies</i>	354
1. <i>Veterans Affairs Medical Center in Lexington, Kentucky</i>	354
2. <i>Physicians Reimbursement Fund</i>	355
3. <i>How the COPIC Insurance Company Encourages</i>	

* J.D. Candidate, 2008, Indiana University School of Law – Indianapolis; B.A. 2005, DePauw University.

<i>Physicians to Apologize</i>	356
V. FAULT-ADMITTING APOLOGIES VS. EXPRESSIONS OF SYMPATHY	357
A. <i>Differences Among the States</i>	357
B. <i>Benefits of Protecting Fault-Admitting Apologies</i>	357
C. <i>Potential Disadvantages of Protecting Fault-Admitting Apologies</i>	359
VI. THE ACTUAL APOLOGY	360
A. <i>Definition of "Apology"</i>	360
B. <i>Presentation of an Apology</i>	360
1. <i>Who Should Give the Apology?</i>	361
2. <i>What Can and Cannot be Said?</i>	361
3. <i>When Should the Apology be Given?</i>	362
4. <i>Advising How to Apologize</i>	363
C. <i>Sincerity and Ulterior Motives</i>	363
VII. IS SAYING "I'M SORRY" ENOUGH?.....	364
A. <i>Where's the Proof?</i>	364
B. <i>Potential for Problems</i>	365
1. <i>Explanations of Error</i>	365
2. <i>Whose Advice Should the Doctor Take?</i>	365
VIII. CONCLUSION	366
APPENDIX 1: SUMMARY OF STATE "I'M SORRY" LAWS.....	366

I. INTRODUCTION

Parents teach their children at an early age to apologize when they have done something wrong. It is an intrinsic characteristic of human behavior taught to us at a young age.¹ There is some indication, however, that this attribute does not readily translate into adulthood. "[The concept of apology] is something every eight-year old knows, yet somehow it tends to be swallowed up during adult . . . discussions of law and business."² After bumping into someone on the street, most people will apologize to the complete stranger without giving it a second thought.³ Apologizing in the wake of a medical error, however, is not a common practice among physicians. The same doctor who apologizes to a stranger on the street is likely to hesitate before offering his or her patient an apology following a medical error.⁴

1. Donna L. Pavlick, *Apology and Mediation: The Horse and Carriage of the Twenty-First Century*, 18 OHIO ST. J. ON DISP. RESOL. 829, 837 (2003).

2. Hiroshi Wagatsuma & Arthur Rosett, *The Implications of Apology: Law and Culture in Japan and the United States*, 20 LAW & SOC'Y REV. 461, 493 (1986).

3. Pavlick, *supra* note 1, at 848. Pavlick uses the term "automatic apology" to describe this type of behavior.

4. *Id.* Pavlick comments that "culture dictates the circumstances in which apologies are used," and apologies are not generally "automatic" when there are potential legal implications. *Id.*

Apologies are generally viewed as common courtesy. If a person fails to apologize, the injured party may feel that the wrongdoer is not remorseful.⁵ Conversely, when someone apologizes, the person who has been injured may view the apology as an admission of wrongdoing. When contemplating whether to apologize for doing something wrong, the wrongdoer may feel vulnerable “to some potentially bad consequences stemming from the apology itself. This tends to make people reluctant to apologize, often to their own detriment.”⁶ Physicians are particularly reluctant to apologize for fear that their expression of sympathy could serve as evidence of an admission of liability in a medical malpractice lawsuit. As such, the physician is torn between the instinctive sympathetic response and the fear of an impending lawsuit. This form of self-preservation on behalf of physicians is detrimental to all parties involved in the medical error.

In a nation where the vast majority of states currently suffer from a medical malpractice liability crisis or are on the verge of a crisis,⁷ it is the responsibility of doctors and patients alike to do what they can to reduce the risk of medical malpractice litigation. Studies suggest⁸ and the recent flood of legislation protecting physicians’ extrajudicial statements confirms that communication between physicians and patients can help ease the tension of looming litigation. Nevertheless, physicians are still hesitant to offer apologies to their patients.

This Note will explore the usefulness of apologies in the field of medicine and the value that they provide to both the physician and patient. Section II explains the integral role communication plays in the physician-patient relationship. Section III explains the reasoning and rationalization as to why physicians and other medical professionals are hesitant to offer expressions of sympathy to their patients. Section IV discusses the current safeguards in place that protect physicians who offer apologies to their patients and describes the mutual benefits of apologies, in both a moral and a legal context. Section V

5. Bill Plaschke, *She Turned Down Millions for Justice for Her Son*, L.A. TIMES, Aug. 2, 2005. The article describes a situation in which Linda Will, mother of the deceased Rashidi Wheeler, refused to accept a \$16 million judgment until she received an explanation and apology from Northwestern University for the death of her son. Linda Will wanted this question answered: “Is it too much for a mother to ask why her son died, and why won’t somebody apologize for it?” *Id.*

6. Peter H. Rehm & Denise R. Beatty, *Legal Consequences of Apologizing*, 1996 J. DISP. RESOL. 115, 115 (1996).

7. AM. MED. ASS’N, AMERICA’S MEDICAL LIABILITY CRISIS: A NATIONAL VIEW (Jan. 2007), http://www.wisconsinmedicalsociety.org/_WMS/communication/press_release/med_liab_jan07.pdf. The map indicates that approximately half of the country is either in a state of medical liability crisis or on the verge of a liability crisis. *Id.*

8. Charles Vincent & Magi Young, *Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action*, 343 LANCET 1609, 1612 (1994). This study surveyed 227 patients and their families who were seeking legal remedies following an adverse medical outcome. The study indicates that the patients and their families decided to take legal action not only because of the original injury, but also because of the insensitive handling and poor communication after the original incident; *see infra* pp. 23-26.

analyzes the difference between mere expressions of sympathy and fault-admitting apologies. This section also discusses the potential benefits and detriments of endorsing fault-admitting apologies. Section VI dissects the apology itself and the potential problems that may accompany widespread use of apologies in a health care setting. Section VII discusses measuring the effect of apologies in the health care industry and the potential ramifications of widespread use. Section VIII concludes that physicians should utilize apologies to heal both the physical and emotional injuries a patient experiences from an adverse medical outcome, thereby benefiting all parties involved.

II. COMMUNICATION IN THE PHYSICIAN-PATIENT RELATIONSHIP

A healthy physician-patient relationship requires a foundation of open and honest communication. The exchange of dialogue between a physician and his or her patient is a fundamental attribute of the relationship.⁹ A patient places faith in his or her physician's skills, while the physician places faith in his or her patient to follow the recommended treatment. The American Medical Association ("AMA") Code of Ethics regarding the physician-patient relationship states: "The relationship between patient and physician is based on trust and gives rise to physicians' ethical obligations to place patients' welfare above their own self-interest and above obligations to other groups, and to advocate for their patients' welfare."¹⁰ When there is a failure to communicate, problems are likely to ensue.¹¹

Communication plays an integral role at every stage of the physician-patient relationship. Prior to treatment, patients rely on the provision of adequate information in order to make an informed decision regarding the course of their medical treatment. The AMA Code of Ethics provides that a "physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice."¹² As such, the communications that take place between the physician and the patient are the

9. AM. MED. ASS'N, CODE OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION, 10.01 FUNDAMENTAL ELEMENTS OF THE PATIENT-PHYSICIAN RELATIONSHIP 311-16 (2006-2007). This provision of the ethical code states that a "patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives . . . to have their questions answered . . . and to receive independent professional opinions." *Id.*

10. AM. MED. ASS'N, CODE OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION, 10.015 THE PATIENT-PHYSICIAN RELATIONSHIP 317 (2006-2007).

11. Ashley A. Davenport, Note, *Forgive and Forget: Recognition of Error and Use of Apology as Preemptive Steps to ADR or Litigation in Medical Malpractice Cases*, 6 PEPP. DISP. RESOL. L.J. 81, 83 (2006) (suggesting that when there is a continued lack of communication, the patient begins to believe that "the physician does not listen, does not speak openly, attempts to mislead the family and does not warn about long-term problems.").

12. AM. MED. ASS'N, CODE OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION, 8.08 INFORMED CONSENT 227-31 (2006-2007). There are, however, exceptions to this requirement if (1) the patient is unconscious and unable to consent to treatment or if (2) disclosing information would pose a risk of detriment to the patient's psychological state. *Id.*

first step to building and strengthening the relationship. A patient who feels comfortable in communicating with his or her physician is likely to have a better relationship with that physician.

Just as the conversations prior to treatment are vital, the communications that transpire between physicians and their patients after treatment are of equal importance. A physician's duty to follow-up with patients does not simply extend to successful treatment. The AMA Code of Ethics also suggests that in the wake of medical error, patients have a right know what happened.¹³ Specifically, the Code of Ethics states that "[c]oncern regarding legal liability which might result following truthful disclosure should not affect the physician's honesty with a patient."¹⁴ Communications that follow an adverse outcome are a topic of heated debate among attorneys, risk management directors, medical malpractice insurance carriers, and physicians themselves. What the conversation should encompass and whether an apology should be offered to the injured party are of special concern. Instinct, morality, and public opinion suggest that communications incorporating an apology may be essential to mending a physician-patient relationship following an adverse outcome.¹⁵

III. WHY PHYSICIANS HOLD THEIR TONGUES

The American College of Physician Executives conducted a study in 2006 titled "Patient Trust and Safety Survey."¹⁶ The study surveyed 1018 physician-members of the American College of Physician Executives.¹⁷ The study suggests that the vast majority of physicians surveyed believed that apologies should be given to patients following a medical error.¹⁸ "Over and over, the adjectives 'right,' 'ethical' or 'honorable' were used to describe a broad convic-

13. AM. MED. ASS'N, CODE OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION, 8.12 PATIENT INFORMATION 240-41 (2006-2007). The Code states that when "a patient suffers significant medical complications that may have resulted from the physician's mistake or judgment . . . [T]he physician is ethically required to inform the patient of all the facts necessary to ensure understanding of what has occurred." *Id.*

14. *Id.*

15. The concept of public opinion regarding apologies is not exclusive to the medical arena. CEOs of large companies have utilized public apologies as a means to regain the trust of their clients and consumers. See Pamela J. Vaccaro, *Putting Politeness Into Practice*, 9 FAM. PRAC. MGMT. 70, 70 (Apr. 2002), available at <http://www.aafp.org/fpm/20020400/70putt.html> (last visited Mar. 31, 2008) (comparing the responses of two CEOs following unfortunate business practices). The CEO of Ford Motor Company spent billions of dollars to replace defective tires, but did not offer an apology. Conversely, the CEO of United Airlines publicly apologized for the airline's inability to get passengers to their destinations on time, but did not offer any sort of compensation. A public poll was conducted, and the CEO of United Airlines was the favored CEO because "[h]e said he was sorry." *Id.*

16. David Ollier Weber, *Who's Sorry Now?*, PHYSICIAN EXECUTIVE, Mar. & Apr. 2006, at 6.

17. *Id.* at 10.

18. *Id.* In response to the question: "In your opinion, do you believe health care organizations should encourage making apologies for medical errors?" Eighty-one percent of the physicians said "yes," four percent said "no," and sixteen percent said "not sure." *Id.*

tion that disclosure/apology is essential.”¹⁹ Thus, the question remains as to why physicians continue to avoid showing remorse and offering expressions of sympathy following an adverse medical outcome.

A. *Fear of Litigation*

The primary argument physicians provide for abstaining from apologies is the fear of an impending lawsuit.²⁰ “[E]ven if an apology is the morally right thing to do, attorneys often will counsel their clients not to apologize because a misunderstanding about liability can disrupt insurance negotiations and effect [sic] the amount of money the offender may have to pay.”²¹ If physicians are told that their expressions of sympathy may be used against them in a medical malpractice lawsuit or that it may jeopardize insurance coverage, the physician will undoubtedly be reluctant to apologize.²² The subsequent effort to try and avoid “legal suicide”²³ contradicts human intuition and promotes an atmosphere of silence.

The Federal Rules of Evidence have furthered physicians’ reluctance to apologize to their patients. These rules have completely disrupted physicians’ ethical and instinctual responses to adverse outcomes. Rule 408 of the Federal Rules of Evidence provides an exception to the hearsay rule, stating that an expression of sympathy offered by the wrongdoer outside of settlement negotiations or mediation may not be protected and may be admissible evidence.²⁴ As such, this rule permits expressions of sympathy to be used against physicians in legal proceedings, thereby fostering their aversion to apologies.

The Federal Rules of Evidence contain an additional exception to the hearsay rule, stating that “[a] statement relating to a startling event or condition made while the declarant was under the stress of excitement caused by the event or condition” is not excluded by the hearsay rule.²⁵ This rule provides another reason why physicians may be hesitant to offer their sympathy. Apologies are often given as a moral reflex,²⁶ but this rule, accompanied with the severity of the situation, may hinder such an instinct.

19. *Id.* at 13.

20. Pavlick, *supra* note 1, at 853; *see also* Weber, *supra* note 16, at 12 (“The most common reason cited for continuing the practice of stonewalling when a medical mistake occurs was simply put by an Illinois group practice head: ‘Apologies . . . for medical errors are used against you in court.’”).

21. Pavlick, *supra* note 1, at 854.

22. Weber, *supra* note 16, at 6. One of the physician’s surveyed commented “Although I believe that apologies should be made . . . our lawyers and risk management personnel are very much against it and block us from doing it.” *Id.* (quotation in original).

23. Daniel Eisenberg, *When Doctors Say, “We’re Sorry,”* TIME, Aug. 15, 2007, at 50.

24. FED. R. EVID. 408; *see also* Jennifer K. Robbennolt, *Apologies and Legal Settlement: An Empirical Examination*, 102 MICH. L. REV. 460, 466 (2003).

25. FED. R. EVID. 803(2).

26. Pavlick, *supra* note 1, at 848 (referencing the term “automatic apology”).

B. *The Patient*

1. *Expectations*

The way in which an expression of sympathy is phrased has a tremendous impact on the recipient's interpretation. Apprehension on the part of the physician and expectation on the part of the patient can lead to misunderstood communications. "[I]f the receiver expects an authentic apology, and the giver offers only an excuse or explanation for his or her behavior . . . forgiveness is not likely to occur. In fact, the receiver, whose expectations are not met, may experience increased anger toward the giver."²⁷ As such, a patient who does not receive the response he or she was expecting may leave feeling resentful and more likely to desire taking legal action against the physician.²⁸

2. *Misinterpretations*

In addition to being angered, a patient who expects to hear a particular sentiment from his or her physician may subconsciously misinterpret what the physician actually said in order to make the statement conform to his or her expectations. "[T]he relational process between both parties may lead to a misunderstanding of what was intended to be communicated by the apology."²⁹ For example, a physician may say to his or her patient, "I'm sorry this happened to you," but the patient, believing the physician owes him or her an apology and an explanation may hear, "I'm sorry I did this to you." While the former statement is a mere expression of sympathy, the latter connotes an admission of fault. This slight variation in wording can be detrimental for the physician.³⁰ This miscommunication may also result in a "he said, she said" situation, where it may be difficult to determine what the parties communicated.

3. *Disclosing the Error*

In some cases, the provider knows a medical error occurred, but the patient is unaware of this fact. In this situation, the provider has to decide not only whether or not to apologize, but whether the error should be disclosed to the patient in the first place. According to AMA ethical policy, the physician

27. *Id.* at 850.

28. Virginia L. Morrison, *Heyoka: The Shifting Shape of Dispute Resolution in Health Care*, 21 GA. ST. U. L. REV. 931, 947 (2005). "Studies document that the failure to meet these expectations, or poor communication in meeting them, can be perceived as measures of disrespect and may inflict as much or more pain than the injury, serving as the catalyst for taking legal action." *Id.*

29. William K. Bartels, *The Stormy Seas of Apologies: California Evidence Code Section 1160 Provides a Safe Harbor for Apologies Made After Accidents*, 28 W. ST. U. L. REV. 141, 150 (2000-2002).

30. See *infra* p. 31.

has a duty to disclose the error to the patient.³¹ Nevertheless, physicians are reluctant to disclose error due to the potential professional and legal ramifications. According to the American Society of Law, Medicine and Ethics, being honest with the patient is the best means of preventing litigation and maintaining the physician-patient relationship.³² “[A]ll types of errors should be disclosed to the patient, not only because the patient has a right to know, but also because good evidence exists that transparency enhances the health care provider-patient relationship.”³³ Evidence also suggests that physicians who try to cover up their errors are the most likely to be sued.³⁴

C. Personal Character

Overall, the public holds the practice of medicine in high regard. Individuals who want to become doctors spend a large portion of their lives trying to achieve that goal. It takes a particular type of person to join the ranks of those who practice medicine, including particular personal attributes that may make it difficult for some to incorporate apologies into the course of their profession.³⁵ Aside from potential legal implications, there are two primary reasons why physicians may find it difficult to apologize to their patients: ego and the nature of the profession.

1. Ego and the Suppression of Apology

Aside from intelligence, physicians tend to have certain personal characteristics that set them apart from others in society. Though not an exhaustive list, some of these characteristics include confidence, competitiveness, and determination. While these attributes may not apply across the board, they are some of the common qualities physicians possess that can unfortunately serve as stumbling blocks when it comes to apologizing.

31. AM. MED. ASS'N, CODE OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION, 8.12 PATIENT INFORMATION 240-41 (2006-2007).

32. See William Winslade & E. Bernadette McKinney, *To Tell or Not To Tell: Disclosing Medical Error*, 34 J.L. MED. & ETHICS 813, 813 (2006).

33. *Id.*

34. Weber, *supra* note 16, at 10. The study also surveyed 1008 adults representing past or future patients. In response to the question, “Suppose you or a family member were the victim of a medical error and the doctor or hospital that made the mistake tried to hide it; would you be more or less likely to sue?” Ninety-two percent of respondents said they would be “more likely” to sue. When asked if they would be more likely or less likely to sue if “the doctor or hospital that made the mistake personally apologized,” twenty-five percent of the respondents said “more likely” and fifty-seven percent of the respondents said “less likely.” *Id.*

35. See generally Aaron Lazare, *Go Ahead Say You're Sorry*, PSYCHOL. TODAY, Jan. & Feb. 1995, at 40. Lazare suggests that apologies are “antithetical to the ever-pervasive values of winning, success, and perfection. The successful apology requires empathy and the security and strength to admit fault, failure, and weakness.” *Id.*

When making an apology, the giver must acknowledge that he or she made a mistake by failing to meet his or her own standards or by failing to live up to the values of the moral community. Worse than the acknowledgment of failure is fear of the shame that accompanies the admission. Pride may keep many individuals from being able to apologize.³⁶

In addition to the fear that potential litigation might result from an apologetic statement, apologizing to one's patient also carries with it the burden of acknowledging the mistake.

2. *Nature of the profession*

At a minimum, an apology may be defined as an admission that there was an error and harm ensued. Although the person expressing the sympathy may not be the one who directly caused the error, it is nevertheless difficult to admit that something went wrong during the course of medical treatment.³⁷ "We all find it difficult to 'fess up,' but it's even harder when your error has caused someone significant physical harm."³⁸ Physicians place a certain amount of pressure on themselves to live up to the ideals society has envisioned for them.³⁹ To admit the existence of an error and to subsequently apologize for it "exposes a chink in that M.D. armor. And if their errors cause serious harm, doctors can feel profound shame and guilt."⁴⁰ Studies indicate, however, that patients realize doctors cannot guarantee medical outcomes. The study conducted by American College of Physician Executives demonstrates that in response to the following two statements, "[M]edical science is so advanced that medical errors should be very rare," and "Medical science is so complex that medical errors are bound to happen," forty-three percent of patients responded "very rare," fifty-three percent of patients responded "bound to happen," and four percent did not know.⁴¹ Accordingly, individual patients and society in general are more forgiving than physicians may presume, but ultimately, a patient's forgiveness is dependent on adequate communication.

36. Pavlick, *supra* note 1, at 852-53.

37. See Lazare, *supra* note 35, at 78. "To apologize, you have to acknowledge that you made a mistake. You have to admit that you failed to live up to values like sensitivity, thoughtfulness, faithfulness, fairness, and honesty. This is an admission that our own self-concept, our story about ourselves, is flawed. To honestly admit what you did and show regret may stir a profound experience of shame, a public exposure of weakness." *Id.*

38. Lucian Leape, *Disclose, Apologize, Explain*, NEWSWEEK, Oct. 16, 2006, at 50.

39. *Id.* The author states that "many physicians still cling to the misguided notion that they need to appear infallible to gain patients' trust and confidence."

40. *Id.*

41. Weber, *supra* note 16, at 11.

IV. IT IS BETTER TO BE SORRY THAN SAFE

A. State Legislation Regarding Expressions of Sympathy

A majority of state legislatures have taken steps to ensure that expressions of sympathy are not considered admissible evidence.⁴² These laws have developed from the basic premise that “[t]he law should not punish people for taking a moral step.”⁴³ This legislation varies from state to state in regard to the specific language that receives protection, the way in which the physician conveys the apology, and whether the apology’s inclusion of an admission of fault. Indiana enacted such legislation in the summer of 2006, protecting expressions of sympathy relating to “(1) a loss; (2) an injury; (3) pain; (4) suffering; (5) a death; or (6) damage to property” from being admitted into evidence.⁴⁴ Questions remain as to what effect the variety of state legislation will have on medical malpractice claims, how apologies will be viewed after such legislation has been enacted, and how the laws will affect the way in which physicians deal with adverse outcomes.

1. *The Massachusetts Approach*

In 1986, Massachusetts enacted the first state legislation designed to protect apologies offered following an accident from being entered as evidence to prove liability.⁴⁵ The legislation originated from a retired Massachusetts legislator whose daughter was struck by a car while riding her bicycle. “Her father, a state senator, was angry that the driver had not expressed contrition. He was told that the driver dared not risk apologizing, because it could have constituted an admission in the litigation surrounding the girl’s death.”⁴⁶ In response to this incident, the senator drafted a bill that would protect wrongdoers who apologized and showed remorse for their actions.

The Massachusetts law protects expressions of sympathy “or a general sense of benevolence relating to the pain, suffering or death of a person involved in an accident and made to such person” from being admissible “as evidence of an admission of liability in a civil action.”⁴⁷ This legislation does not reference the admissibility of communicating fault. As such, it remains unclear whether the law protects fault-admitting expressions of sympathy. Although Massachusetts legislators did not design the language of this state law with as

42. See *infra* Appendix 1 [hereinafter app. 1].

43. Jonathan R. Cohen, *Legislating Apology: The Pros and Cons*, 70 U. CIN. L. REV. 819, 864 (2002).

44. IND. CODE § 34-43.5-1-4 (2007).

45. See Cohen, *supra* note 43, at 827; see generally MASS. GEN. LAWS ANN. ch. 233, § 23D (West 2007).

46. Cohen, *supra* note 43, at 827.

47. ch. 233, § 23D.

much specificity as seen in some other state legislation, they nevertheless set the stage for the future protection of apologies.

2. Reasoning for Legislation

Physicians who commit errors are likely to forgo an apology or expression of sympathy out of fear that it might be held against them in court.⁴⁸ Laws that protect those who offer apologies in the wake of an error will not only benefit the parties directly involved, but the laws will also promote an atmosphere of open communication. Serving as the foundation of a physician-patient relationship, the presence of open communication may lessen the chance that the injured party will file a lawsuit.⁴⁹ Gerald B. Hickson, M.D., Vice Chair of Pediatrics at Vanderbilt University conducted a study in 1992 that demonstrated a strong correlation between malpractice suits and communication issues.⁵⁰ The study indicated that people primarily filed a lawsuit against their physician because they felt that the “physicians covered up facts, did not provide requested information, did not listen when asked questions or attempted to mislead them.”⁵¹ Through the drafting and enacting of legislation that protects such communication, legislators possess the power to potentially decrease the incidence of malpractice claims arising from poor communication.

Apologies may be necessary not only for the injured party, but also for the person who may have caused the harm.⁵² Offering and accepting an apology serve as the basis for the healing process on behalf of both parties involved, providing condolences to the injured and a sense of closure to the injurer. In addition, laws protecting expressions of sympathy benefit more than just those working in the medical field. “Embracing apology is really part of a broader social movement to treat others with respect and directly take responsibility for one’s actions.”⁵³ By passing legislation that protects expressions of sympathy, the state is urging adverse parties to engage in conversations in which the injurer can convey his or her regret and sympathy without fear of imminent liability.⁵⁴

48. Jonathan R. Cohen, *Advising Clients to Apologize*, 72 S. CAL. L. REV. 1009, 1028 (1999) (stating that “it is liability, or the fear of liability, that forms the central barrier to apology in most disputes.”).

49. See Linda O. Prager, *New Laws Let Doctors Say “I’m Sorry” for Medical Mistakes*, AMNEWS, Aug. 21, 2000, <http://www.ama-assn.org/amednews/2000/08/21/prsa0821.htm> (last visited Mar. 20, 2008).

50. Andis Robeznieks, *Being Open May Avoid Lawsuits*, AMNEWS, June 10, 2002, <http://www.ama-assn.org/amednews/2002/06/10/prsb0610.htm> (last visited Feb. 20, 2008). Hickson gathered the results from interviews of 127 Florida families claiming perinatal injury. *Id.*

51. *Id.*

52. See Rehm & Beatty, *supra* note 6, at 116; see also Cohen, *supra* note 48, at 1021.

53. Cohen, *supra* note 43, at 850.

54. See *id.* at 855.

3. Legislative Trends

Since the inception of the Massachusetts law in 1986, a flood of legislation from states across the nation protecting apologies has emerged in the health care field and others. There are currently thirty-two states that protect expressions of sympathy from being admissible evidence.⁵⁵ In 2003, Oregon and Colorado enacted legislation that protected expressions of sympathy specifically in a health care setting from being entered into evidence.⁵⁶ The majority of state legislation protecting expressions of sympathy falls under rules of evidence pertaining specifically to medical error.⁵⁷ A number of states, however, have protected communications of sympathy from being admitted into evidence, regardless if the adverse outcome resulted from the practice of medicine or not.⁵⁸

Additionally, some state laws provide specific guidance as to when the protection applies. For example, the law in Georgia protects expressions of regret and mistake generally, but specifically encourages such communication to take place between health care providers and their patients.⁵⁹ States that have passed legislation protecting apologies in the last couple of years have traditionally utilized language that closely resembles the language originally developed by the states that pioneered “I’m Sorry” legislation. Physicians and attorneys, however, should be cautious when interpreting the applicable state law. Minor differences in the wording of a statute can have a dramatic effect on what a court deems admissible evidence.⁶⁰ Though the differences in statutory language may initially appear trivial, physicians must recognize what constitutes a protected apology under their specific state law.

55. See AM. MED. ASS’N, ADVOCACY RES. CTR., I’M SORRY LAWS: SUMMARY OF STATE LAWS (Jan. 2007), <http://www.ama-assn.org/ama/pub/category/7470.html> (on file with the Author); see *infra* app. 1.

56. Ansley Boyd Barton, *Recent Remedies for Health Care Ills*, 21 GA. ST. U. L. REV. 831, 846-47 (2005).

57. See *infra* app. 1.

58. See *infra* app. 1. Currently, eight states have enacted legislation that protects expressions of sympathy generally and does not limit the protection to specific communications following medical error.

59. See GA. CODE ANN. § 24-3-37.1(a) (West 2007).

60. For example, the law in Tennessee, adopted in 2003, and the law in Missouri, adopted in 2006, utilize very similar language. The Missouri statute, however, excludes the phrase “involved in an accident” and it only protects expressions of sympathy arising from improper health care. The Tennessee statute, on the other hand, protects all expressions of sympathy. Compare TENN. CODE ANN. § 409.1 (2006) with MO. REV. STAT. § 538.229 (2006).

B. In the Courtroom

1. Case Law

Seeing that fear of litigation is physicians' primary reason for abstaining from offering apologies to their patients, it is helpful to consider decisions courts have made in the past. "No matter how many times doctors, hospital administrators, attorneys and malpractice insurers are told so, they still have a hard time believing that there has yet to be a case in which an apology was used as evidence and made a difference in the outcome"⁶¹ Given the large number of cases that end up in settlement or dismissal, little case law exists on this particular subject. Nevertheless, the cases discussed below demonstrate that the use of apologies and other extrajudicial statements made by the physician following a medical error are not alone sufficient to prove negligence.

One of the most frequently referenced opinions regarding extrajudicial statements made by a physician following an adverse outcome is *Lashley v. Koeber*.⁶² In this case, the physician failed to take an x-ray of the patient's finger in a timely manner, resulting in further damage.⁶³ According to plaintiff's testimony, once the physician realized his error, he said, "I know, it is not your fault, Mrs. Lashley, it is all my own."⁶⁴ The court decided to reverse the lower court's decision to grant the defendant's motion for nonsuit, finding that the statement was sufficient to establish that the issue of the physician's negligence should be decided by a jury.⁶⁵ The court acknowledged, however, that "[a]n extrajudicial admission of 'fault' . . . may amount to no more than an admission of bona fide mistake or misfortune and thus be insufficient to establish negligence."⁶⁶

The Supreme Court of California revisited the issue of extrajudicial statements made by physicians twenty-seven years later in *Cobbs v. Grant*.⁶⁷ In response to the plaintiff alleging that the physician told him that "he blamed himself for me being back in there [the hospital for a second time]," the court stated:

[E]ven if the jury had chosen to believe plaintiff, defendant's statement signifies compassion, or at most, a feeling of remorse, for plaintiff's ordeal. Since a medical doctor is not an insurer of result, such an equivocal admission does not constitute a concession that he lacked

61. Eisenberg, *supra* note 23, at 50.

62. *Lashley v. Koeber*, 156 P.2d 441 (Cal. 1945).

63. *Id.* at 442.

64. *Id.*

65. *Id.* at 445.

66. *Id.*

67. *Cobbs v. Grant*, 502 P.2d 1 (Cal. 1972).

or failed to use the reasonable degree of learning and skill ordinarily possessed by other members of the profession in good standing in the community, or that he failed to exercise due care.⁶⁸

California passed its “I’m Sorry” law in 2003, excluding any statement or gesture expressing sympathy offered to the victim following an accident.⁶⁹

The Supreme Court of Vermont also addressed the issue of extrajudicial statements in *Senesac v. Associate in Obstetrics and Gynecology*.⁷⁰ There the patient sued the physician for medical negligence following an abortion procedure.⁷¹ The physician’s motion for directed verdict was granted, because the patient failed to offer expert testimony to show the physician lacked the “requisite care and skill as is required.”⁷² The patient tried to demonstrate that the physician’s statement that she “made a mistake, that she was sorry, and that it had never happened before” was sufficient to prove negligence.⁷³ The court denied the patient’s argument, stating:

It is conceivable that in some circumstances the extrajudicial admission of a defendant physician could establish a prima facie case of negligence in a medical malpractice action. . . . the asserted statement of Dr. Gray . . . does not establish a departure from the standard of care ordinarily exercised by a reasonably skillful gynecologist.⁷⁴

The Supreme Court of Vermont echoed a similar sentiment in *Phinney v. Vinson*,⁷⁵ in which the court held that the physician’s apology for failing to perform an adequate resection for the patient’s prostate was “insufficient to meet plaintiffs’ burden” of proof.⁷⁶

As the aforementioned cases evince, even if a patient does take his or her doctor to court, the use of an apology to prove negligence is not likely to pass muster.⁷⁷ Although each court may differ in its characterization of a defen

68. *Id.* at 6.

69. See CAL. GOV’T CODE § 11440.45 (West 2007).

70. *Senesac v. Assocs. in Obstetrics & Gynecology*, 449 A.2d 900 (Vt. 1982).

71. *Id.* at 901.

72. *Id.* at 903.

73. *Id.* at 314.

74. *Id.* at 314-15.

75. *Phinney v. Vinson*, 605 A.2d 849 (Vt. 1992).

76. *Id.* at 849.

77. Pavlick, *supra* note 1, at 847. “[I]f apology does not appeal to reason and deals more with moral rather than legal roles, it is not surprising that it does not play a larger part in dispute resolution within a court-based legal system.” *Id.*

dant's extrajudicial statement, the majority of case law gives the impression that saying "I'm sorry" does not produce a prima facie case of medical malpractice.

2. *Effect of Apologies in Litigation*

Even if the wrongdoer apologizes to the injured party and the apology is entered into evidence, studies indicate that jurors perceive those who show remorse more positively than those who do not.⁷⁸ In *Wardrip v. Hart*, the district court took into consideration the fact that the defendant physician "never apologized to the plaintiff or demonstrated genuine remorse for his conduct" after injecting the plaintiff's foot with absolute alcohol.⁷⁹ The court imposed a punitive damage award against the defendant in the amount of \$200,000.⁸⁰ As such, apologies, or lack thereof, inevitably weigh on the minds of judges and juries during litigation. A defendant that apologizes to the injured party will likely invoke sympathy on behalf of the judge and jury.⁸¹ "Judges and juries understand that expression of sympathy, regret, remorse and apology are not necessarily admissions of responsibility or liability."⁸² In the courtroom, the judge and jurors are also aware that the defendants in medical malpractice trials are more than just physicians;⁸³ they are human beings capable of feeling regret and sympathy.

C. *Scholarly Studies*

1. *The Robbennolt Study*

Jennifer K. Robbennolt conducted a study entitled the "Effects of Apologies on Settlement Decisionmaking and Factors Influencing the Effects of Apologies."⁸⁴ Robbennolt's study investigated the effect of apologies on settlement decision-making. In conducting this study, Robbennolt considered three forms of communication: no apology, partial apology, and full apology. She defined a partial apology as one in which the party "merely expressed sympathy for the potential claimant's injuries," and a "full apology" as one in which the party "also took responsibility for causing the injuries."⁸⁵ In other

78. Robbennolt, *supra* note 24, at 476.

79. See *Wardrip v. Hart*, 949 F.Supp. 801, 805 (D. Kan. 1996).

80. *Id.*

81. Cohen, *supra* note 48, at 1022.

82. Robbennolt, *supra* note 24, at 470.

83. Rehm & Beatty, *supra* note 6, at 121. "It appears that there is an understanding that the result of an operation is not guaranteed, not every operation will be successful, and an apology for the inadequacy of an operation does not mean the doctor is liable for negligence." *Id.*

84. Robbennolt, *supra* note 24, at 484-501.

85. *Id.* at 484.

words, Robbennolt differentiated between a simple expression of sympathy and a fault-admitting apology.

The results of this study demonstrated that injured patients were more inclined to accept settlement offers when given a full apology, rather than a partial apology or no apology at all.⁸⁶ The responses indicate, however, that a partial apology was better than no apology at all.⁸⁷ This study furthers the assertion that doctors who take it upon themselves to not only apologize to their patients in the wake of a medical error, but also accept responsibility for the error may suffer a lesser monetary and emotional detriment.

2. *The Vincent Study*

In 1992, Charles Vincent and others conducted a study entitled "Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action."⁸⁸

Vincent's study demonstrates that families and patients who filed a medical malpractice lawsuit against a physician would not have done so if the physician had offered a full explanation and an apology.⁸⁹ Additionally, the study indicated that the factors that were present weighed more heavily in favor of communicating about the issue rather than seeking mere monetary compensation.⁹⁰ Similar to the Robbennolt study, this survey demonstrates that open communication that includes an expression of sympathy will likely reduce the physician's odds of ending up in the courtroom.

3. *The Gallagher Study*

Thomas Gallagher's study utilized focus groups comprised of patients and physicians who discussed the proper way to handle a hypothetical medical error.⁹¹ Gallagher's study demonstrated that patients wanted to be assured that their physician felt remorse and would make changes to prevent the error from

86. *Id.* at 485-86. The participants in the study each assumed the role of a patient who was injured as a result of a physician's medical error. Each participant was given a settlement offer. When no apology was offered to the patient, fifty-two percent of respondents stated that they would "definitely or probably accept the offer," forty-three percent said they would "definitely or probably reject the offer," and five percent were unsure. When a partial apology was offered, thirty-five percent accepted the offer, twenty-five percent were inclined to reject the offer, and forty-percent were unsure. When a full apology was offered, seventy-three percent of the respondents were "inclined to accept the offer" and only thirteen to fourteen percent either rejected the offer or remained unsure. *Id.*

87. *Id.* at 480.

88. Vincent & Young, *supra* note 8, at 1612.

89. *Id.* at 1611. Almost forty percent of respondents who filed a medical malpractice claim stated that the litigation would not have been necessary if the physician had explained the circumstances to the patient and family, as well as apologized. *Id.*

90. *Id.* at 1612.

91. Thomas H. Gallagher et al., *Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors*, 289 JAMA 1001, 1001 (2003).

reoccurring.⁹² The study also revealed that the physicians wanted to apologize to their patients following an adverse outcome, but were concerned about the potential for legal liability.⁹³ Many physicians who participated in the study expressed the belief that if the patient desired more information or further communication, the patient would simply ask “follow-up” questions.⁹⁴ The study demonstrates that there is a gap in the communication between the physician and the patient, which may lead to potential legal ramifications for the physician. Patients indicated that “they would be less upset if the physician disclosed the error honestly and compassionately and apologized . . . [and] . . . that explanations of the error that were incomplete or evasive would increase their distress.”⁹⁵ Gallagher’s study suggests that if physicians strive to bridge the communication gap that typically arises after an adverse medical outcome, the patient will be more inclined to discuss the matter with the physician directly rather than with an attorney.

*D Economic Benefits to Protecting Apologies*⁹⁶

1. Preventing Litigation

Apologies are likely to reduce the injured party’s anger, thereby reducing the possibility of the party filing suit.⁹⁷ Studies demonstrate that the majority of patients who have been injured as a result of a medical error would not have pursued a lawsuit against the physician if the physician had apologized for the harm after it occurred.⁹⁸

Many patients who have been injured as a result of medical malpractice simply want to ensure that the physician who allegedly caused the harm will not cause harm to other patients. “[A] recipient’s interpretation of an apology as an indication that the behavior will not be repeated may predict willingness to settle.”⁹⁹ Accordingly, injured parties often feel that if the wrongdoer expresses sympathy and remorse for his or her actions, he or she is not likely to let the same harm take place in the future.¹⁰⁰ Likewise, physicians who utilize open communication with their patients are likely to engage in open communication

92. *Id.* at 1004.

93. *Id.*

94. *Id.* at 1003-04.

95. *Id.* at 1005.

96. Jonathan R. Cohen, *Apology and Organizations: Exploring an Example from Medical Practice*, 27 *FORDHAM URB. L.J.* 1447, 1458 (2000).

97. Cohen, *supra* note 48, at 1022.

98. Cohen, *supra* note 45, at 842.

99. Robbennolt, *supra* note 24, at 479.

100. *Id.* at 478.

with their risk managers and staff supervisors, increasing the potential for preventative action to be taken.¹⁰¹

2. Encouraging Settlement Discussions

Under some circumstances, serious settlement discussions cannot take place until a genuine expression of sympathy is offered to the injured party.¹⁰² “Indignity can be a large barrier to compromise, and in many cases, an apology is needed before other aspects of the dispute, such as monetary compensation, can be settled.”¹⁰³ An apology alone may not be a sufficient remedy for the injured party. “[A] statement of sympathy does not mend the wound nor restore a party to her pre-injured status.”¹⁰⁴ Nevertheless, physicians who apologize for their errors begin the healing process for the injured party and enable the patient to look beyond anger and towards recovery.

E. Case Studies

1. Veterans Affairs Medical Center in Lexington, Kentucky

The state of Kentucky does not currently have a law that protects expressions of sympathy from being admitted as evidence. Kentucky, however, has made its mark by the way one of its hospitals handles adverse medical outcomes. The Veterans Affairs Medical Center in Lexington (the “Lexington VA hospital”) emphasizes the importance of telling the truth. In 1987, the Lexington VA hospital initiated a revolutionary approach to handling medical errors.¹⁰⁵ The new approach required physicians to inform patients of any medical error that resulted in harm, even if the patient was unaware that the harm took place.¹⁰⁶ “[I]f the Lexington VA’s risk management committee determined that the hospital was at fault, the hospital would offer an apology to the patient and family and admit fault both verbally and in writing.”¹⁰⁷ In addition to disclosing the error and apologizing to the patient and his or her family,

101. Cohen, *supra* note 96, at 1467. “[E]xternal apology can prompt the disclosure and the investigation of errors that is needed for preventive measures.” *Id.*

102. Bartels, *supra* note 29, at 154. The author suggests that an expression of sympathy may “serve as a lubricant to advance settlement by softening the psychic injury that prevents the parties from agreeing on the amount of compensation.” *Id.*

103. Cohen, *supra* note 48, at 1020.

104. Bartels, *supra* note 29, at 155; see also Anushka Asthana, *Try Saying Sorry, NHS Doctors Told*, OBSERVER, Sept. 18, 2005 (suggesting that although litigation might be reduced as a result of protecting apologies, patients who deserve compensation for their injuries should get it).

105. Cohen, *supra* note 96, at 1447.

106. *Id.* at 1452.

107. Davenport, *supra* note 11, at 86-87.

the Lexington VA hospital actually offers direction on how to file a claim.¹⁰⁸ While this practice would presumably increase the amount of medical malpractice litigation, the opposite has proven true.¹⁰⁹

The Lexington VA hospital adopted the error disclosure policy after suffering two malpractice lawsuits in 1986, costing approximately \$1.5 million in damage awards. Since the inception of the program, the Lexington VA hospital “has reduced its claims payments from among the highest in the 178-hospital VA system to one of the lowest.”¹¹⁰ It is worth mentioning that as a veterans’ hospital, the VA is a governmental entity, and its liability is therefore governed under the federal Tort Claims Act.¹¹¹ This is noteworthy because VA hospitals enjoy protection from punitive damages, as well as distinct procedural rules, which may reduce the amount of liability exposure a VA hospital has as compared to a private hospital.¹¹² In comparison to other VA hospitals across the nation, however, the Lexington VA hospital is in the top quarter for total claims payments and the top sixth for average payment per claim.¹¹³ This first case study suggests that it is in the interest of both physicians and health care facilities to adopt policies governing the procedures for dealing with medical error claims.¹¹⁴

2. *Physicians Reimbursement Fund*

The Physician Reimbursement Fund, a professional liability insurance provider, has made a name for itself over the past thirty years by becoming the longest standing program with the “most comprehensive, least cautious, and most true to conflict resolution principles.”¹¹⁵ This physician-operated carrier, based in San Francisco, California, was developed in response to rising malpractice insurance rates.¹¹⁶ The program encourages physicians to utilize their communication skills and natural problem-solving talents to respond to medical errors.¹¹⁷

108. Robert J. Walling & Shawna S. Ackerman, *Having to Say You’re Sorry*, CONTINGENCIES, Nov. & Dec. 2006, at 46, available at <http://www.contingencies.org/nov-dec06/trade.pdf> (last visited Mar. 31, 2008).

109. *Id.* In the past seventeen years, only three cases have gone to trial, and the average settlement costs \$16,000, as opposed to the national VA average of \$98,000.

110. Cohen, *supra* note 96, at 1449 (quoting Andrea Gerlin, *Accepting Responsibility*, PHILADELPHIA INQUIRER, Sept. 14, 1999, at A18.).

111. Cohen, *supra* note 96, at 1455.

112. *Id.*

113. *Id.* at 1457.

114. Berkley Rice, *10 Ways to Guarantee a Lawsuit*, MED. ECON., July 8, 2005, at 66, available at <http://www.memag.com/memag/Medical+Malpractice%3A+Communication/10-ways-to-guarantee-a-lawsuit/ArticleStandard/Article/detail/168737> (last visited Mar. 20, 2008).

115. Morrison, *supra* note 28, at 949.

116. *Id.*

117. *Id.* at 949-50.

The underlying policy of the program is called "Code Green".¹¹⁸ Code Green's primary goal is the patient's health and safety, as well as the maintenance of the physician-patient relationship.¹¹⁹ "Physicians are asked to give a full apology, including admitting error if accurate, for everyone involved in the care; they are counseled that sincerity is much more important than particular language."¹²⁰ These communications, however, do not automatically infer that the physician is liable or to blame for the error.¹²¹ As a result of the program, the Physician Reimbursement Fund pays less than \$600 dollars on average for the early resolution of a case as opposed to the average cost of \$19,541 to enter into the legal arena.¹²² In addition to a decrease in pay-outs, the program has also been able to offer physicians practicing in high-risk specialties premiums that are considerably lower than market price.¹²³

3. *How the COPIC Insurance Co. Encourages Physicians to Apologize*

The COPIC Insurance Company, established in Denver, Colorado, developed a new program that also encourages physicians to apologize for any medical errors. "The program focuses on teaching doctors to discuss medical errors, say 'I'm sorry' and figure out how to 'make the patient whole.' The goal is to keep patients happy with their doctors and avoid costly lawsuits."¹²⁴ The program places the duty on the physician to communicate about the error, whereas the carrier only speaks to the patient specifically about reimbursement.¹²⁵ This approach eliminates any potential insinuation that the physician's concern for the patient's health is influenced by the desire to avoid stuffing the patient's pockets. Within four years of the COPIC program's inception, 1325 physicians joined and 433 claims were adjudicated, with payouts ranging from \$100 to \$26,000.¹²⁶ In addition to coaching physicians in the wake of medical error, COPIC also offers mandatory training for doctors on the discussion of medical errors, apologizing, and how to make the patient whole after an adverse outcome.¹²⁷ COPIC's policy serves as additional evidence that utilizing apologies

118. PHYSICIANS REIMBURSEMENT FUND, INC., CODE GREEN, http://www.prfrfg.com/code_green.shtml [hereinafter PHYSICIANS REIMBURSEMENT FUND] (last visited Feb. 20, 2008).

119. *Id.*

120. Morrison, *supra* note 28, at 950.

121. PHYSICIANS REIMBURSEMENT FUND, *supra* note 118.

122. Morrison, *supra* note 28, at 953.

123. *Id.* at 954. The Fund says it can offer specialists in obstetrics and gynecology, orthopedic surgery, and general surgery insurance premiums that are forty percent less than market price. *Id.*

124. Rachel Brand, *Doctors Taught to Admit Mistakes and Apologize: COPIC Seeks More Disclosure, Cut in Malpractice Lawsuits*, ROCKY MOUNTAIN NEWS, Mar. 10, 2004, at 3B.

125. Morrison, *supra* note 28, at 949.

126. Brand, *supra* note 124, at 3B.

127. Walling & Ackerman, *supra* note 108.

in a structured approach to handle medical error lessens the burden on the physician, the patient, and the insurance company.

V. FAULT-ADMITTING APOLOGIES VS. EXPRESSIONS OF SYMPATHY

A. Differences Among the States

One of the primary variations among the state laws protecting apologies is whether the protection includes apologies admitting fault. Almost half of the states that afford protection to physicians who apologize do not protect admissions of fault, even if the admission is subsumed within an expression of sympathy.¹²⁸ “It is the power of an apology to resolve conflict that makes the exemption so attractive . . . , and it is the powerful content of an apology – the admission of fault – that makes [others] so opposed to these laws.”¹²⁹ Colorado, Connecticut, South Carolina, and Georgia are the only states that currently protect fault-admitting expressions of sympathy from being entered into evidence.¹³⁰ “While the intuition is that such apologies [not admitting fault] will not be as effective as more complete apologies that acknowledge responsibility, partial apologies are thought by some to be better than failing to apologize at all.”¹³¹ It is imperative that physicians know what type of apologies their state laws protect, because the vast majority of “I’m Sorry” legislation does not shield physicians who admit fault when apologizing.

B. Benefits of Protecting Fault-Admitting Apologies

At about the same age children are taught to apologize when they have done something wrong, children are also taught that honesty is the best policy. Intuition and ethics urge individuals to take full responsibility for their actions, regardless of the consequence. In spite of learned behavior, the imminent threat of a medical malpractice lawsuit may encourage health care providers to limit their disclosures of error to the patient. “[I]f the doctor really cares about having a positive relationship with the patient, the best foundation is by revealing the whole truth. A doctor who wants to be fully forthcoming should be counted

128. See AM. MED. ASS’N, ADVOCACY RES. CTR., I’M SORRY LAWS: SUMMARY OF STATE LAWS (Jan. 2007), <http://www.ama-assn.org/ama/pub/category/7470.html> (on file with the author); see *infra* app. 1.

129. Cohen, *supra* note 43, at 866.

130. Barton, *supra* note 56, at 848. The article does not include Connecticut or South Carolina as states that protect fault-admitting apologies because those laws were approved after the Barton article was published; see also Matt Kempner, *Legislature ’05: Tort Bill covers Doctors’ Words, Too*, ATLANTA J. & CONST., Feb. 12, 2005, at F1.

131. Robbennolt, *supra* note 24, at 469.

as morally praiseworthy”¹³² States with laws that protect fault-admitting apologies reward those who take responsibility for their actions.

Jonathan Cohen, Associate Professor of Law and Associate Director of the Institute for Dispute Resolution at the University of Florida Levin College of Law, identifies four reasons for protecting fault-admitting expressions of sympathy.¹³³ The first is to encourage parties to settle and avoid the costly and time-consuming litigation.¹³⁴ Second, fault-admitting apologies “promote natural, open and direct dialogue between people after injuries”¹³⁵ Communication is an essential component of a good physician-patient relationship. In the aftermath of an unfavorable outcome, communication is essential to salvage that relationship. Thirdly, apologies that admit fault “express the culmination of the logic already implicit in the evidence codes”¹³⁶ In essence, fault-admitting apologies are the equivalent of admitting one’s guilt. Under the Federal Rules of Evidence, party-opponent admissions are admissible evidence.¹³⁷ Thus, fault-admitting apologies not only express the physician’s sympathy, but also express the physician’s willingness to admit he or she committed error. The final and perhaps most important benefit of protecting fault-admitting apologies is the encouragement of individuals to engage in the “moral and humane act of apologizing after they have injured another.”¹³⁸

In addition to the benefits outlined by Cohen, fault-admitting apologies can also prevent future mistakes. “[A]pologizing involves admitting mistakes, and when mistakes are more easily admitted future mistakes are more easily prevented.”¹³⁹ As such, fault-admitting apologies are beneficial to more than just the health care provider and the patient. Hospitals can utilize the information disclosed following medical error to prevent future occurrences. Thus, disclosure of the mistake will likely improve both the efficiency of the hospital and the safety of future patients.

Finally, fault-admitting apologies benefit those who are directly involved in the adverse incident. “The patient may benefit from learning information about the specific medical error and from feeling that he is being dealt with honestly. The medical provider may benefit as well, finding a psycho-ethical release from the guilt attached to a concealed mistake.”¹⁴⁰ This sort of

132. Cohen, *supra* note 48, at 1061.

133. Cohen, *supra* note 43, at 841.

134. *Id.*

135. *Id.*

136. *Id.*

137. FED. R. EVID. 801(d)(2).

138. Cohen, *supra* note 43, at 841.

139. *Id.* at 863; *see also* Cohen, *supra* note 96, at 1465 (discussing the link between expressions of sympathy and the prevention of future errors). Cohen states, “As an act of external honesty, openness and humility, apology can facilitate the same internally and thus promote change.” *Id.*

140. Jonathan R. Cohen, *Toward Candor After Medical Error: The First Apology Law*, 5 HARV. HEALTH POL’Y REV. 21, 22 (2004).

communication promotes an atmosphere in which physicians maintain their integrity and patients receive sincere responses to their questions and concerns.

C. Potential Disadvantages of Protecting Fault-Admitting Apologies

In protecting apologies that incorporate an admission of fault there is potential for abuse. It is possible that wrongdoers will “issue apologies knowing that there’s no real risk involved, but naïve injured parties will think these apologies are meaningful [They] will think the injurers are putting their necks on the line when in fact they aren’t.”¹⁴¹ By preventing fault-admitting apologies from being entered into evidence, lawyers and legislators could potentially be undermining a key aspect of an apology: admitting you are wrong and accepting the consequences.¹⁴²

No one likes to communicate unwelcome information, but if statutory protection minimizes penalties for doing so, the inclination to disclose one’s fault increases. “When the performer of apology is protected from the consequences of the performance through carefully crafted statements and legislative directives, the moral thrust of apology is lost.”¹⁴³ Where wrongdoers once felt compelled by their conscience to offer apologies to those they harmed, they may now have ulterior motives for apologizing.

Apologies involve more than just words. A physician executive who participated in the “Patient Trust and Safety Survey” conducted by the American College of Physician Executives remarked:

The word ‘apology’ seems inappropriate unless the provider were to perceive negligence on his/her/its own part. To acknowledge that there has been an adverse event directly related to what was done or not done by the provider, genuine concern for the patient’s ongoing welfare, and an effort to provide support and continuity of care is what is important. ‘I’m sorry’ is too easy, too dangerous, and meaningless unless associated with the above three components.¹⁴⁴

By protecting individuals from the consequences of admitting they did something wrong, states that enact legislation protecting fault-admitting apologies run the risk of eliminating the essence of a true apology.

141. Cohen, *supra* note 4, at 856.

142. Lee Taft, *Apology Subverted: The Commodification of Apology*, 109 YALE L.J. 1135, 1157 (2000).

143. *Id.*

144. Lola Butcher, *Lawyers Say ‘Sorry’ May Sink You in Court*, PHYSICIAN EXECUTIVE, Mar. & Apr. 2006, at 20, 23.

VI. THE ACTUAL APOLOGY

A. *Definition of "Apology"*

The art of apologizing requires more than a simple declaration of "I'm sorry." Given the varying styles of presenting an apology and the numerous ways an apology may be interpreted, attorneys advising their physician-clients "will have to first be precise about what constitutes expressions of sympathy and statements of fault, and second, properly determine the meaning behind the apology at issue."¹⁴⁵ What one person considers an expression of sympathy, another person may consider an admission of fault.

An "apology" is defined as "an *admission of error* or discourtesy accompanied by an expression of regret" (emphasis added).¹⁴⁶ This definition alone implies that the declarant of an apology is at fault, rather than merely expressing sympathy for the injured party. Accordingly, some state statutes have left the word "apology" out of statutory language, so as not to infer protection of an admission of fault. Other states have utilized the word "apology," but added an additional provision specifying that fault-admitting apologies are considered admissible as evidence.¹⁴⁷ Some states, however, have enacted legislation that protects "apologies" and yet does not address the admissibility of fault-admitting apologies.¹⁴⁸ These examples highlight that the definition of "apology" combined with the lack of specificity in certain state laws could potentially lead to legislative misinterpretation and confusion. As such, attorneys and physicians should take great care when interpreting and applying the protections afforded by their applicable state law.

There are three possible elements to an apology: "(i) admitting one's fault, (ii) expressing regret for the injurious action, and (iii) expressing sympathy for the other's injury."¹⁴⁹ The presence of any one of these elements, in particular the first, may result in the statement being admitted into evidence, depending on the language of the relevant state statute. Therefore, both physicians and their attorneys must know which elements of an apology are protected and which are not.

B. *Presentation of an Apology*

An expression of sympathy that is given by the injuring party out of his or her own free will is likely to produce a better outcome. "[I]n general, the more

145. Bartels, *supra* note 29, at 149-50; *see also* Rehm & Beatty, *supra* note 6, at 117.

146. MERRIAM-WEBSTER ONLINE DICTIONARY, <http://www.merriam-webster.com/dictionary/Apology> (definition of apology) (last visited Mar. 20, 2008).

147. *See infra* app. 1.

148. *See infra* app. 1.

149. Cohen, *supra* note 48, at 1014-15.

an apology is coerced, the less meaning it carries, for the less sincere is the regret it expresses.”¹⁵⁰ Given the delicate nature of an injured victim following his or her injury, it is important that the communication between the injurer and injured be honest and devoid of ulterior motives. Therefore, in preparing to discuss an adverse medical outcome with a patient, physicians should consider the “who, what, and when” of apologizing prior to making the communication.

1. *Who Should Give the Apology?*

An injured party may accept an apology as being more sincere if it comes from the party who caused the harm.¹⁵¹ If possible, “[t]he doctor who treated the patient – not a staff person – should explain the rationale for his diagnosis and treatment, why complications may have occurred, and how he’ll manage them.”¹⁵² If the communications come directly from the wrongdoer, the patient is more likely to feel that the wrongdoer acknowledges the error, prioritizes the importance of communicating with the patient, and expresses sympathy for the patient.

2. *What Can and Cannot be Said?*

Syntax can determine whether the physician’s words were simply an expression of sympathy or instead an admission of fault. There is a difference between saying “I am sorry that you are hurt,” and “I am sorry that I hurt you.”¹⁵³ Patients may interpret a physician’s expression of sympathy as an admission of fault, resulting in later complications during settlement negotiations and/or litigation.¹⁵⁴ Therefore, certain words such as, “mistake,” “error,” or “accident” should be avoided.¹⁵⁵

There are four parts to a good apology: “an acknowledgment of the mistake or wrongdoing, the acceptance of responsibility, an expression of regret, and a promise that the offense will not be repeated.”¹⁵⁶ It should be noted that an admission of fault is not considered one of the primary components of an apology. This is because there is a distinction between acknowledging a mistake and admitting fault for the mistake.

150. *Id.* at 1018.

151. *Id.* at 1051.

152. Rice, *supra* note 114, at 66.

153. Davenport, *supra* note 11, at 99.

154. Prager, *supra* note 49. The article quotes Ron Neupauer, Vice President of Medical Underwriters of California, who states, “The problem many doctors have is finding the distinction between expressing sorrow and admitting fault.” *Id.*

155. Rice, *supra* note 114, at 66.

156. Barbara Kellerman, *When Should a Leader Apologize and When Not?*, HARV. BUS. REV., Apr. 2006, at 72, available at 2006 WLNR 6089299 (asserting that “a less-than-perfect apology is often better than no apology at all.”).

3. *When Should the Apology be Given?*

The sooner the apology is given, the more likely the injuring party will avoid a conflict. “An early apology may prevent an injury from turning into a dispute, nipping possible conflict in the bud.”¹⁵⁷ In order to smooth the way for future conversations, many experts agree that the sooner an apology is given, the better.¹⁵⁸ Some professional liability insurance providers, however, encourage the physician not to apologize until he or she knows that an error actually occurred. The Doctor’s Company, a medical malpractice insurance provider, suggests that physicians should take a moment to assess the incident before instinctively offering an apology.¹⁵⁹

While the empathetic concern and emotional support expressed during this meeting [with the patient] require sensitivity, an apology is usually not appropriate at this time – unless the investigation of the event has been completed and shows that a clear-cut error has occurred and could have been prevented, and that the person making the apology was responsible.¹⁶⁰

Although the Doctor’s Company encourages full disclosure of adverse events along with a genuine expression of sympathy and even an apology if necessary,¹⁶¹ it also wants to ensure that their physicians are not inadvertently exposing themselves to liability by offering apologies in absence of error.

Gerald B. Hickson, M.D., Vice Chair of Pediatrics at Vanderbilt University, has spent over fifteen years studying the reasons why doctors get sued.¹⁶² Hickson’s study indicated that one of the reasons doctors get sued is a result of “deteriorating relationships.”¹⁶³ In order to preserve the physician-patient relationship, timely communication is essential.¹⁶⁴ “[F]ull disclosure of an adverse event at 5 a.m. may not be understood or explained well, but waiting may create distrust if the patient and his or her family learn later that not all the information

157. Cohen, *supra* note 48, at 1049.

158. Reni Gertner, *The Art of Apologizing Takes Hold in the Legal World*, DAILY RECORD, Dec. 22, 2005, available at 2005 WLNR 22036598 (Ashley McCown, executive vice president of the public relations firm Solomon McCown emphasizes the importance of quick apologies, but warns physicians that “[y]ou never want to say something when you’re not absolutely sure about the facts.”).

159. David B. Troxel, *Physician Disclosure of Adverse Events*, THE DOCTOR’S ADVOCATE, Second Quarter 2006, at 1, 6.

160. *Id.*

161. *Id.*

162. Robeznieks, *supra* note 50.

163. *Id.*

164. See 735 ILL. COMP. STAT. ANN. 5/8-1901 (West 2007). Illinois law only protects expressions of sympathy or explanation “within 72 hours of when the provider knew or should have known of the potential cause of such outcome.” *Id.*

was given when it was first known.”¹⁶⁵ While it seems there is never a good time to disclose unpleasant news, the sooner an injured party receives communication regarding the adverse event, the less likely the issue will give rise to a lawsuit.¹⁶⁶

4. *Advising How to Apologize*

With the increasing presence of “I’m Sorry” laws, some practitioners and activist groups have started to develop strategies on how to communicate an effective apology. For example, in Scotland, the Scottish Public Services Ombudsman’s office is currently drafting a seven-point advice list to serve as a guideline when offering apologies, detailing what an injured party expects when resolving a complaint.¹⁶⁷ Sherry Kwater, director of quality and performance improvement at St. Francis Medical Center in Peoria, Illinois, believes that physicians should rehearse what they plan to say to their patients and should avoid words that suggest blame, such as “mishap.”¹⁶⁸ The problem with these strategies and guidelines is that they may begin to depreciate the true value of the apology. “[A] sincere apology that is delivered too cavalierly or given after months of legal posturing, may be perceived to be insincere and could actually increase tension between the parties.”¹⁶⁹ A scripted apology may engender more anger on behalf of the injured party than had there been no communication between the two parties at all.¹⁷⁰ Physicians first have to become comfortable with the concept of apologizing in the wake of a medical error, and then try to apply it in the proper context. Given the traditional disfavor of utilizing apologies in the health care field, physicians will need guidance before implementation.

C. *Sincerity and Ulterior Motives*

Safeguarding apologies through state laws and judicial protections may affect the way in which apologies are viewed. If a patient is aware that apologies are offered without the potential for consequence, then he or she may be less likely to view the apology as serving its purpose. By barring apologies

165. Robeznieks, *supra* note 50.

166. Andis Robeznieks, *The Power of an Apology: Patients Appreciate Open Communication*, AMNEWS, July 28, 2003, <http://www.ama-assn.org/amednews/2003/07/28/prsa0728.htm> (last visited Mar. 31, 2008) (according to Ilene Corina, president of Persons United Limiting Substandards and Errors in Health Care, “Patients will keep looking until their questions are answered. . . . If all the doors are closed to them, they will go to lawyers.”) (last visited Mar. 20, 2008).

167. Damien Henderson, *Public Services Are Given Guidelines on How to Say Sorry*, HERALD (Glasgow, Scot.), Sept. 27, 2006, at 6.

168. Robeznieks, *supra* note 166.

169. Bartels, *supra* note 29, at 150; *see also* Cohen, *supra* note 48, at 1051 (“A natural expression will sound sincere, but staged sycophancy will ring empty.”).

170. Robeznieks, *supra* note 166.

from entry as admissible evidence, a wrongdoer might apologize for the wrong reasons. It might “cheapen the meaning of an apology,” because the wrongdoer knows he has nothing to lose by apologizing.¹⁷¹ Some scholars suggest that only full, unprotected apologies serve the moral and ethical purpose of an apology.¹⁷² In this respect, the argument is that without the potential for consequences arising from an apology, “we risk subverting its moral dimension.”¹⁷³ Without the moral dimension, an apology may be seen as nothing more than a “get out of the courtroom free” card.¹⁷⁴ Additionally, physicians who utilize apologies as a means to manipulate the injured party may engender hostility between the parties, rather than easing the conflict by offering a genuine expression of sympathy.¹⁷⁵

VII. IS SAYING “I’M SORRY” ENOUGH?

A. *Where’s the Proof?*

The effect of utilizing apologies in the wake of a medical error is hard to quantify, given the difficulty in tracking medical malpractice settlements and other forms of alternative dispute resolution. “[T]here is a growing body of empirical evidence that apologies can have important effects on a variety of judgments that may underlie legal-settlement decisions. There has been very little systematic investigation, however, of the particular effects of apologies on legal-settlement decisionmaking.”¹⁷⁶ As such, the desire for more states to “legislate morality” may not be very intense, given the nominal proof that protecting apologies will have any effect on medical malpractice claims.¹⁷⁷ Additionally, those states that currently have “I’m Sorry” laws in effect do not necessarily enjoy a state of medical malpractice tranquility.¹⁷⁸ Case law and case studies suggest, however, that apologies do not render guilty verdicts and may actually prevent the physician from having to set foot in a courtroom in the first place.

171. Cohen, *supra* note 43, at 847.

172. Lee Taft, *Apology Within a Moral Dialectic: A Reply to Professor Robbennolt*, 103 MICH. L. REV. 1010, 1013 (2005).

173. *Id.*

174. Eisenberg, *supra* note 23, at 50 (noting that many critics feel that “[a]pology laws . . . could just usher in an epidemic of playacting.”).

175. Bartels, *supra* note 29, at 154.

176. Robbennolt, *supra* note 24, at 480.

177. Prager, *supra* note 49 (quoting Paul R. Barach, M.D., a safety researcher and professor of intensive care and cardiac anesthesia at the University of Chicago, who was skeptical about the necessity of “I’m Sorry” laws and believes that states can’t “legislate morality.”).

178. See MASS. GEN. LAWS ANN. ch. 233, § 23D (West 2007); AM. MED. ASS’N, *supra* note 7 (considering that Massachusetts, which has protected the use of apologies in the health care context for over twenty years, is still in a state of medical malpractice crises).

B. Potential for Problems

1. Explanations of Error

As described above, the use of apologies in the medical arena generally can't take place unless the physician acknowledges that a medical error occurred. Accordingly, the suggestion that apologizing for medical errors will reduce litigation and encourage stronger physician-patient relationships is built on the assumption that physicians will also discuss the circumstances of the error with patients. Disclosure may be contrary to the physician or hospital's standard practice. Thus, utilizing apologies may implicate broader changes in the way in which medical error is handled.

In order to achieve such a change in culture, hospitals must work as a system to remove the stigma of failure that is currently placed upon physicians when errors are revealed. Exemplifying such change in action, "some medical schools, including Vanderbilt University School of Medicine in Nashville, [Tennessee,] [provide] courses in communicating errors and apologizing [that] are now mandatory for medical students and residents."¹⁷⁹

Medical school curriculums may be the first place in which such changes should be made. The earlier a physician accepts the benefits of disclosure and apologies, the sooner the medical field will be able to reap the benefits of such tools.

2. Whose Advice Should the Doctor Take?

Sometimes it is not clear whether a physician should apologize or not, given the varied instructions he or she has received from different entities.¹⁸⁰ As such, it is essential that physicians contact the appropriate people and entities prior to offering apology. Even prior to the occurrence of a medical error, physicians should be proactive and contact entities such as their risk manager, legal counsel, or insurance carrier for guidance.¹⁸¹ In this respect, physicians should not only engage in open communications with their patients, but they should also practice open communication with those people and entities that may have specific procedures in place for handling medical errors. It is likely that the risk managers, health care attorneys, professional liability insurers, and the individual physician will have opposing interests and thoughts regarding the

179. Davenport, *supra* note 11, at 91 (quoting Rachel Zimmerman, *Doctors' New Tool to Fight Lawsuits: Saying 'I'm Sorry': Malpractice Insurers Find Owning up to Errors Soothes Patient Anger 'The Risks are Extraordinary'*, WALL ST. J., May 18, 2004, at A1).

180. Butcher, *supra* note 144, at 20.

181. Staci Kusterbeck, *Sitting Down to Talk Can Keep Patients From Suing*, ED LEGAL LETTER, Sept. 1, 2006.

approach to apologies.¹⁸² If the recommendations and guidance of the varying entities are not in agreement, the physician should take it upon him or herself to consider the risks and benefits of each approach, along with any applicable state law, and try to strike a balance.

VIII. CONCLUSION

It is difficult to determine whether state legislation that protects expressions of sympathy and/or admissions of fault will definitively mend the current state of medical malpractice liability crisis. A medical error and the subsequent communications between the physician and the patient is an extremely fact sensitive situation. The effect of an apology will likely depend on the state in which the error took place, the specific content of the physician's communication, the severity of the harm, the history of the physician-patient relationship, and countless other factors. There will inevitably be patients that will settle for nothing less than a lawsuit. Regardless, instinct and morality encourage us to apologize nonetheless. Additionally, scholarly studies, case law, and case studies suggest that apologetic communications lend themselves to be advantageous in the wake of medical error. As with any implementation of new procedures, physicians will have to adapt to the changed practice and suppress the innate fear of litigation. Physicians must accept that apologies can benefit both themselves and their patients. Only when this occurs will the advantageous effects of apologies within the health care arena truly be realized.

APPENDIX 1: SUMMARY OF STATE "I'M SORRY" LAWS¹⁸³

STATE	LAW	DATE OF APPROVAL	MEDICAL SPECIFIC	PROTECTION OF FAULT	USE OF THE WORD "APOLOGY" ¹⁸⁴
Ala.	None				
Alaska	None				
Ariz.	ARIZ. REV. STAT. ANN. § 12-2605	Apr. 25, 2005	Yes	Does Not Mention	Yes

182. Butcher, *supra* note 144, at 20, 23 (quoting a physician executive who participated in ACPPE's Patient Trust and Safety Survey who stated: "There are disconnects in my organization among the corporate level, the local hospitals and the medical staffs on whether or not it is appropriate to make an apology . . . Most physicians are very uncomfortable about making an apology because they have been instructed by their malpractice carriers not to do this.").

183. Last updated Oct. 25, 2007.

184. Whether or not the language of the state law specifically uses, and thereby protects, the term "apology" or any form of the word "apology."

Ark.	None				
Cal.	CAL. GOV. CODE § 11440.45	June 30, 2002	No	No	No
Colo.	COLO. REV. STAT. ANN. § 13-25- 135	Apr. 17, 2003	Yes	Yes	Yes
Conn.	CONN. GEN. STAT. § 52-184d	July 13, 2005	Yes	Yes	Yes
Del.	DEL. CODE ANN. tit. 10 § 4318	July 10, 2006	Yes	No	Yes
Fla.	FLA. STAT. ANN. § 90.4026	June 1, 2001	No	No	No
Ga.	GA. CODE ANN. § 24-3-37.1	Feb. 16, 2005	No ¹⁸⁵	Yes	Yes
Haw.	HAW. REV. STAT. § 626-1, Rule 409.5	Feb. 27, 2006	Yes	No	No
Idaho	IDAHO CODE ANN. § 9- 207	July 1, 2006	Yes	No	Yes

185. While the law protects expressions of sympathy used outside of the health care context, the law states that "conduct, statements, or activity should be particularly encouraged between health care providers and patients experiencing an unanticipated outcome resulting from their medical care."

Ill.	735 ILL. COMP. STAT. 5/8-1901	Aug. 25, 2005	Yes	Does Not Mention	Yes
Ind.	IND. CODE § 34-43.5- 1-4	Mar. 17, 2006	No	No	Yes
Iowa	IOWA CODE § 622.31	May 24, 2006	Yes	Does Not Mention	No
Kan.	None				
Ky.	None				
La.	LA. REV. STAT. ANN. § 13:3715. 5	June 16, 2005	Yes	No	Yes
Me.	ME. REV. STAT. ANN. tit. 24, § 2907	June 10, 2005	Yes	No	Yes
Md.	MD CODE ANN., Cts. & Jud. Proc. § 10-920	Jan. 11, 2005	Yes	No	Yes
Mass.	MASS. GEN. LAWS ch. 233 § 23D	Dec. 24, 1986	No	Does Not Mention	No
Mich.	None				
Minn.	None				
Miss.	None				
Mo.	MO. ANN. STAT. § 538.229	Mar. 29, 2005	Yes	No	No
Mont.	MONT. CODE ANN. § 26-1-814	July 1, 2005	Yes	Does Not Mention	Yes

Neb.	None				
Nev.	None				
N.H.	N.H. REV. STAT. ANN. § 507-E:4	June 17, 2005	Yes	No	No
N.J.	None				
N.M.	None				
N.Y.	None				
N.C.	N.C. GEN. STAT. ANN. § 8C-1, Rule 413	Aug. 2, 2004	Yes	Does Not Mention	Yes
N.D.	None				
Ohio	OHIO REV CODE ANN. § 2317.43	Sept. 13, 2004	Yes	Does Not Mention	Yes
Okla.	OKLA. STAT. tit. 63, § 1- 1708.1H	May 28, 2004	Yes	Does Not Mention	Yes
Or.	OR. REV. STAT. ANN. § 677.082	June 16, 2003	Yes	Does Not Mention	Yes
Pa.	None				
R.I.	None				
S.C.	S.C. CODE ANN. § 19-1-190	June 9, 2006	Yes ¹⁸⁶	Yes	Yes
S.D.	S.D. CODIFIED LAWS § 19-12-14	Feb. 18, 2005	Yes	No	Yes

186. Language used here similar to that used in Georgia's statute.

Tenn.	TEN. RULES OF EVID., Rule 409.1	July 1, 2003	No	No	No
Tex.	TEX. CIV. PRAC. & REM. CODE ANN. § 18.061	June 18, 1999	No	No	No
Utah	UTAH CODE ANN. § 78-14-18	Mar. 1, 2006	Yes	Does Not Mention	Yes
Vt.	VT. STAT. ANN. tit. 12, § 1912	2nd Legis. Session, 2005	Yes	Does Not Mention	Yes
Va.	VA. CODE ANN. § 8.01-52.1	Mar. 23, 2005	Yes	No	No
Wash.	WASH. REV. CODE ANN. § 5.66.010	Apr. 3, 2002	No	No	No
W. Va.	W. VA. CODE ANN. § 55-7-11a	May 4, 2005	Yes	Does Not Mention	Yes
Wis.	None				
Wyo.	Wyo. Stat. Ann. § 1-1-130	July 17, 2004	Yes	Does Not Mention	Yes