

June 23, 2011

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Peter G. McCabe
Secretary of the Committee on Rules of Practice and Procedure
Administrative Office of the United States Courts
One Columbus Circle, NE
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Dear Secretary McCabe,

I am writing to submit a suggestion to the Federal Rules of Evidence. Unfortunately, I am not exactly clear on how to do this, so I hope this way of communicating is acceptable.

I am a recent law school graduate and wrote my law review note on amending the Federal Rules of Evidence to exclude physician apologies and even general admissions of fault. I know it seems a bit radical, but current research shows that physician admissions and apologies significantly reduce the rate of malpractice suits and lead to improved preventative measures. As it stands now, physicians end up in a catch-22 because if a mistake has been made, an apology can be used against them in a lawsuit but if they do not apologize, they are more likely to be sued in the first place. Although this might seem like a state issue, it is, in fact, a national concern and one that would be ameliorated through a federal amendment.

I am including my law review note (72 Ohio St. L.J. 687) which explains the above points in more detail. If nothing else, it might entertain you! The article is also available through this link:
<http://moritzlaw.osu.edu/lawjournal/issues/volume72/number3/pearlmutter.pdf>.

I apologize in advance if this letter and the enclosed material is not an appropriate way to approach the committee and I thank you for your time.

Sincerely,
Maria Pearlmutter



Physician Apologies and General Admissions of Fault: Amending the Federal Rules of Evidence

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In most states, physician apologies and general admissions of fault are currently admissible as evidence in medical malpractice claims. This lack of legal protection results in an understandable reluctance to disclose and apologize when an error is made. In turn, the lack of disclosure and admission of fault not only hampers error-prevention efforts, but also fuels increases in malpractice lawsuits. A physician who inadvertently injures a patient is immediately thrust into the midst of this catch-22: if she apologizes, this may be used against her in a lawsuit, but if she does not apologize, she is more likely to be sued in the first place. This Note explores the possibility of amending the Federal Rules of Evidence to exclude admission of such apologies, including general admissions of fault. Apology research and current initiatives in this field are summarized for background information. Later parts discuss the inadequacy of current measures and a proposed amendment to the Federal Rules of Evidence. The last Part speaks to potential objections to an amendment and ways in which those concerns are addressed.

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* J.D. Candidate, The Ohio State University Moritz College of Law, 2011. I would like to thank my family for their continued support of my academic endeavors, and Professor Merritt for advice during the process of writing this Note.

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I. INTRODUCTION

Imagine a thirty-year-old male admitted to the emergency room with chest pain. He is young, appears to be in good health, and presents no risk factors for heart disease. The cardiologist decides to delay an angiogram, choosing instead to order blood work and see if the issue resolves on its own. The next day, however, the symptoms persist and further testing shows advanced coronary disease.¹ Moreover, an EKG shows evidence of a heart attack the previous evening, a heart attack that could have been avoided if the angiogram had been done earlier.²

Should the doctor apologize? Should he apologize and admit fault, or is a general apology enough? What if the patient does not realize that he was harmed? In most states, many doctors do neither, for fear that any apology may be used against them as evidence of liability in a future malpractice suit.³

Medical malpractice reform is a national concern, both on the lay level and in the professional legal and medical arenas. Medical malpractice tort awards have increased at a faster rate than in other tort areas, and this has led to direct and indirect difficulties for physicians and their patients.⁴ Physicians

¹ Sandeep Jauhar, *Explain a Medical Error? Sure. Apologize Too?*, N.Y. TIMES, Jan.1, 2008, at F5. In this article, the physician author describes this event and explains his decision to apologize and admit fault.

² *Id.* For a similar example with a more tragic outcome, see DOUG WOJCIESZAK ET AL., SORRY WORKS: DISCLOSURE, APOLOGY, AND RELATIONSHIPS PREVENT MEDICAL MALPRACTICE CLAIMS 1–5 (2008) (a heart attack was initially misdiagnosed as a bacterial infection and surgery took place too late to save Jim, the lead author's brother).

³ See *infra* Part III.

⁴ See generally Alexander Tabarrok & Amanda Agan, *Medical Malpractice Awards, Insurance, and Negligence: Which Are Related?*, CIV. JUST. REP. (Ctr. for Legal Policy at the Manhattan Inst., N.Y.C., N.Y.), May 2006, at I, available at http://www.manhattan-institute.org/pdf/cjr_10-bw.pdf. The authors conclude that higher medical malpractice

are directly affected as malpractice insurance premium rates have skyrocketed in many areas, and this has resulted in a dearth of specialists in some high-risk medical areas and reduced access to particular services.⁵ In addition to the loss of these services—which include trauma care, some surgical procedures, and obstetrical services—consumers are affected through the increasing practice of defensive medicine.⁶ Defensive medicine takes place when physicians order and perform expensive tests and procedures not out of medical necessity but out of concern for legal liability.⁷ These practices have been shown to result in increased insurance premiums for consumers and have been noted as one of the factors in the recent health care crisis.⁸

Another result of the flourishing medical malpractice arena is the subsequent physician reluctance to disclose errors and apologize. Although thirty-five states and Washington, D.C. have passed some form of apology

premiums are a direct result of higher malpractice jury verdicts. *Id.* at 5. At the same time, other researchers note that rising costs for medical treatment are factors in the overall increased size of tort awards in general. Seth A. Seabury et al., *Forty Years of Civil Jury Verdicts*, 1 J. OF EMPIRICAL LEGAL STUD. 1, 3 (2004). It seems that both malpractice and non-malpractice awards are affected by the increasing costs of medical practice which are in turn affected by increased malpractice insurance premiums.

⁵ See FRANK A. SLOAN & LINDSEY M. CHEPKE, *MEDICAL MALPRACTICE* 63–68 (2008) (a collection of anecdotal evidence as well as a thorough meta-analysis of survey studies assessing reduction in services and limitations of such studies).

⁶ David J. Becker & Daniel P. Kessler, *The Effects of the U.S. Malpractice System on the Cost and Quality of Care*, in *MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM* 84, 89 (William M. Sage & Rogan Kersh eds., 2006) [hereinafter *MEDICAL MALPRACTICE*]. For example, the authors cite a study that demonstrates that malpractice reforms limiting liability resulted in a 5–9% decrease in overall hospital expenditures. *Id.* at 87. Another study found that the expenditure-to-benefit ratio from defensive medical practices, with regard to elderly individuals with heart disease, was more than half a million dollars for each year per patient. *Id.*

⁷ *Id.* at 85. Defensive medicine can be categorized as either “positive” defensive medicine, which refers to unnecessary, wasteful tests and practices, or “negative” defensive medicine, which refers to medical treatment that doctors hesitate to provide despite the benefits the treatment may bring to patients. *Id.* Both types are caused by the perception that inaction or action may increase the chance and outcome of litigation. *Id.*

⁸ Rebecca Rubel-Seider, Comment, *Full Disclosure: An Alternative to Litigation*, 48 SANTA CLARA L. REV. 473, 478 (2008). Critics of this data note that studies measuring defensive medicine seldom eliminate the beneficial aspects of litigation-influenced practices that may improve care for patients. See TOM BAKER, *THE MEDICAL MALPRACTICE MYTH* 118–37 (2005) for a thorough critique of the data cited in defensive medicine studies.

law⁹ prohibiting, for example, expressions of sympathy to be used against a physician in court,¹⁰ the vast majority of defense attorneys still advise hospitals and physicians against speaking to patients or their families once an adverse event has taken place.¹¹ This legal advice continues to be dispensed despite a plethora of evidence that indicates that the number of medical malpractice suits drops significantly once an apology and disclosure program is implemented.¹² In other words, the reluctance to apologize is both a result of the current state of malpractice suits and a contributing factor to the high number of such suits. A physician who inadvertently injures a patient is immediately thrust into the midst of this catch-22: if she apologizes, this may be used against her in a lawsuit, but if she does not apologize, she is more likely to be sued in the first place.

Moreover, this reluctance to apologize and disclose errors has ramifications beyond the immediate physician-patient relationship. When hospitals and practitioners are less likely to admit and disclose errors, they are also less likely to collect data on these errors and less likely to take steps to prevent such mistakes in the future.¹³ In addition, the public is more likely to view the medical profession skeptically because of the perceived “culture of secrecy” that purportedly protects physicians from the consequences of

⁹ *I'm Sorry Laws: Summary of State Laws*, AM. MED. ASSOC. ADOVOCACY RES. CTR. (Feb. 2008), <http://www.ama-assn.org/ama1/pub/upload/mm/378/sorry-laws.pdf> [hereinafter *I'm Sorry Laws*].

¹⁰ See, e.g., OHIO REV. CODE ANN. § 2317.43(A) (West 2006) (“Use of Defendant’s Statement in Medical Liability Action Prohibited: In any civil action brought by an alleged victim of an unanticipated outcome of medical care or in any arbitration proceeding related to such a civil action, any and all statements, affirmations, gestures, or conduct expressing apology, sympathy, commiseration, condolence, compassion, or a general sense of benevolence that are made by a health care provider or an employee of a health care provider to the alleged victim, a relative of the alleged victim, or a representative of the alleged victim, and that relate to the discomfort, pain, suffering, injury, or death of the alleged victim as the result of the unanticipated outcome of medical care are inadmissible as evidence of an admission of liability or as evidence of an admission against interest.”)

¹¹ See *infra* Part III for examples of attorney advice.

¹² See *infra* Part II.C & II.D for examples of research studies and hospital initiatives.

¹³ Carol B. Liebman & Chris Stern Hyman, *Disclosure and Fair Resolution of Adverse Events*, in *MEDICAL MALPRACTICE*, *supra* note 6, at 191, 214. Although some unfortunate medical events are unavoidable, “the number of errors is more likely to be reduced if physicians and other healthcare providers are able to speak freely with each other and with patients about what has happened.” *Id.* at 214; see also WOJCIESZAK ET AL., *supra* note 2, at 21–22 (describing an effective disclosure and apology program as a “living, learning laboratory” where mistakes are openly discussed and treated as “golden learning opportunities”).

their actions.¹⁴ Such skepticism erodes the trust and honesty that is so critical to accurate diagnoses and treatment.¹⁵ Regardless of the serious repercussions of this reluctance, however, it is unlikely that physicians will begin to routinely admit and disclose mistakes unless legal liability is minimized in some manner.

This Note explores the possibility of amending the Federal Rules of Evidence to exclude admission of such apologies, including general admissions of fault. Part II summarizes the relevant Federal Rules of Evidence and describes several current initiatives in medical malpractice and apology admissions.¹⁶ Apology research is also summarized. Part III presents several reasons why current measures are inadequate and further reform is needed.¹⁷ This Part also presents the theoretical underpinnings of the proposed amendment. Part IV describes a possible amendment to Federal Rule of Evidence 409 and explains the suggested language.¹⁸ Importantly, this Note suggests that the proposed amendment exclude not only statements of apology, but also general admissions of fault. Finally, Part V discusses several common objections to the apology protection movement and how this amendment would address those concerns.¹⁹

II. BACKGROUND AND CURRENT INITIATIVES

Before discussing an amendment to the Federal Rules of Evidence, it is important to briefly review the relevant evidentiary rules as well as some of the existing approaches to the medical malpractice problem, especially with regard to programs promoting apologies and disclosure. Section A reviews the relevant Federal Rules of Evidence. Section B presents examples of national initiatives in malpractice reform. Section C summarizes apology research, and Section D presents examples of individual hospital initiatives focused on disclosure and apology. Section E describes state regulations on physician apologies and mentions limitations in this area.

¹⁴ See, e.g., Stephen Kiernan, *Breaking the Medical Malpractice Code of Secrecy*, NIEMEN REPORTS (Summer 2003), <http://www.nieman.harvard.edu/reportsitem.aspx?id=101192>. The author relates several instances of medical malpractice in Vermont that went undetected because state laws prohibited public disclosure of physician performance, resulting in regulations that were “surrounded by secrecy.” *Id.*

¹⁵ WOJCIESZAK ET AL., *supra* note 2, at 22. The authors explain that a strong disclosure and apology program encourages communication, serves to keep the physician “on the same side of the table as the patient” and strengthens the relationship. *Id.* at 16.

¹⁶ See *infra* Part II.

¹⁷ See *infra* Part III.

¹⁸ See *infra* Part IV.

¹⁹ See *infra* Part V.

A. *The Federal Rules of Evidence*

At the present time, apologies are allowed as evidence of liability under several Federal Rules.²⁰ First, Federal Rule of Evidence 801(d)(2) allows admissions by party-opponents, meaning that any statement made by the opposing party in a civil or criminal trial is not considered and excluded as hearsay, even if made out of court.²¹ The estoppel-based rationale behind this rule suggests that a party's own statement is considered reliable enough to use against that party in court.²²

Next, if the physician is not available to testify at trial, the apology may be allowed as a statement against interest under Rule 804(b)(3).²³ This rule assumes that a statement that may subject the speaker to civil or criminal liability is more likely to be true and is, therefore, more reliable than other out of court statements.²⁴

There are several ways that apologies might be excluded from admission into evidence; however, these have significant limitations. First, Rule 408 provides that statements made in compromise negotiations regarding the claim are not admissible to show liability.²⁵ Therefore, an apology made during settlement negotiations, for example, should be inadmissible in court.²⁶ However, this apology must be made during formal settlement negotiations and, therefore, a claim must have already been filed and a

²⁰ State law may or may not be applied in diversity cases depending on whether the state law is seen as part of an overall scheme. See *infra* Part III.B for a discussion of forum shopping.

²¹ FED. R. EVID. 801(d)(2).

²² DEBORAH JONES MERRITT & RIC SIMMONS, *LEARNING EVIDENCE: FROM THE FEDERAL RULES TO THE COURTROOM* 652 (2009); see also *United States v. DiDomenico*, 78 F.3d 294, 303 (7th Cir. 1996) (“The standard justification of its admissibility is a kind of estoppel or waiver theory, that a party should be entitled to rely on his opponent’s statements.”).

²³ FED. R. EVID. 804(b)(3).

²⁴ MERRITT & SIMMONS, *supra* note 22, at 635; see also Dr. Marlynn Wei, *Doctors, Apologies and the Law: An Analysis and Critique of Apology Laws*, 40 J. HEALTH L. 107, 140 (2007) (“Given this backdrop, the decision to disclose, and therefore possibly expose oneself to a lawsuit, runs against the physician’s basic fear of exposing oneself to harm—whether professional, emotional, or physical.”). Dr. Wei posits that the process of disclosure itself is so stigmatized and traumatic that removing legal obstacles to disclosure and apologies may not be enough to affect an actual increase in such apologies. *Id.* at 154; see also *infra* Part V.C.

²⁵ FED. R. EVID. 408(a)(2).

²⁶ Jonathan R. Cohen, *Legislating Apology: The Pros and Cons*, 70 U. CIN. L. REV. 819, 825–26 (2002). The public policy rationale behind this rule suggests that courts favor compromises and settlements and will protect statements made during negotiations in order to encourage such communications between the parties. *Id.*

lawsuit must be in progress before this rule can take effect.²⁷ Moreover, an apology made during settlement negotiations can be introduced in court for a variety of other purposes as long as it is not to show liability or to impeach the declarant.²⁸

Next, Rule 403 has sometimes been cited in attempts to exclude apologies because this rule prohibits evidence where “its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues or misleading the jury.”²⁹ However, this strategy has not seen much success because courts may find such statements to be probative and not unfairly prejudicial.³⁰

Finally, Rule 407 forbids admission of subsequent remedial measures,³¹ and Rule 409 excludes offers to pay medical expenses.³² However, neither of these rules address apologies. Under the current regime, a physician whose error has injured a patient can take measures to prevent the mistake from happening again and she can even pay for future medical bills, but she cannot apologize without risking incurring legal liability.³³

B. *National Medical Malpractice Reforms*

Although a comprehensive review of all medical malpractice reform measures is beyond the scope of this Note, a brief mention of some of the

²⁷ *Id.* In contrast, however, those apologies made earlier are the ones most valued by patients, and apology experts recommend speaking to the patient or family as soon as possible after the event. WOJCIESZAK ET AL., *supra* note 2, at 49.

²⁸ FED. R. EVID. 408(b). For example, an apology made during settlement negotiation can be introduced in court to show the bias or prejudice of a witness or negating a contention of undue delay. *Id.*

²⁹ FED. R. EVID. 403.

³⁰ *See, e.g.,* Woods v. Zeluff, 158 P.3d 552, 555 (Utah Ct. App. 2007) (explaining that the physician’s admission of fault and apology was highly probative “because it reveals a medical expert’s assessment of his own actions, an assessment that has bearing on the determination of negligence—specifically, on the question of breach of the standard of care.”).

³¹ FED. R. EVID. 407; *see, e.g.,* Bauman v. Volkswagenwerk Aktiengesellschaft 621 F.2d 230, 233 (6th Cir. 1980) (“Its purpose is to permit people to improve their products without running the risk of increasing their liability in the past.”).

³² FED. R. EVID. 409; *see, e.g.,* Ford v. Nat’l R.R. Passenger Corp., 734 F. Supp. 215, 218 (D. Md. 1990) (medical bills may not be used to prove damages).

³³ *See* Jonathan R. Cohen, *Advising Clients to Apologize*, 72 S. CAL. L. REV. 1009, 1063 (1999) (“Under the current rules, you can build a fence around the pit into which the plaintiff fell and you can offer to pay the plaintiff’s hospital bills, but you cannot say that you are sorry.”).

most prominent approaches to this problem will be helpful in placing apology-based initiatives in context.³⁴

On a national level, some prominent reform initiatives have focused on the creation of specialized healthcare courts, capping noneconomic damage awards, and reducing the statute of limitations for malpractice claims.³⁵ For example, in 2005, Senators Michael Enzi (R-WY) and Max Baucus (D-MT) introduced the Fair and Reliable Medical Justice Act, which would have allocated federal funds for exploring alternatives to current litigation systems, including the creation of specialized healthcare courts.³⁶ These measures have not been adopted through any federal legislation, although some individual states have implemented caps on jury-awarded damages,³⁷ and some states have reduced the statute of limitations for medical malpractice suits to two years or less.³⁸

With regard to apology-based reform, in 2005, then-Senators Barack Obama and Hillary Clinton proposed the National Medical Error Disclosure and Compensation Act that would have required mandatory disclosure, created a national database, and protected apology statements from being used in malpractice actions.³⁹ This bill was not passed at that time, although

³⁴ For a comprehensive list of first- and second-generation malpractice reforms, see SLOAN & CHEPKE, *supra* note 5, at 86–91. First-generation reforms are considered relatively minor attempts at modifying existing tort liability systems, such as caps on awards and punitive damage limits. *Id.* at 86. In contrast, second-generation reforms involve more fundamental changes, such as mandated alternative dispute resolution methods and using medical practice guidelines to determine the standard of care. *Id.*

³⁵ *Id.* at 88.

³⁶ *Id.* at 177; *Bipartisan Legislation to Create Special Health Courts Is Introduced in U.S. Senate*, COMMON GOOD (June 30, 2005), <http://commongood.org/healthcare-newscommentary-inthenews-241.html>. This bill would have allotted funds to states for the creation of specialized health care courts. *Id.* These courts would be staffed by judges with health-care experience, “whose sole focus would be on addressing medical malpractice cases.” *Id.*

³⁷ SLOAN & CHEPKE, *supra* note 5, at 107; Am. Bar Assoc. Standing Comm. on Med. Liab., *Caps on Medical Malpractice Awards*, AM. BAR ASS’N (Jan. 2005), http://www.abanet.org/poladv/priorities/impl/2008_scimpl_chart.pdf (arguing that such caps are not effective in reducing malpractice litigation). Florida, Massachusetts, Mississippi, Missouri, Nevada, Ohio, Texas, and West Virginia are listed as having caps on non-economic damages. *Id.*

³⁸ *Medical Malpractice*, STATUTE OF LIMITATION LAWS SUMMARIZED FOR ALL 50 STATES, http://www.statuteoflimitations.net/medical_malpractice.html (last visited Feb. 5, 2011). Three states, Louisiana, Ohio, and South Dakota, limit filing of medical malpractice to one year from date of injury. *Id.*

³⁹ Hillary Rodham Clinton & Barack Obama, *Making Patient Safety the Centerpiece of Medical Liability Reform*, 354 NEW ENG. J. MED. 2205, 2206 (2006). The proposed bill would have provided grants and technical assistance to hospitals, doctors, and insurers for the purpose of implementing disclosure and patient compensation. *Id.* More specifically:

the focus recently returned to federal funding of state initiatives in September of 2009, when President Obama pledged twenty-five million dollars in federal grants for state programs designed to reduce malpractice suits.⁴⁰

Another very recent and interesting approach is the possibility of “safe-harbor” legislation that would protect physicians from liability if they have complied with evidence-based medical practices.⁴¹ For example, Senator Ron Wyden (D-OR) has recently introduced legislation that would create a rebuttable presumption against negligence if the doctor followed clinical practice guidelines.⁴² The underlying assumption of this approach, namely

Participants would submit a safety plan and designate a patient-safety officer, to whom these disclosures and notices of related legal action would be reported. If a patient was injured or harmed as a result of medical error or a failure to adhere to the standard of care, the participant would disclose the matter to the patient and offer to enter into negotiations for fair compensation.

The terms of negotiation for compensation ensure confidentiality, protection for any disclosure made by a health care provider to the patient in the confines of the MEDiC program, and a patient’s right to seek legal counsel; they also allow for the use of a neutral third-party mediator to facilitate the negotiation. Any apology offered by a health care provider during negotiations shall be kept confidential and could not be used in any subsequent legal proceedings as an admission of guilt if those negotiations ended without mutually acceptable compensation.

Participating insurance companies and health care providers would be required to apply a percentage of the savings they achieve from lowered administrative and legal costs to the reduction of premiums for physicians and toward initiatives to improve patient safety and reduce medical errors.

Id. The full text of the bill is available at <http://www.thomas.gov/cgi-bin/query/z?c109:S.178>.

⁴⁰ Kristin Gunderson Hunt, *Federal Grants Back Medical Malpractice Reduction Efforts*, BUS. INS., Nov. 9, 2009, at 18 (grant proposals will be reviewed and pilot programs selected). The author cites health care experts who suggested that some contenders would include states with apology statutes, health courts, safe harbor rules, and early offer rules. *Id.*

⁴¹ Michelle M. Mello & Troyen A. Brennan, *The Role of Medical Liability Reform in Federal Health Care Reform*, 361 NEW ENG. J. MED. 1, 3 (2009).

⁴² *Id.* The text of the bill is available at <http://www.thomas.gov/cgi-bin/query/z?c111:S.391>. Mello and Brennan suggest that physicians could be given immunity if they follow guidelines issued by the Federal Coordinating Council for Comparative Effectiveness Research (CER). Mello & Brennan, *supra* note 41, at 3. However, it seems that following the guidelines of the appropriate licensing agency, whether state or federal, would be sufficient to create such a presumption of non-negligence. In addition, Mello and Brennan note that because safe-harbor legislation would incentivize physicians to comply with medical guidelines in order to take advantage of the offered protections, this type of tort reform may be easier to pass because it does not involve limiting coverage or reimbursement. *Id.* The authors also

that physicians are not negligent unless they have breached accepted medical protocol, is compatible with standard elements in a tort claim. This assumption also shapes a fundamental proposition made in this Note: specifically, that general admissions of fault should not be admitted as evidence of liability because such statements are not indicative of a breach of duty.⁴³

C. *Apology Research*

Over fifteen years of research consistently indicates that malpractice lawsuits are often filed to satisfy psychological needs rather than financial ones. A 1992 study by Gerald B. Hickson indicated that only 24% of families who filed malpractice claims for perinatal injuries did so for financial reasons.⁴⁴ Other motivations described by the families included the need to obtain more information, the fear of a “cover-up,” and the desire to protect others from similar harms.⁴⁵ A more recent study indicates that in the aftermath of a medical error, patients most want information about the extent of the errors, how the consequences will be handled, and how a reoccurrence will be prevented in the future.⁴⁶

Several researchers posit theories that attempt to explain how apologies alter the course of interactions between a physician and his patients. Bernard Virshup presents a service model in which empathy and active listening results in more effective communications and fewer lawsuits.⁴⁷ Other

suggest that the proposed safe-harbor legislation could be implemented together with health courts and disclosure programs. *Id.*

⁴³ See *infra* Part III.C. Physicians apologize for a variety of reasons. For example, some do so because they hope to maintain rapport with patients. See *infra* note 187.

⁴⁴ Gerald B. Hickson et al., *Factors That Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries*, 267 J. AM. MED. ASS'N 1359, 1359 (1992). Hickson finds that “[t]he desire for information, perception of being misled, anger with the medical profession, desire to prevent injuries to others” were all contributory factors in patients’ desire to sue. *Id.* at 1362.

⁴⁵ *Id.* at 1359.

⁴⁶ Thomas H. Gallagher et al., *Patients’ and Physicians’ Attitudes Regarding the Disclosure of Medical Errors*, 289 J. AM. MED. ASS'N 1001, 1001 (2003). In addition to findings about patient wishes for additional information and consequences, the authors noted that the physicians in the study theoretically endorsed disclosing errors but had more difficulty doing so when presented with a specific hypothetical scenario. *Id.* at 1003–04. For example, the doctors spoke about not revealing errors when it might upset or confuse the patient or if the mistake went unnoticed. *Id.* The doctors also revealed a tendency to use words cautiously, specifically due to the perceived risk of increased litigation. *Id.* at 1004.

⁴⁷ Bernard B. Virshup et al., *Strategic Risk Management: Reducing Malpractice Claims Through More Effective Patient-Doctor Communication*, 14 AM. J. MED.

approaches focus on attribution theory, in which an apology serves to disrupt the patient's attribution of blame from the individual physician to broader systemic faults.⁴⁸

Some recent studies have even attempted to document the decreased likelihood of lawsuits following an apology.⁴⁹ In a seminal paper on this topic, Jennifer Robbennolt presented the results of a set of studies done to examine the effects of apologies on the victim's willingness to accept a settlement offer.⁵⁰ When a full apology was presented, 73% of respondents were inclined to accept the offer, in contrast with 52% who would accept the offer when no apology was offered.⁵¹ A full apology was seen as more moral and regretful, and the giver of such an apology was perceived to be less likely to reoffend in the future.⁵² Notably, however, these benefits were limited to full apologies, those that expressed sympathy and accepted responsibility.⁵³ Partial apologies, which merely expressed sympathy, did not show many of these benefits, although in some circumstances, a partial apology was seen as better than no apology at all.⁵⁴ An apology represents a

QUALITY 153, 157–58 (1999). Although Virshup frames his research in psycho-analytic terms and attempts to address the needs of the “dysfunctional” patient, it seems evident that the basic interaction principles he sets forth would apply to all patients.

⁴⁸ Liebman & Hyman, *supra* note 14, at 199 (“Receiving information about what happened can change the negative motivations that the patient attributes to the health care providers and avoid the anger and blame. In addition, providing information about what happened can help resolve the patient’s cognitive dissonance when the physician she has trusted to provide her with care has harmed her.”). For further analysis of how apologies work to restore relationships, see Donna L. Pavlick, *Apology and Mediation: The Horse and Carriage of the Twenty-First Century*, 18 OHIO ST. J. ON DISP. RESOL. 829, 841–48 (2003). Pavlick notes that an apology affects not only the giver and receiver, but also the relationship as a whole and impacts social norms by restoring moral power. *Id.*

⁴⁹ Jennifer K. Robbennolt, *Apologies and Legal Settlement: An Empirical Examination*, 102 MICH. L. REV. 460 (2003).

⁵⁰ *Id.*

⁵¹ *Id.* at 485–86.

⁵² *Id.* at 487.

⁵³ *Id.* at 491. Robbennolt concluded that only a full responsibility-accepting apology was more likely to influence a party to accept a settlement, whereas the partial apology that only expresses sympathy “increased participants’ uncertainty about whether or not to accept the offer.” *Id.*

⁵⁴ *Id.* at 497. Robbennolt found that partial apologies are beneficial if the harm is less severe or if “the offender is less clearly at fault.” *Id.* at 498. In contrast, where the injury is severe or “when there is strong evidence of the offender’s responsibility,” a partial apology is actually seen as worse than no apology at all. *Id.* at 497. This research is critical in evaluating effects of “I’m sorry” laws in states that only protect partial apologies. See *infra* Part II.D. Although this study examined willingness to accept a settlement and not whether an injured party would accept an apology instead of commencing a lawsuit to begin with, the results may be indicative of the extent to which

non-confrontational way to resolve disputes and is therefore a desirable option in limiting medical malpractice suits.

D. Individual Program Initiatives

Perhaps the best evidence of the effectiveness of apology and disclosure after medical errors comes not from carefully scripted studies, but from individual hospital initiatives. The earliest and most often cited program of this kind is the apology and disclosure system established by the Veteran's Affairs Medical Center in Lexington, Kentucky.⁵⁵ After a series of large malpractice verdicts, the hospital implemented a comprehensive disclosure program in which patients were informed of errors that caused them harm.⁵⁶ Following disclosure, the risk management committee met with each patient to determine ways that the patient could be assisted, either through medical treatment or compensation.⁵⁷ If the risk committee determined that a hospital employee was at fault, that individual would be present at the meeting and would offer an apology.⁵⁸ Following the implementation of this program in 1987, the hospital reported reaching the lowest quartile of medical malpractice payments when compared to other similar hospitals and also reported placing in the bottom sixth with regard to liability per claim through 1996.⁵⁹

Likewise, Johns Hopkins Children's Center reports that a formal policy established in 2001 encourages physicians to disclose errors and apologize.⁶⁰ The hospital's attorneys estimate that payments for legal claims have

apologies are effective in affecting patients' perceptions of the other party and the situation itself. These factors, in turn, may affect whether a lawsuit is filed in the first place.

⁵⁵ Rubel-Seider, *supra* note 8, at 487–88.

⁵⁶ *Id.* at 489.

⁵⁷ *Id.* at 488.

⁵⁸ *Id.*

⁵⁹ *Id.* Not only were fewer suits filed, but those that were filed were settled more quickly and fewer appeals were sought, resulting in lower litigation costs. *Id.* at 489. Dr. Steve Kraman, the physician responsible for managing the disclosure program and speaking with the patients and families, noted that part of the success of the program was due to the positive media exposure associated with the disclosure. Rubel-Seider, *supra* note 8, at 489; Kevin B. O'Reilly, "I'm Sorry": *Why is That So Hard for Doctors to Say?*, AM. MED. NEWS, Feb. 8, 2010, at 14. Dr. Kraman explained that when "a bad thing that happened was followed by appropriate behavior on the part of the hospital, like disclosure of the facts, apology and compensation, the media reports tended to focus on that rather than bad behavior." *Id.*

⁶⁰ Rachel Zimmerman, *Doctors' New Tool to Fight Lawsuits: Saying 'I'm Sorry'*, WALL ST. J., May 18, 2004, at A1.

dropped 30% since that time because victims and their families “appreciate that [the hospital has] been candid and forthright.”⁶¹

A more recent paper examines the approach implemented by the University of Michigan Health System and its financial effects.⁶² Cases are reviewed not only by a risk-management group but also by a committee of independent health practitioners.⁶³ The error is disclosed to the patient, and if an unreasonable medical error was the cause of the harm, compensation to the patient is made quickly and fairly.⁶⁴ As a result, the number of pending lawsuits has been halved and the payout per lawsuit has decreased, resulting in average annual savings of over two million dollars.⁶⁵

Insurance companies have also begun to implement disclosure policies in an effort to reduce costs.⁶⁶ COPIC, a Colorado medical malpractice insurance carrier, developed a no-fault system in which patients can receive a flat award and reimbursement.⁶⁷ Doctors are encouraged to disclose all unanticipated events, “respond soon after the event occurs,” and resolve any related concerns.⁶⁸ Malpractice claims dropped 50% after the implementation

⁶¹ *Id.* The new policy was established after the tragic, preventable death of an infant from dehydration. *Id.* The parents were preparing to file suit when the director of the hospital came to their home, apologized, and took full responsibility. *Id.* The parents dropped the suit and settled for an undisclosed amount, which they proceeded to donate back to the hospital for the purpose of improving pediatric safety. *Id.* This is an example of a situation in which the acceptance of responsibility seems to have been critical in patients’ perceptions of the hospital and it is dubious whether a partial, sympathy-only apology would have accomplished the same results.

⁶² Richard C. Boothman et al., *A Better Approach to Medical Malpractice Claims? The University of Michigan Experience*, 2 J. HEALTH & LIFE SCI. L. 125 (2009).

⁶³ *Id.* at 140. Interestingly, the committee’s discussions and activities are seen by some as legally protected as “conducted ‘in anticipation of litigation’” and would therefore be shielded from subpoenas. *Id.* at 140–41. It is not clear, however, whether this type of program would shield general data and error statistics only or also specific notes about individual cases.

⁶⁴ *Id.* at 139.

⁶⁵ *Id.* at 144. The author identifies a number of other factors that may have played a role in this dramatic result, including the Joint Committee’s efforts at improving safety standards and reducing patient risk. *Id.*

⁶⁶ See O’Reilly, *supra* note 59. It appears that insurance companies owned by active or retired physicians are more likely to implement policies encouraging apologies. *Id.* For example, the vice-president of The Doctors’ Company, a physician-owned carrier, is quoted as encouraging insured physicians to disclose “any error or any process” that may have caused injury to patients. *Id.* In addition, The Physicians Liability Insurance Co., which is owned by Oklahoma State Medical Association, now offers a 6% discount to doctors who attend special training sessions on disclosure and apologies. *Id.*

⁶⁷ Boothman, *supra* note 62, at 147.

⁶⁸ *Id.*

of this program and settlement costs decreased 23%.⁶⁹ A few other insurance carriers have started to follow suit and offer seminars on the beneficial effects of disclosure and apology.⁷⁰

E. State Regulation of Physician Apologies

Although the Federal Rules of Evidence do not generally protect physician apologies,⁷¹ a majority of states have some sort of law protecting physician apology or disclosure.⁷² These are known as “I’m sorry” laws” and currently thirty-five states and Washington, D.C. have legislated some version of an “I’m sorry” law.⁷³ However, in the majority of states, only an expression of sympathy—and not an admission of fault—is protected from being admitted to show liability. For example, an apology such as “I’m sorry, I was wrong” would be split in these states, with the first part (“I’m sorry”) being inadmissible, while the second part (“I was wrong”) could be used against the physician to show liability.⁷⁴ Currently only eight states have apology laws that protect both admissions of fault and expressions of sympathy.⁷⁵ This is significant because research has shown that partial

⁶⁹ *Id.* Additional information about the COPIC 3Rs program is available at *A Success Story*, COPIC’S 3RS PROGRAM (COPIC Insur. Co., Denver, Colo.), Mar. 2004, available at <http://www.callcopic.com/resources/custom/PDF/3rs-newsletter/vol-1-issue-1-mar-2004.pdf>.

⁷⁰ *See, e.g.*, Zimmerman, *supra* note 60 (“[T]he insurance industry, which actually carries most of the costs of malpractice suits, has emerged as a force behind the move toward openness and apologies.”); *see also supra* note 66 (discussing physician-owned insurance companies that grant discounts for doctors who have undergone apology training).

⁷¹ *See infra* Part III (discussing the limits of state statutes).

⁷² *See* O’Reilly, *supra* note 59. These measures, however, are the exception and not the rule. In general, physicians continue to be wary of disclosures and apologies. *See infra* Part III for a discussion of the limits of state statutes.

⁷³ William M. McDonnell & Elisabeth Guenther, *Narrative Review: Do State Laws Make It Easier to Say “I’m Sorry?”*, 149 *ANNALS INTERNAL MED.* 811, 812. *See also infra* Part III.B for an analysis of how the differences between state and federal regulations can contribute to forum shopping difficulties.

⁷⁴ McDonnell & Guenther, *supra* note 73, at 812. The authors suggest that states currently considering apology laws explore whether a regulation protecting full apologies may be more useful than one that only protects partial ones. *Id.* at 813. However, they also acknowledge that there is insufficient data because a majority of the laws have only recently gone into effect and it is likely that not enough physicians know about their added protections. *Id.*

⁷⁵ *Id.* at 812. States that protect both apologies and admissions of fault include Arizona, Colorado, Connecticut, Georgia, South Carolina, Vermont, Washington, and Wyoming. *Id.* at 813. Additional summaries of state apology laws are available through the American Medical Association. *I’m Sorry Laws*, *supra* note 9.

apologies that do not accept responsibility for the mistake may, in fact, be counterproductive and be seen by patients as worse than no apology at all.⁷⁶

In addition, several states further reduce incentives to apologize by protecting only some forms of remorse. For example, Vermont's "I'm sorry" law protects only oral apologies made within thirty days of the incident,⁷⁷ and Illinois only protects apologies made within seventy-two hours of the incident.⁷⁸ Although these limitations were likely implemented to encourage hospitals and practitioners to apologize earlier in the process, the law effectively discourages any apologies that may be appropriate in later conversations.⁷⁹ For example, simply due to logistics, hospitals that have

⁷⁶ Robbenolt, *supra* note 49, at 497. Partial apologies were most deleterious when the injury was severe or when it was obvious who was to blame. *Id.* These apologies were more acceptable when there was ambiguity about the causes of the harm. *Id.* at 498. The author suggests that the degree of responsibility taken by the offender is expected to correlate with the severity of the injury. *Id.* at 498–99.

⁷⁷ VT. STAT. ANN. tit. 12, § 1912(a) (2005) ("An oral expression of regret or apology, including any oral good faith explanation of how a medical error occurred, made by or on behalf of a health care provider or health care facility, that is provided within 30 days of when the provider or facility knew or should have known of the consequences of the error, does not constitute a legal admission of liability for any purpose and shall be inadmissible in any civil or administrative proceeding against the health care provider or health care facility, including any arbitration or mediation proceeding.").

⁷⁸ 735 ILL. COMP. STAT. ANN. 5/8-1901 (2005) ("Any expression of grief, apology, or explanation provided by a health care provider, including, but not limited to, a statement that the health care provider is 'sorry' for the outcome to a patient, the patient's family, or the patient's legal representative about an inadequate or unanticipated treatment or care outcome that is provided within 72 hours of when the provider knew or should have known of the potential cause of such outcome shall not be admissible as evidence in any action of any kind in any court or before any tribunal, board, agency, or person."). The tort caps sections of this law were held to be unconstitutional because they conflicted with the separation of powers doctrine. *Lebron v. Gottlieb Mem'l Hosp.*, 930 N.E.2d 895, 914 (Ill. 2010); *see also* Kevin Sack, *Illinois Court Overturns Malpractice Statute*, N.Y. TIMES, Feb. 5, 2010, at A13.

⁷⁹ Physicians are sometimes given contradictory messages about the timing of an apology. On one hand, they are told to address incidents immediately, "as soon as an error is identified (or even suspected)." Allen Kachalia, *Disclosure of Medical Error*, AGENCY FOR HEALTHCARE RES. & QUALITY (Jan. 3, 2009), <http://www.webmm.ahrq.gov/perspective.aspx?perspectiveID=70>. At the same time, doctors are also told not to be too hasty in apologizing because "[w]e still have the American justice system to contend with." O'Reilly, *supra* note 59 (quoting Robin Diamond, an insurance provider who warns that "physicians who are very familiar with 'I'm sorry' programs sometimes say 'I'm sorry' too quickly before . . . we are sure the event wasn't the result of patient comorbidities or some other factor"). It is therefore unclear what type of conversation a physician is expected to have with a

committee meetings regarding adverse patient outcomes, engage in risk-management assessments after an unanticipated event, or both are unlikely to allow a doctor to apologize within seventy-two hours of an adverse event.⁸⁰

As of yet, there is no evidence as to the effectiveness of these state laws, and no comparisons are available between outcomes for states that protect only expressions of sympathy versus those that also protect admissions of fault.⁸¹ However, it seems unlikely that these laws will result in effective changes if syntax and verbiage concerns continue to complicate apologies.⁸² In other words, if physicians and their defense attorneys need to worry about the exact phrasing necessary to avoid a lawsuit, many will simply choose to delay or forgo the apology altogether.⁸³

III. NEED FOR AMENDMENT TO THE FEDERAL RULES OF EVIDENCE

Despite the available research on the benefits of disclosure and apology programs, in addition to the increasing legislative trend towards protecting apologies, the majority of defense attorneys still counsel physicians against apologizing to a patient.⁸⁴ Even those experts who do recommend apologizing take great care to emphasize the legal risk inherent in a full apology that accepts fault as well as expresses remorse.⁸⁵

patient in the immediate aftermath of a harmful incident. State laws that only protect apologies done earlier in the process seem to add to this confusion.

⁸⁰ For example, the review process at the University of Michigan Hospital System may take several months. *See Boothman, supra* note 62, at 144.

⁸¹ *See McDonnell & Guenther, supra* note 73, at 813.

⁸² Dr. Gallagher, a researcher in the field of medical ethics, finds that physicians are unclear on even which words to use in an initial conversation with patients. Robert Wachter, *In Conversation with . . . Thomas H. Gallagher, M.D.*, AGENCY FOR HEALTHCARE RES. & QUALITY (Jan. 3, 2009), <http://www.webmm.ahrq.gov/perspective.aspx?perspectiveID=69> (“Our research has shown, for example, that physicians are unsure even about basics of disclosure content, like should you say the word ‘error’? How much information should you give the patient about the error?”).

⁸³ McDonnell & Guenther, *supra* note 73, at 812 (“Unless the scope, availability, and potential benefits of existing apology laws are presented to physicians in a clear, succinct manner, such laws are unlikely to affect physician disclosure and apology.”).

⁸⁴ *See* Robin E. Ebert, *Attorneys, Tell Your Clients to Say They’re Sorry: Apologies in the Health Care Industry*, 5 IND. HEALTH L. REV. 337, 341–43 (2008); Liebman & Hyman, *supra* note 13, at 191 (“When something goes wrong in patient care, physicians and hospitals withhold apologies and offer as little information as possible for fear that anything they say may be used against them should patients or family members sue.”); Pavlick, *supra* note 48, at 854.

⁸⁵ *See, e.g.,* WOJCISZAK ET AL., *supra* note 2, at 11 (“Do not say: *I’m sorry. It is all my fault . . . I’m sorry I made such a mistake.*”); Ebert, *supra* note 84, at 361 (“[C]ertain words such as ‘mistake,’ ‘error,’ or ‘accident’ should be avoided.”); *see also* PERRY

There are a variety of reasons for this continued reluctance, ranging from the self-interest of defense attorneys in continuing litigation that may end if an apology is given, to the the fear of legal malpractice on the part of those same defense attorneys if the apology should end up being used in court against the client.⁸⁶ This Part addresses how an amendment to the Federal Rules of Evidence might improve the status quo by encouraging a clarified, uniform approach. In addition, the theoretical underpinning of such an amendment will be presented.

A. *Inadequacy of State Laws*

Although medical malpractice is a state tort, most state laws are inadequate to protect physician apologies, and, therefore, a federal amendment is needed.

As mentioned previously, most state laws addressing apologies protect only expressions of sympathy and not admissions of fault.⁸⁷ In those states, subtle nuances in the apology statement itself have serious legal implications.⁸⁸ For example, “I am sorry that I hurt you” would be admissible in court whereas “I am sorry that you are hurt” may be excluded.⁸⁹ Because the protection of the law extends only to specifically formulated phrases, risk-averse attorneys and nervous physicians may shy away from apologizing altogether, for fear that that the apology may be done

HOOKMAN, MEDICAL MALPRACTICE EXPERT WITNESSING INTRODUCTORY GUIDE FOR PHYSICIANS AND MEDICAL PROFESSIONALS 182 (2008) (advising physicians that apologizing to ward off a lawsuit is naïve and should not be done without attorney approval).

⁸⁶ See Cohen, *supra* note 33, at 1042–46 (reviewing reasons lawyers hesitate to counsel clients to apologize). Aside from those reasons mentioned above, possible reluctance stems from fear of appearing disloyal, soft, or not “macho,” as well as from a lack of knowledge about safe venues for apologies, or a risk-averse approach to defensive practice. *Id.*; see also Wachter, *supra* note 82 (explaining that, aside from concerns about litigation, physicians worry about harming the patient further by increasing anxiety and decreasing compliance and trust).

⁸⁷ See *supra* Part II.E; *I’m Sorry Laws*, *supra* note 9.

⁸⁸ See Wachter, *supra* note 82 (“They protect the words, ‘I’m sorry,’ but they don’t protect the statement about what happened. If you admit liability elsewhere in the disclosure statement, it’s still admissible.”). In addition, some insurance companies may even refuse to provide coverage if a physician apologizes. O’Reilly, *supra* note 59 (“[I]f you as the insured do something that affects our ability to defend the case, we’re not going to cover it. Going out and saying ‘I’m sorry’ not only is going to adversely impact any ability to defend the case, but may well relieve you of that insurance coverage.”).

⁸⁹ Cohen, *supra* note 26, at 829–30; Ashley Davenport, *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, 99 (2006).

incorrectly and jeopardize their case.⁹⁰ Moreover, patients may view such partial apologies as incomplete and ineffective because such vague statements often do not provide enough information for the harmed individual to understand what happened or to gain assurance that error will not reoccur.⁹¹

Because the Federal Rules of Evidence influence many state evidentiary laws,⁹² a Federal Rule protecting physician apologies would present a clear model for states to follow.⁹³ Such a change would reduce syntax confusion and reassure attorneys, who are worried about the risks of an apology being used against their client, possibly resulting in a subsequent malpractice suit against themselves. In fact, if a federal law clearly protected physician apologies, continuing to counsel against such apologies in the face of research that demonstrates the benefits of such statements, may eventually be considered legal malpractice.

B. *Forum Shopping*

Inconsistencies among state laws and between state and federal laws encourage forum shopping⁹⁴ and an amendment to the Federal Rules would limit this practice. Forum shopping takes place when a party selects a court or jurisdiction for her claim because of the perceived likelihood of a

⁹⁰ See Cohen, *supra* note 33, at 1044 (arguing that loss aversion prevents physicians from apologizing). In a survey of 2,500 physicians from the United States and Canada, researchers found that after a serious injury, 56% of physicians “would mention the adverse event,” but not that it was an error. Thomas H. Gallagher et al., *Choosing Your Words Carefully: How Physicians Would Disclose Harmful Medical Errors to Patients*, 166 ARCHIVES INTERNAL MED. 1585, 1591 (2006). Likewise, 61% of physicians would express regret at the outcome but only 33% would explicitly apologize. *Id.*

⁹¹ Robbenmolt, *supra* note 49, at 497–99 (“Overall, one who offered a partial apology was judged to be more responsible than one offering no apology.”); see also Cohen, *supra* note 26, at 838 (“It’s insulting to merely express sympathy or benevolence when you should be admitting your fault.”); Norman G. Tabler, *Should Physicians Apologize for Medical Errors?*, HEALTH L., Jan. 2007, at 23 (“A patient who hears a physician (or hospital representative) disclose an error without apologizing may, in his or her mind, hear the physician saying something like, ‘I made an error that harmed you, but I’m not sorry.’”).

⁹² MERRITT & SIMMONS, *supra* note 22, at 24 (“[M]ore than forty states have adopted state codes that are nearly identical—in language and numbering—to the Federal Rules.”).

⁹³ In contrast, asking states to amend their own laws would be more time consuming and less efficient, because currently only eight states have statutes protecting both apologies and admissions of fault. See *supra* note 75 and accompanying text.

⁹⁴ Stephen H. Legomsky, Response, *Learning to Live with Unequal Justice: Asylum and the Limits to Consistency*, 60 STAN. L. REV. 413, 427 (2007).

favorable outcome in that court based on differences in law.⁹⁵ Although forum shopping can occur in any tort claim, medical malpractice lawsuits are especially vulnerable,⁹⁶ and states have taken steps to prevent forum shopping in litigation between residents of different states.⁹⁷ In addition, forum shopping may also be a factor if either party attempts to remove the claim to federal court.⁹⁸ Under the *Erie* doctrine,⁹⁹ forum shopping is undesirable and, therefore, the state law governs diversity cases unless an Act of Congress applies.¹⁰⁰ Because the Federal Rules of Evidence were passed by Congress in 1975,¹⁰¹ the federal laws will typically govern in diversity cases¹⁰² and federal courts will only defer to state law if the state law is intimately bound up with the rights being asserted or the state rule serves a substantive state policy.¹⁰³ With regard to medical malpractice claims, federal courts have deferred to state law in cases where the state has an integrated scheme for handling such claims,¹⁰⁴ but not in situations where

⁹⁵ BLACK'S LAW DICTIONARY 544 (9th ed. 2009) ("The practice of choosing the most favorable jurisdiction or court in which a claim might be heard.").

⁹⁶ Sloan & Chepke, *supra* note 5, at 181 ("[M]edical malpractice suits are also subject to this [forum shopping] problem, perhaps even more so.").

⁹⁷ *Id.* (discussing the implementation of specialized health courts to limit forum shopping); see also Barbara J. Tyler, *Cyberdoctors: The Virtual Housecall—The Actual Practice of Medicine on the Internet Is Here; Is It a Telemedical Accident Waiting to Happen?*, 31 IND. L. REV. 259, 264 (1998) (discussing forum shopping that can result from interstate medicine practiced on-line and possible state responses).

⁹⁸ See Lindsey C. Boney IV, *Forum Shopping Through The Federal Rules of Evidence*, 60 ALA. L. REV. 151, 188 (2008) ("What is known, though, is that forum shopping is alive and well in the current system whereby federal courts can ignore state substantive rules of evidence.").

⁹⁹ *Erie R.R. Co. v. Tompkins*, 304 U.S. 64, 77–78 (1938).

¹⁰⁰ *Id.* at 78.

¹⁰¹ MERRITT & SIMMONS, *supra* note 22, at 22.

¹⁰² *Sims v. Great Am. Life Ins.*, 469 F.3d 870, 877 (10th Cir. 2006) ("We are persuaded that the Federal Rules of Evidence are not governed by the *Erie* Doctrine.").

¹⁰³ *Wray v. Gregory*, 61 F.3d 1414, 1417 (9th Cir. 1995). In *Wray*, the plaintiff underwent an emergency caesarian section delivery and the attending physician was not able to locate the preferred anesthetic in the few seconds he had before the surgery. *Id.* at 1416. The plaintiff suffered a heart attack post-delivery and spent five weeks in a coma. *Id.* As per Nevada law, plaintiff had to submit her case to a medical-legal screening panel before filing suit. *Id.* The medical panel found that no malpractice took place and the plaintiff filed a diversity suit in federal court. However, Nevada law allows the findings of the panel to be submitted as evidence in trial and after these findings were presented to the jury, the jury found in favor of the defendant. *Id.* The Court of Appeals for the Ninth Circuit reversed, finding that the panel's findings were not presented in conformity with state law and were, therefore, not admissible as evidence to a jury. *Id.* at 1420.

¹⁰⁴ *Sims*, 469 F.3d at 1418 (finding that where Nevada had an integrated scheme for handling medical malpractice claims and the findings of the medical screening panel

such a comprehensive scheme is absent.¹⁰⁵ However, it is not always clear whether a particular state evidentiary rule is substantive in nature or more procedural.¹⁰⁶ Therefore, it is possible that medical malpractice plaintiffs may engage in forum shopping at the federal level where, for example, the physician has apologized and the federal laws do not protect such an apology.¹⁰⁷ An amendment to the Federal Rules of Evidence would eliminate most instances of this type of forum shopping.¹⁰⁸

were a central feature of that scheme, state law and not the Federal Rules of Evidence applied to those findings).

¹⁰⁵ See, e.g., *Gil v. Reed*, 381 F.3d 649, 659 (2004) (finding that Wisconsin's expert rule is a rule of evidence and is procedural rather than substantive in nature and therefore does not apply in federal court). In *Gil*, an inmate sued the United States under the Federal Tort Claims Act and alleged negligent post-operative care. *Id.* at 654. The district court granted summary judgment to defendants because the plaintiff did not present expert medical witnesses to support his malpractice claims, as required by Wisconsin law, and relied simply on the testimony of the prison doctors who treated him. *Id.* The Court of Appeals, however, found that no medical expert witnesses were necessary because the Federal Rules of Evidence do not require an expert when the presented symptoms are within the layperson's grasp. *Id.* at 659. The Wisconsin expert law is not a substantive rule, the court found, and so does not apply in federal proceedings. *Id.*

¹⁰⁶ See Boney, *supra* note 98, at 162 (“[T]here is little uniform application among the circuit courts of appeals of either the state or federal rule in this area.”). The author argues that when faced with a conflict between a federal evidentiary rule allowing evidence and a state law excluding it, the federal court should consistently exclude such evidence, assuming that the state law is substantive in nature. *Id.* at 188. However, at the same time, the author notes that these rules can “fall into a muddy state of either ‘substantive procedure’ or ‘procedural substance,’ and there is no real way to decide which to apply in a diversity case based on these distinctions.” *Id.* at 175 (internal citations omitted).

¹⁰⁷ See Michael B. Runnels, *Apologies All Around: Advocating for Federal Protection for the Full Apology in Civil Cases*, 46 SAN DIEGO L. REV. 137, 157 (2009) (discussing Colorado's “I’m sorry” law, which provides protection for full apologies, but is “not guaranteed deference in federal courts in cases involving federal causes of action”); cf. *Hill v. Onge*, No. 2:06-CV-329, 2009 WL 2833145, at *1 (S.D. Ohio Sept. 1, 2009) (granting defendant's motion to exclude evidence of apology in an Ohio federal court because the Ohio “I’m sorry” law “is ‘intimately bound up’ with the state's substantive concern or policy of allowing doctors to express sympathy to patients without penalty”).

¹⁰⁸ Boney's solution in which federal courts would almost always cede to state laws excluding apologies, see *supra* note 106, is inelegant for several reasons. First, as the author acknowledges, it can be difficult to ascertain whether a state apology law is substantive or procedural. Boney, *supra* note 98, at 175. Second, even if state apology laws were substituted for federal laws that admit such apologies, only eight states currently exclude both apologies and admissions of fault; the majority of states do not provide adequate protection to physicians. See *supra* Part III.A.

C. *Apologies and Admissions of Fault Do Not Prove Liability*

Apologies, and even general admissions of fault, are not indicative of liability in and of themselves.¹⁰⁹ In order to prove liability in the classic tort case, the plaintiff must show that there was a duty of care, a breach of that duty, causation, and damages.¹¹⁰ In a medical malpractice action, the plaintiff shows a breach of the duty of care by proving that the defendant failed to exercise the degree of care ordinarily exercised by a reasonably skilled physician under similar circumstances.¹¹¹ Importantly, a statement of regret, even one in which the physician accepts responsibility for the outcome, is an emotional expression of subjective remorse,¹¹² and it does not address the objective “reasonable care” standard cited in common and statutory law. In other words, the doctor’s personal feelings of disappointment over the unfortunate outcome are not relevant in determining whether a particular standard of care was met.¹¹³ A physician can meticulously adhere to prudent standards and can nevertheless experience regret over a tragic outcome that occurred despite all possible precautions.¹¹⁴ Likewise, a physician can be sloppy in his care and fail to meet even minimum professional standards

¹⁰⁹ See *infra* notes 111–19 and accompanying text.

¹¹⁰ See, e.g., *Wyatt v. Occidental Petroleum Corp.*, 392 F. Supp. 2d 1274, 1280 (N.D. Okla. 2005).

¹¹¹ For example, see VT. STAT. ANN. tit. 12, § 1908 (2010), which states that in a negligence malpractice action, the plaintiff has the burden of proving:

- (1) The degree of knowledge or skill possessed or the degree of care ordinarily exercised by a reasonably skillful, careful, and prudent health care professional engaged in a similar practice under the same or similar circumstances whether or not within the state of Vermont.
- (2) That the defendant either lacked this degree of knowledge or skill or failed to exercise this degree of care; and
- (3) That as a proximate result of this lack of knowledge or skill or the failure to exercise this degree of care the plaintiff suffered injuries that would not otherwise have been incurred.

¹¹² Cohen, *supra* note 33, at 1018 (“An apology is a communication of the emotion of remorse for one’s past acts.” (citations omitted) (internal quotation marks omitted)).

¹¹³ *Id.* at 1028–29 (“Where one’s culpability can readily be proved by independent evidence other than an apology, admitting one’s fault when making an apology will also have little impact on the plaintiff’s ability to prove his case, for he already can.”). Cohen gives an example of a defendant who ran a red light and hit the plaintiff’s car in front of witnesses and notes that “the plaintiff will be able to prove the case irrespective of an apology.” *Id.* at 1029. Likewise, the evidence against a physician who has failed to meet the required standard of care will likely not turn on whether the doctor apologized or not, because there will be other evidence of failure to meet the standard of care.

¹¹⁴ See *infra* note 115.

while experiencing no remorse and no regret over an unfortunate result.¹¹⁵ The physician's demeanor and subjective statements should play no part in determining whether a particular standard of care has been met.¹¹⁶

An analogy to a common situation may help clarify an apology's lack of probative value. An angry customer calls her cell phone service provider to complain about malfunctioning equipment. The network is busy, the texting function is broken, or perhaps even the number cannot be completed as dialed.¹¹⁷ Within the very first few sentences, the customer service representative will apologize for whatever problem is presented.¹¹⁸ She might say something like, "I am so sorry for the difficulties you are experiencing." Her statement, though it may be sincere and heartfelt, bears no relevance to whether the company is at fault for the situation or to whether anyone breached any relevant duty of care. It is simply a statement of regret and a wish that the outcome would have been different.

Likewise, an investment broker who apologizes to her client and says "I'm so sorry about your losses, I guess we should have sold those stocks before the market crashed," is expressing merely a sense of regret and sympathy. Even if she does feel responsible for the financial losses, her subjective feelings are irrelevant in deciding whether she was negligent and breached a duty of care.¹¹⁹ As in the above examples, an apology from a

¹¹⁵ See, e.g., *Wardrip v. Hart*, 949 F. Supp. 801, 804 (D. Kan. 1996) (finding that physician's lack of remorse and apology at trial "is an important factor to take into account when determining the amount of punitive damages to award in this case in order to deter defendant's demonstrated indifference from reoccurring in the future").

¹¹⁶ See Cohen, *supra* note 26, at 834 ("There's little or no logical connection between such expressions and the issue of fault."). Cohen uses an innovative technique to develop his points—the article describes a debate between two old friends from law school. *Id.* The friends discuss whether the law should protect only partial apologies or also full ones. *Id.* at 834–59.

¹¹⁷ For a listing of the most common problems with cell phones, see Theodore, *Cell Phone Problems?*, MOBILE DEVICES (Sept. 7, 2008), <http://www.lockergnome.com/cellphones/2008/09/07/cell-phone-problems>.

¹¹⁸ See Matthew Stein, *The Ten Commandments of Customer Support*, INBOUND INTERNET MARKETING BLOG (Dec. 28, 2010), <http://blog.hubspot.com/blog/tabid/6307/bid/7510/The-10-Commandments-of-Customer-Support.aspx>. The author, a customer service team manager, directs representatives dealing with angry customers that "[e]ven if it's not your fault, apologizing and taking ownership of a problem is one of the fastest ways to defuse an emotional situation."

¹¹⁹ Business decisions, interestingly, are often protected by the business judgment rule, meaning that courts will not second-guess a corporation's business decision, regardless of how ill-fated it turns out to be, unless there is evidence of self-dealing or fraud. See *Aronson v. Lewis*, 473 A.2d 805, 812 (Del. 1985) ("It is a presumption that in making a business decision the directors of a corporation acted on an informed basis, in good faith and in the honest belief that the action taken was in the best interests of the

physician does not necessarily indicate that the doctor was at fault or legally responsible for the outcome.

1. *Probative Value of Apologies*

Although apologies are often admitted as probative, courts have acknowledged the limited value of such apologies and even general admissions of fault in several prominent cases.¹²⁰ Early cases emphasize the need for expert testimony and the dangers of relying on a defendant's own admissions.¹²¹ For example, the risk of relying on hindsight statements was highlighted when a verdict for the plaintiffs was reversed because the appellate court found that physician statements admitting a "wrong operation" and a "misoperation" were not sufficient to show liability.¹²² The court there noted that "[t]his 'wrong operation' may have been deemed right at the time it was performed."¹²³

In a similar case, a physician admitted fault in selecting the wrong type of blade for a tracheotomy on a five-year-old boy.¹²⁴ The appellate court subsequently held that allowing the defendant's admissions of fault in as evidence violated his "substantial rights" because the standard of care cannot

company."). Medical decisions, although often just as risky, appear not to be entitled to the same presumptions.

¹²⁰ See *supra* notes 108–19 and accompanying text. However, because not all courts acknowledge that an apology is not indicative of liability and some courts do see apologies as probative, an amendment to the Federal Rules of Evidence would protect apologies in those jurisdictions, as well as limit forum shopping. See *supra* Part III.B.

¹²¹ See *infra* notes 126–32 and accompanying text.

¹²² *Markart v. Zeimer*, 227 P. 683, 685 (Cal. Ct. App. 1924). Defendants were surgeons who were to operate on plaintiff's hernia. *Id.* at 683. However, an error occurred and as a result, plaintiff lost his right testicle. *Id.* The surgeons freely admitted the mistake and one told a friend of the plaintiff that "[w]e made a wrong operation on him." *Id.* at 685. The plaintiff relied on this statement alone to prove liability and did not offer expert testimony at trial. *Id.* at 684–65. The court found this to be unpersuasive because this admission was not an "admission of negligence or lack of the skill ordinarily required for the performance of the work undertaken." *Id.* at 685.

¹²³ *Markart*, 227 P. at 685.

¹²⁴ *Phillips v. Powell*, 290 P. 441, 443 (Cal. 1930). During a tracheotomy on a five-year-old patient, a piece of the surgical knife broke off and remained embedded in the patient's neck. *Id.* at 442. The physician admitted that the knife, although his best one, was not "crystallized" and it was his own fault for using that kind of knife for the operation. *Id.* at 443. The jury found for the plaintiffs in the amount of \$25,000, but the appellate court reversed, finding that the only standards by which liability can be determined is whether the defendants did not possess and use that reasonable degree of learning and skill which was ordinarily possessed by the members of their profession in good standing practicing in their vicinity." *Id.* at 442–43.

be determined by the defendant's own admissions.¹²⁵ Likewise, when a physician admitted, "[I]t is not your fault, it is all my own," regarding his failure to take x-rays of a broken finger, the appellate court clarified that such a statement by itself would "amount to no more than an admission of bona fide mistake or misfortune and thus be insufficient to establish negligence."¹²⁶

Several later cases similarly emphasize the importance of objective testimony in establishing standards of care.¹²⁷ In *Senesac v. Associates in Obstetrics & Gynecology*,¹²⁸ an operation resulted in a uterine perforation and the physician apologized, saying that "she made a mistake, that she was sorry, and that [the perforation of the uterus] had never happened before."¹²⁹ The appellate court discounted this statement and noted that the doctor did not admit to deviating from reasonable standards of care, regardless of her personal feelings on the result.¹³⁰

In *Short v. United States*,¹³¹ a physician failed to diagnose cancer. The court noted that doctors are not required to be infallible, and that "[a] bad medical result does not automatically require the Court to find a breach of the standard of care."¹³² Importantly, written statements made by the defendant

¹²⁵ *Id.* at 443.

¹²⁶ *Lashley v. Koerber*, 156 P.2d 441, 445 (Cal. 1945). This court ultimately held that the defendant's admission could be used to determine negligence under the totality of the circumstances. The court also considered conflicts in the defendant's testimony and evidence regarding standards of care in that community. *Id.* at 445–46. If the defendant's admission of apology were protected by law, as this Note suggests, liability in this case could have been established through expert testimony on the appropriate use of x-rays in this situation.

¹²⁷ These cases are noted for their deviation from the norm. Typically, apologies are admissible to establish liability at trial. Christopher J. Robinette, *The Synergy of Early Offers and Medical Explanations/Apologies*, 103 NW. L. REV. 2007, 2010 (2009) (citing FED. R. EVID. 801(d)(2)).

¹²⁸ 449 A.2d 900 (Vt. 1982).

¹²⁹ *Id.* at 901.

¹³⁰ The court explained:

The fact the physician may have believed, and, if so, verbalized the belief that her performance was not in accordance with her *own* personal standards of care and skill, is not sufficient in the absence of expert medical evidence showing a departure from the standards of care and skill *ordinarily* exercised by physicians in similar cases.

Id. The court here emphasized that an apology is a subjective statement that reflects the physician's own disappointment and does not reflect on the standard of care offered to the patient.

¹³¹ 908 F. Supp. 227 (D. Vt. 1995).

¹³² *Id.* at 235.

about alternative courses of action were found to be insufficient to prove that the doctor breached a standard of care.¹³³

Even states that permit using a medical malpractice defendant's own admissions to show liability may limit admissibility to situations in which the physician spoke directly "to the standard in such a clear way that the plaintiff has little trouble demonstrating a deviation from that standard."¹³⁴ In other words, a plaintiff who does not wish to use expert testimony and wishes to rely on the admissions of fault made by her doctor must be sure that the admission statement speaks to a specific standard and is not a general acceptance of responsibility.

In *Wilke v. United States*, for example, a patient at a VA clinic fell while recuperating from hip surgery.¹³⁵ Although the VA set out a detailed investigative memorandum finding numerous errors and ways the fall could have been avoided, the court found that relying on this memorandum was insufficient to sustain a claim for medical malpractice because the memorandum did not establish a standard of care and did not address a breach of that standard.¹³⁶ It is apparent that there are many instances where courts will not consider general admissions of fault to be adequate in establishing liability precisely because such admissions do not specifically address a relevant standard of care.¹³⁷ Therefore, their evidentiary value is

¹³³ *Id.* at 236. The patient was a veteran and the treating physician did not refer him for further testing and did not provide referral to a specialist after a routine physical found evidence of an enlarged prostate. *Id.* at 231–32. After the cancer was discovered by another specialist at a different facility, the patient wrote a letter to the VA hospital and the director wrote back, seemingly agreeing that other options could have been suggested. *Id.* at 233. The court eventually found that the standard of care at that time would have required at least a referral to a specialist, but at the same time the court emphasized that this finding was a result of expert testimony only and was not influenced by the director's letter and apparent admissions of fault. *Id.* at 236.

¹³⁴ See, e.g., *Wilke v. United States*, No. 1:07CV465 LG-JMR, 2009 WL 590306, at *1 (S.D. Miss. Mar. 5, 2009).

¹³⁵ *Id.*

¹³⁶ *Id.* at *2. The court notes very clearly that "the standard of care is not a factual matter or within the knowledge of a lay person" and therefore, expert witnesses are always necessary to establish the standard of care. *Id.* This again underscores the limited probative value of the physician's own apology and admission of fault. If an expert witness is needed to establish the standard of care, a defendant's own statements certainly cannot establish such a standard.

¹³⁷ For additional examples of cases where admissions of fault were not seen as sufficient to establish liability, see *Sutton v. Calhoun*, 593 F.2d 127, 128 (10th Cir. 1979) (holding that lower court's refusal to instruct jury that defendant's admission of mistake is equal to an admission of negligence was proper); *Cobbs v. Grant*, 502 P.2d 1, 6 (Cal. 1972) (holding that defendant physician's statement that surgery was not typically necessary was not admission of a negligent decision when all other medical experts testified that such a surgery was advisable); *Phinney v. Vinson*, 605 A.2d 849, 850 (Vt.

likewise diminished, and statements of apology and general admissions of fault should be excluded from admission as proof of liability.¹³⁸

2. *Relevance Value of Apologies*

Are apologies generally relevant? Might it be argued that even if apologies and general admissions of fault do not determine liability independently, they should still be admitted into evidence as these statements are still relevant in helping the fact-finders assess the entirety of the circumstances? In other words, perhaps apologies by themselves do not prove anything, but maybe taken altogether with the other evidence, they are helpful in establishing liability or lack of liability.¹³⁹ Although this argument has merit, it is important to note that such an assertion would apply equally to other types of evidence that are excluded on public policy grounds.¹⁴⁰ For example, Federal Rule of Evidence 407 prohibits admission of subsequent remedial measures to show liability¹⁴¹ and Rule 409 forbids introducing offers to pay medical expenses to show the same.¹⁴² Surely evidence that a defendant offered to pay for the plaintiff's medical expenses and took measures to prevent the error from happening again may be helpful and useful in helping a jury to assess the entirety of the circumstances. Surely such evidence would be relevant. However, Congress took specific steps to exclude such evidence because society wants to encourage desirable behavior, and punishing those who do the right thing would be counterproductive.¹⁴³ In addition, such evidence is excluded because logical

1992) (holding that apology for inadequate procedure was insufficient to allow the case to proceed to trial).

¹³⁸ An amendment is important, however, because the courts do not routinely dismiss the probative value of apologies. In fact, apologies are generally admissible to establish liability at trial. See *Senesac v. Assocs. In obstetrics & Gynecology*, 449A.2d 900, 903 (Vt. 1982).

¹³⁹ See, e.g., *Lashley v. Koerber*, 156 P.2d 441 (Cal. 1945). The court noted that a defendant physician's admissions of fault can be relevant to a jury when combined with a defendant's own contradictory statements in court and the ambiguous standards of care in that jurisdiction with regard to x-ray usage. *Id.* at 445.

¹⁴⁰ Just like relevant evidence is excluded on public policy grounds as per Rules 407 and 409, so too is the relevance of an apology limited when balanced against countervailing public policy considerations. See *supra* Part II.

¹⁴¹ FED. R. EVID. 407.

¹⁴² FED. R. EVID. 409.

¹⁴³ See Aviva Orenstein, *Apology Excepted: Incorporating a Feminist Analysis into Evidence Policy Where You Would Least Expect It*, 28 SW. U. L. REV. 221, 230-31 (1999) (analyzing Rules 407 and 408 from a utilitarian and feminist perspective). The author argues that women are more likely to apologize and suffer as a result. *Id.* at 223.

relevance is not established; just because a remedial measure is taken does not indicate that liability necessarily exists.¹⁴⁴ Similarly, apologizing and admitting fault is the right and ethical thing to do,¹⁴⁵ and punishing those who take this courageous step is counterproductive. Moreover, as explored above,¹⁴⁶ courts have noted that an admission of fault is not necessarily indicative of liability. Therefore, physicians' apologies and general admissions of fault should be protected by an amendment to the Federal Rules of Evidence.

IV. AMENDMENT TO THE FEDERAL RULES OF EVIDENCE

This Part presents the text of the proposed amendment and then discusses the reasoning behind the text and its placement.

A. Text of Proposed Amendment: Rule 409

The current text of Rule 409 reads as follows: "Evidence of furnishing or offering or promising to pay medical, hospital, or similar expenses

The author also suggests that the "feminist advocacy of an ethic of care support[s] the need for an apology exception" with regard to medical professionals. *Id.* at 223–24.

¹⁴⁴ *Id.* at 231 ("[J]ust because one improves something does not mean the item was broken before.").

¹⁴⁵ The American Medical Association's Code of Medical Ethics provides:

It is a fundamental ethical requirement that a physician should at all times deal honestly and openly with patients. Patients have a right to know their past and present medical status and to be free of any mistaken beliefs concerning their conditions. Situations occasionally occur in which a patient suffers significant medical complications that may have resulted from the physician's mistake or judgment. In these situations, the physician is ethically required to inform the patient of all the facts necessary to ensure understanding of what has occurred. Only through full disclosure is a patient able to make informed decisions regarding future medical care.

Ethical responsibility includes informing patients of changes in their diagnoses resulting from retrospective review of test results or any other information. This obligation holds even though the patient's medical treatment or therapeutic options may not be altered by the new information.

Concern regarding legal liability which might result following truthful disclosure should not affect the physician's honesty with a patient.

COUCL ON ETHICAL & JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION 240 (2006) (Opinions on Practice Matters 8.12).

¹⁴⁶ *See supra* Part III.C.1. and accompanying notes.

occasioned by an injury is not admissible to prove liability for the injury.”¹⁴⁷
The proposed text of Rule 409 would read:

1. Evidence of furnishing or offering or promising to pay medical, hospital, or similar expenses occasioned by an injury is not admissible to prove liability for the injury.
2. Evidence of an apology or general statement of fault when made by a medical professional¹⁴⁸ is not admissible to prove liability for the injury.¹⁴⁹

B. *The Placement and Rationale Behind the Text of the Amendment*

Although several proponents of an amendment have recommended adjusting Rule 408 to exclude apologies,¹⁵⁰ this result seems confusing and convoluted. Rule 408 is designed to protect settlement negotiations after a claim is already in existence,¹⁵¹ and courts have already developed case law

¹⁴⁷ FED. R. EVID. 409.

¹⁴⁸ It is possible that protecting other medical professionals, such as nurses and pharmacists, would also be advisable. This Note, however, focuses on physicians because they are subject to greater legal and financial liability. For example, although non-physician professionals can be sued directly, in some states physicians can also be held responsible for malpractice of others under the doctrine of respondeat superior. See Judge Janette A. Bertness, *Rhode Island Nurse Practitioners: Are They Practicing Medicine Without a License?*, 14 ROGER WILLIAMS U. L. REV. 215, 247 (2009).

¹⁴⁹ Whether the apology should be admissible to show anything other than liability is an interesting question, somewhat beyond the scope of this Note. It would seem, however, that the usual concerns about plaintiff attorneys who find loopholes to introduce evidence otherwise inadmissible are not as relevant here because plaintiffs’ attorneys may be somewhat reluctant to present the jury with an apologetic, contrite defendant. See WOJCIESZAK ET AL., *supra* note 2, at 66 (quoting the president of the South Carolina Trial Lawyers Association as saying he would never introduce a doctor’s apology in court because it is his job to make the doctor look bad in front of a jury and such an admission would “kill” his case).

¹⁵⁰ Cohen, *supra* note 33, at 1061–62; Runnels, *supra* note 107, at 157 (acknowledging the support).

¹⁵¹ The rule states:

(a) Prohibited uses.— Evidence of the following is not admissible on behalf of any party, when offered to prove liability for, invalidity of, or amount of a claim that was disputed as to validity or amount, or to impeach through a prior inconsistent statement or contradiction:

(1) furnishing or offering or promising to furnish—or accepting or offering or promising to accept—a valuable consideration in compromising or attempting to compromise the claim, and

to determine whether compromise negotiations are in progress.¹⁵² Attempting to change Rule 408 to include any discussions that take place before a claim is filed seems to expand the rule beyond all recognition and original intent.¹⁵³ At the same time, adding a new rule would be a drastic and unlikely move. Rule 409 is the next natural option as the original text already focuses on medical injuries and efforts made to ameliorate them. Rule 409 is also a good alternative because the rule itself is relatively short and simple, unlike the more complex language of Rule 408.¹⁵⁴

The proposed amendment limits the apology exclusion to statements made by medical professionals. Although offering an apology may be appropriate after any kind of tort takes place,¹⁵⁵ the lack of protection for physician apologies is particularly detrimental for society as a whole. Physician failure to disclose errors and apologize is implicated not only in the high numbers of medical malpractice claims and increasing insurance rates, but also in the overall distrust that the public has towards those in the

(2) conduct or statements made in compromise negotiations regarding the claim, except when offered in a criminal case and the negotiations related to a claim by a public office or agency in the exercise of regulatory, investigative or enforcement authority.

(b) Permitted uses.—This rule does not require exclusion if the evidence is offered for purposes not prohibited by subdivision (a). Examples of permissible purposes include proving a witness's bias or prejudice; negating a contention of undue delay; and proving an effort to obstruct a criminal investigation or prosecution.

FED. R. EVID. 408.

¹⁵² See, e.g., *Lee Middleton Original Dolls, Inc. v. Seymour Mann, Inc.*, 299 F. Supp. 2d 892, 895 (E.D. Wis. 2004) (holding that a unilateral offer without attorneys present does not indicate compromise negotiations).

¹⁵³ See, e.g., Runnels, *supra* note 107, at 146–49 (attempting to present a modified version of Rule 408 that excludes all apologies and admissions of fault). Runnels argues that in addition to the modified text, compromise negotiations would have to be redefined as “attaching immediately after an injury.” *Id.* at 148. The result is confusing and appears to overreach.

¹⁵⁴ For example, Rule 408 includes an exception for statements made to a regulatory agency when such statements are offered in a criminal case. See *supra* note 151. This may potentially affect physicians who disclose errors to regulatory agencies. It also prevents the defendant from using his own statement in his own defense, if such a statement were made during compromise negotiations. See FED. R. EVID. 408 advisory committee's note. For these reasons, a simpler rule is easier to amend and adjust.

¹⁵⁵ Cohen, *supra* note 33, at 1009 (describing the differences between the ways in which children and adults are advised to act when they have injured others). Cohen argues that apologies should be protected for all harmful actions. There are considerable benefits to this approach, such as the uniformity of approaches that would be absent if the rule, as proposed here, only protected apologies made in medical situations. However, it seems that such an approach would require a more comprehensive overhaul, one that the litigation system is not yet prepared to accept.

medical field.¹⁵⁶ In addition, medical errors can hardly be addressed and prevented if they cannot be admitted and disclosed.¹⁵⁷ Finally, the phenomenon of victims who want an apology and an explanation more than financial compensation has been documented exclusively in the medical malpractice field.¹⁵⁸ For these reasons, an amendment addressing the specific apologies made by medical personnel is more critical at this time than a general amendment that would protect all apologies for all torts.

Notably, protecting full apologies and even general admissions of fault is not the same thing as allowing negligent physicians off the hook after they apologize. A physician who breached a standard of care would still face potential liability, assuming this could be proven through evidence other than the physician's own apology. As Cohen notes, "Where one's culpability can readily be proved by independent evidence other than an apology, admitting one's fault when making an apology will also have little impact on the plaintiff's ability to prove his case."¹⁵⁹

The proposed amendment would, therefore, serve to separate claims for which independent corroborating evidence exists from those where the only evidence of malpractice is the physician's own admission.¹⁶⁰ The former

¹⁵⁶ See *supra* Part I.

¹⁵⁷ Lucinda E. Jesson & Peter B. Knapp, *My Lawyer Told Me to Say I'm Sorry: Lawyers, Doctors and Medical Apologies*, 35 WM. MITCHELL L. REV. 1410, 1417 (2009) ("[U]nderstanding the causes of errors, and to put in place systems to catch and prevent them, requires discussion of the errors in the first place."). Jesson and Knapp argue that the creation of state evidentiary exclusions for physician apologies will needlessly involve more attorneys and result in more delay and confusion. *Id.* at 1447–50. The authors posit that the benefits of apologies, which come from openness of communication, will be limited when attorneys interfere. *Id.* The focus, they argue, should remain not on changing the laws, but on changing medical culture. *Id.* at 1452. However, a Federal Rule protecting all statements of apology from admission, as proposed here, would seem to be broad enough to minimize legal involvement to the extent possible. In addition, it is likely that no matter how much medical culture is exhorted to change with regard to apology-giving, this change will not take place unless the legal culture changes as well, simply because physicians cannot afford to take on additional legal risk. See *infra* Part V for additional challenges to the apology law movement.

¹⁵⁸ See Tabler, *supra* note 91, at 25 ("There are no studies showing, for example, that what automobile crash victims most want is an explanation and apology from the other driver or assurance that the driver's behavior will be corrected. There are no studies showing that the primary reason crash victims sue is that they didn't receive an apology.")

¹⁵⁹ Cohen, *supra* note 33, at 1028; see also *supra* Part III.C. (discussing the probative value of apologies).

¹⁶⁰ Allowing an exception and admitting admissions of fault into evidence when the physician statements address a specific standard of care is also a possibility. However, if such an exception were made, it would rarely be useful because doctors are unlikely to

could continue to trial or settlement while the latter could be dismissed for lack of evidence. At first glance, this may seem to be a harsh ending for the malpractice victim who has no witnesses and no evidence other than the doctor's own statements. However, as the law stands now, this same victim would likely be in the identical situation because, if admission of fault and acceptance of responsibility would determine the outcome of a trial, such an admission is unlikely to be made in the first place, given the current risk-averse climate.¹⁶¹

For example, think back to the initial scenario of the young man with a hidden heart attack. There are two primary options: either there are witnesses and corroborating evidence reflecting the fact that the doctor chose not to order an angiogram, or the only witness is the doctor and no one else knows about this decision. In the first case, if failure to do an angiogram were a breach of the standard duty of care, these facts would come out at trial anyway because of the witnesses and other evidence. Here the physician has nothing to lose by apologizing and everything to gain. In the second case, the physician is the only one who knows about the mistake. Is he likely to make a full apology and admit this breach of duty? No. In the current climate, the most he would likely do is craft a partial apology with his attorney and use carefully structured language to express sympathy while avoiding anything remotely close to an acceptance of responsibility.¹⁶² The victim is still left with nothing to bring to court and now he has no expression of remorse nor explanation from his doctor.

Therefore, protecting full apologies and admissions of fault is unlikely to either detract or add to the legal arsenal at the victim's disposal. Instead, protecting such apologies would result primarily in emotional benefits to the parties involved, which may likely serve to reduce the number of malpractice claims and burdens on state courts, as well as to encourage disclosure and prevention of future errors.¹⁶³

V. POSSIBLE OBJECTIONS TO AMENDING THE FEDERAL RULES OF EVIDENCE

There are a variety of possible objections to the proposed amendment and this Part attempts to address several of the more prominent ones.

make statements specific enough to address the reasonable standard of care and instead such an exception would engender considerable confusion and litigation over which statements would qualify and which would not qualify, leading again to more linguistic caution and wariness. A categorical exclusion for all statements of fault is cleaner and more workable.

¹⁶¹ See *supra* notes 82–84 and accompanying text.

¹⁶² See *supra* notes 86–87.

¹⁶³ See *supra* Part II.C.

Specifically, this Part discusses possible negative consequences of protecting apologies, such as a decrease in care quality, a decrease in the value of an apology, or no change in the status quo at all. Questions about the probative value of an apology have already been discussed elsewhere in this Note,¹⁶⁴ as has the rationale for limiting protection to only medical apologies.¹⁶⁵

A. Will Protecting Apologies Result in Lower Quality Medical Care or Excessive Forgiveness?

Some critics, most notably Professor Erin Ann O'Hara, contend that protecting apologies would result in more medical errors and lower quality care overall precisely because overly-forgiving patients will be more reluctant to sue.¹⁶⁶ However, as O'Hara herself points out, disclosure and reporting requirements are likely to be ameliorative factors.¹⁶⁷ Disclosure is a difficult, if not impossible goal, if the threat of litigation hangs over each and every admission of fault.¹⁶⁸ Laws that protect apologies would encourage disclosure, lead to greater error-prevention efforts, and, ultimately, higher quality medical care.¹⁶⁹

Moreover, if patients truly desire an apology in lieu of a larger settlement,¹⁷⁰ they and their physicians should have that option.¹⁷¹ Some individuals, for a variety of reasons, are not interested in the time and expenses involved in a lawsuit and would much prefer a frank explanation

¹⁶⁴ See *supra* Part III.C.

¹⁶⁵ See *supra* Part IV.B. Protecting all apologies would be a drastic change and this process should be done and evaluated in increments. See *supra* notes 15–16 and accompanying text. Medical apologies should be protected first because of the value that the physician-patient relationship has to society as a whole and the damage that fear of apologizing has done to that relationship. *Id.*

¹⁶⁶ 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 (2004) ("If doctors are prone to apologize when they cause harm, then meritorious claims tend to drop out of the pool.").

¹⁶⁷ *Id.* at 1084–89 (explaining that monitoring the quality of doctors' care through peer review and disclosure programs can overcome "the weaknesses of the liability system").

¹⁶⁸ See *supra* note 14 and accompanying text.

¹⁶⁹ See *supra* notes 14–16 and accompanying text.

¹⁷⁰ Tabler, *supra* note 91, at 24–25.

¹⁷¹ O'Hara, *supra* note 166 (noting that comparison between victims of spousal abuse and patients who have suffered an adverse event seems somewhat paternalistic in its underlying assumption that society needs to protect these patients from their own self-destructive tendencies to accept insincere apologies despite the harm this causes them).

and an apology.¹⁷² Just like the law protects these individuals' right to accept a smaller settlement than their claim may be worth,¹⁷³ so too must it protect their right to receive an apology in lieu of filing a claim, no matter how meritorious that claim may be. Words can be, and often are, more precious than money, and victims are entitled to decide which they prefer on their own, without congressional or judicial impediments.¹⁷⁴

Finally, studies suggest that the severity of the damage suffered affects the extent to which a mere apology suffices.¹⁷⁵ In other words, patients with the most severe medical outcomes are less likely to accept an apology by itself while those with more moderate or minor injuries are more likely to accept an apology alone.¹⁷⁶ Protecting apologies would, therefore, potentially serve to limit the types of suits that are eventually filed and weed out less meritorious claims.

B. *Will Protecting Apologies Dilute Their Value?*

Other critics of the apology protection movement argue that protecting apologies simply makes them insincere and meaningless.¹⁷⁷ To these

¹⁷² See Hickson et al., *supra* note 44, at 1359 (analyzing why injured patients choose to sue). In addition, there is considerable evidence that for every lawsuit filed, there are many serious medical injuries for which a malpractice lawsuit is not filed. See BAKER, *supra* note 8, at 23.

¹⁷³ See FED. R. EVID. 408.

¹⁷⁴ See Cohen, *supra* note 26, at 846, for an example of a religion-based approach to forgiveness, in which the victim stated "I'm a Christian When a person asks me to forgive them, I do." Looking at the issue through this lens, limiting the ability of victims to accept apologies may disrespect their religious and cultural beliefs.

¹⁷⁵ See Robbennolt, *supra* note 49, at 493–99 (finding that when the injury was minor, even a partial apology was seen as beneficial, whereas a partial apology was seen as worse if the injury was greater).

¹⁷⁶ *Id.* The apology would serve as a type of screener because, presumably, more severely harmed patients would be more likely to continue with a lawsuit.

¹⁷⁷ See, e.g., Lee Taft, *Apology Within a Moral Dialectic: A Reply to Professor Robbennolt*, 103 MICH. L. REV. 1010, 1012 (2005) ("Yet, apology is not moral simply because of the acknowledgment that one has caused injury. What elevates it to a truly moral and corrective communication is the offending party's willingness to accept the consequences that flow from the wrongful act."). In addition to his main argument against protecting apologies, Taft notes that negotiations can and do fail, and then the plaintiff is in the undesirable position of having to prove during the negotiation session what the physician has already admitted privately. *Id.* at 1015. He finds this situation intolerable and suggests that this problem would increase if apologies were protected outside the negotiating room as well. *Id.* However, just as Congress saw fit to enact Rule 408 to protect such statements if made within compromise negotiations, apologies provide enough societal benefit for them to be protected even when made before any claim has been filed. Plaintiffs are often placed in the position of proving statements that

theorists, an apology is valued only insofar as it comes with consequences attached. Therefore, protecting apologies from legal consequences inherently weakens their moral value.

However, apologizing and admitting fault does not magically eliminate all consequences. An overwhelming number of physicians feel guilt and shame after an error has been made.¹⁷⁸ The process of disclosure causes anxiety and feelings of self-defeat.¹⁷⁹ For those who are not yet remorseful, the process of apologizing may “trigger a process of internal remorse.”¹⁸⁰ Moreover, an apology may be insufficient and settlement negotiations or a trial would follow, with all the commensurate professional and social repercussions. In the medical field, admission of fault is a humiliating experience,¹⁸¹ and no amount of legal protection for apologies could possibly make up for that.

C. Will Protecting Apologies Actually Affect Doctors’ Willingness to Apologize?

Another critique of apology protection laws is that they will be useless in the face of deeply ingrained medical cultural norms.¹⁸² Because doctors are trained to strive for perfection, and because the process of disclosure and apology exposes their shame and guilt, physicians will resist apologizing no matter how well the law protects them.¹⁸³ Moreover, because doctors distrust the law and are skeptical of it, they will not accept its protection, but will instead continue to fear allegations and lawsuits.¹⁸⁴

have been admitted privately but are not admissible in court; that is a common feature of “hearsay” statements. Having to prove liability when the physician has admitted fault in private is no more burdensome than having to prove the content of inadmissible hearsay through some other means.

¹⁷⁸ Wei, *supra* note 24, at 151–52. Wei argues that legal protections will not be of much help to physicians because the very process of disclosure is so inherently traumatic. She posits that instead of advocating for evidentiary exclusions for apologies, a more effective way of encouraging disclosure would be through the gradual changing of cultural norms in the medical profession. *Id.* at 155. This can be done through increasing physician confidence in the law, mandatory hospital-based disclosure policies, and additional medical education and training. *Id.* at 155–59.

¹⁷⁹ *Id.* at 150–51. Wei suggests that the historical notions of the “infallible physician” create a perfectionism mentality which makes errors more difficult to acknowledge and admit. *Id.* at 147–48.

¹⁸⁰ Cohen, *supra* note 33, at 1066 (“Saying sorry may help you to feel sorry.”).

¹⁸¹ See Wei, *supra* note 24, at 151.

¹⁸² *Id.* at 154 (“Apology laws will not overcome these barriers to disclosure.”).

¹⁸³ See *id.*

¹⁸⁴ See *id.*

These concerns are real ones. The physician frame of reference may indeed be firmly programmed against disclosures and apologies. However, using this mindset as an argument against apology laws ignores the variety of other players involved in the medical practice field. Hospital administrators, risk assessment teams, defense attorneys, and insurance carriers all have an interest in limiting legal liability. These groups can and do exert influence over physicians, no matter how reluctant the latter may be to express remorse and disclose fault. The apology movement is gaining momentum and disclosure programs are being implemented in medical centers across the country.¹⁸⁵ Even some insurance carriers are beginning to advocate for prompt apologies and disclosures.¹⁸⁶ Medical schools are beginning to teach students the benefits of apologies in preserving the doctor-patient relationship.¹⁸⁷ Over the next several decades, these centers and organizations will undoubtedly develop new paradigms for communicating about unexpected medical events and these will become the national standards against which all other doctor-patient exchanges will be measured. The protection of the law, particularly the federal law which serves as a model for all states,¹⁸⁸ is especially necessary for these gains to continue to build momentum.

VI. CONCLUSION

The Federal Rules of Evidence protect many types of statements based on public policy grounds. The Rules protect letters detailing subsequent remedial measures, settlement offers and conduct, plea bargaining, and offers to pay medical expenses. The Rules do this because otherwise parties would not take these actions and society would suffer as a result. It is time to add physician apologies and general admissions of fault to the protected list by amending Rule 409 to protect such statements.

An apology or a general acceptance of responsibility does not reflect liability. Physicians can and do feel regret even though all standards of care have been followed. Mistakes happen despite their very best precautions. In contrast, other physicians can apologize until they are blue in the face but it

¹⁸⁵ See *supra* Part II.D.

¹⁸⁶ See *id.*

¹⁸⁷ Electronic Interview with Anna Serels, student, Sackler Faculty of Med., N.Y. St./Am. Program, Tel Aviv Univ. (Jan. 4, 2010). Ms. Serels stated that her program emphasized the need to maintain positive rapport with patients and she was advised to apologize whenever the relationship would seem to benefit from an apology. *Id.* This educational approach is another example of how apologies are not necessarily indicative of liability; the physician may be apologizing because she wants to maintain a rapport with her patient or simply because she was trained to do so in school. *Id.*

¹⁸⁸ See *supra* Part III.A.

will not change their egregious departure from reasonable care one bit. That is the key evidence in a trial—whether the physician departed from a reasonable standard of care—not whether she apologized or said she was at fault.

The current state of medical malpractice has significant consequences for the Nation, not only financially, but also in terms of quality of care. Disclosure and prevention of medical errors cannot take place if physicians cannot admit their mistakes and apologize for them. In lieu of lawsuits, many patients truly want sincere remorse and forthright explanations. Moreover, physicians often want to give them. It is time to make sure the legal system does not get in the way.