The Value of Voluntary Disclosure of Medical Error
To a Community Hospital

Harold L. Gallick [FN a1]

PROLOGUE

In my cardiothoracic surgery residency, the most erudite attending surgeon I knew, with the most gifted hands I ever watched, repeatedly admonished us: “Never apologize.” I recall him once sending me from the operating room during a very lengthy and difficult procedure to update a family, and later chastising me for explaining to them that the defect was more complex than preoperative evaluation had revealed. His legacy is measured by countless lives saved, surgeons trained, articles written, and textbooks authored. Unfortunately, an intolerable surfeit of medical malpractice allegations curtailed his practice. Our community lost a valuable resource. True to his teaching, no one apologized.

INTRODUCTION

Hospitals in the United States are dangerous places. Preventable deaths due to medical error occur with alarming frequency. [FN 1] Traditional supervisory processes, self-policing by medical quality assurance committees and the occasional identification and removal of an incompetent practitioner through tort liability, are simply inadequate methods for significantly reducing harmful errors. In 1999, the Institute of Medicine issued a startling report entitled “To Err Is Human: Building a Safer Health System” (“IOM Report”) [FN 2]. Using published data from retrospective reviews of inpatient medical records, the IOM Report estimated that 44,000 to 98,000 deaths of hospitalized patients occurred annually in the United States due to medical error. [FN 3] The IOM Report attributed most errors not to individual practitioners, but to faulty delivery systems unsuited for error prevention or repetition. The IOM Report recommended individual states administer a mandatory system of reporting and publishing errors causing serious harm or death. It also called for a goal of a 50% reduction of errors within five years. [FN 4]

Although the IOM Report was not uniformly accepted, it sounded an alarm heard by state and federal governments, private oversight agencies such as the Joint Commission for the Accreditation of Hospitals (“JCAHO”), health insurance providers, medical educators, professional societies and associations, hospitals, and the lay press, initiating the era of patient safety. Many of these stakeholders independently reacted with plans and proposals to improve patient safety, but five years after the IOM Report, progress was reported to be slow in reaching the laudable goal of a 50% reduction of error and death. [FN 5] The hesitancy of health care practitioners, institutions, their insurers, and legal counsel to accept and employ voluntary disclosure of error as a means to patient safety is one impediment to adoption. Failures to define error, establish a reliable reporting system, and disseminate knowledge also create barriers to use of disclosure.

The fragmented nature of health care in the United States and a traditional wariness over ethical, legal, and business aspects of voluntary disclosure continue to thwart widespread realization, despite anecdotal reports of successful implementation. Overcoming this trepidation, and coordinating efforts between private, public, professional, governmental, and business interests to develop a system of voluntary disclosure as part of an overall improvement scheme for national health care delivery may be an impossible dream. For local community hospitals, understanding and firm leadership in conquering this unease is possible and may start a groundswell toward national acceptance of voluntary disclosure. This paper will discuss, ethical, legal, and business considerations surrounding voluntary disclosure of error, and offer suggestions for implementation of voluntary disclosure principles to improve patient safety in community hospitals.

I. Ethical, Legal, and Business Aspects of Voluntary Disclosure

For centuries, medicine has been practiced from an elevated position. Decisions were made for patients, outcomes were unquestioned by patients, and errors were concealed from patients. This approach persisted in the twentieth century as the consequence of doctors fearing tort liability, lawyers denying and defending errors, and hospitals shielding themselves from financial loss. The advent of the twenty-first century heralded a transformation of traditional social and professional relationships, including that of the doctor and patient. Surprisingly, transparency in the practice of medicine demonstrated that doctors' fears were unfounded, lawyers' tactics were unwarranted, and hospitals' posturing unnecessary. If practitioners are able to surmount historic barriers, voluntary disclosure of medical error has the potential to lead the practice of medicine to greater achievements in this new century.

A. Ethical Considerations in Voluntary Disclosure

i. The Duty to Disclose

The traditional relationship between doctors and patients in America is a hierarchical one that is premised on public belief in the infallibility of doctors and the health care system. In this situation, doctors comfortably and confidently undertake open and honest communication with patients regarding many subjects: informed consent, advance directives, difficult treatment choices, even delivery of grim news. Doctors also speak candidly with each other concerning difficult diagnoses or technical procedures. Broaching the topic of error, however, is painfully difficult in any circumstance. Silence is often professionally accepted and a seemingly more secure option for the physician.

In this age of transparency however, this traditionally unilateral relationship between doctor and patient is less satisfactory. Patients are now "full partners in their care," [FN 6], and doctors have become educators, responsible for fully discussing all aspects of care and possible outcomes. In this modern relationship, patients expect full disclosure of errors leading to adverse outcomes. Physicians then face a personal dilemma. They recognize a moral and ethical need to disclose errors, but think that admitting less than perfection to a patient weakens the relationship and invites retribution. Additionally, many physicians believe admitting error to a colleague implies ineptitude and invites loss of respect, trust, and referrals. This fear of shame or embarrassment over making a mistake creates a very real barrier to physicians accepting and practicing voluntary disclosure.

Progress in surmounting this barrier is underway. Ethical guidelines promulgated by professional societies such as the American Medical Association [FN 7] and the American College of Surgeons [FN 8] have advocated the physician's duty to disclose harmful error to patients. In 2006, the Full Disclosure Working Group of the Harvard Hospitals released a consensus statement supporting disclosure policy. [FN9] Some medical schools and residency training programs are beginning to teach disclosure policy and techniques [FN 10], and when evidence-based studies revealing advantages of disclosure reach the literature, the routine practice of voluntary disclosure may expand.

ii. The Need for Apology

Simple disclosure of an error by the physician however, is not sufficient to sustain a working relationship with the patient. Studies indicate that harmed patients want to understand what happened, how their care is affected, and be assured that recurrences would be prevented. [FN 11] Additionally, patients desire an apology. [FN 12] Apologies were traditionally repugnant to physicians and their attorneys fearing association with liability. [FN 13] Now they are becoming an accepted practice for reducing tension, antagonism, and anger between parties

in a lawsuit. [FN 14] The role of apology in medicine and law is rapidly evolving. As Robbennolt noted, "[a]pology is, after all, consistent with a professional ethic that cares for and respects patients." [FN15]

Just as patients desire apology, providers need forgiveness. In fact, "an authentic apology [FN16] has the capacity to inspire a unique kind of healing that contains the potential to heal both doctor and patient." [FN17] An authentic apology can strengthen the new age "partners in health care" relationship between doctor and patient.

Unfortunately, governing boards and societies that recommend disclosure offer no guidance regarding apology. Until recently, doctors received little training in this most delicate communication skill, and "botched apology" can further harm a strained relationship. [FN18] Recognition of this discrepancy prompted formation of the "Sorry Works! Coalition," an organization of patient advocates, doctors, lawyers, and insurers dedicated to promoting disclosure and apology following medical error. [FN 19] This web-based public awareness organization has drawn criticism as overly simplistic from academically recognized authorities [FN 20]. Nonetheless, it represents a growing level of private and professional interest and involvement in modernizing the physician-patient relationship.

B. Legal Considerations of Voluntary Disclosure

i. The Role of Tort Law

Physicians are not the only group within the health care field who are reexamining traditional views. The deterrent purpose of tort liability has long been assumed contributory in reducing medical error. In 1978, a special article co-authored by a doctor and lawyer explaining the deterrent value of tort law in malpractice cases appeared in the highly respected New England Journal of Medicine (NEJM). [FN 21] At that time, damage awards in malpractice liability cases were approaching $50,000 and fear of a malpractice insurance crisis (high cost or unavailability for some medical specialties) loomed. The authors explained that threats of large awards incentivized doctors to avoid errors. Three decades later, citing the IOM Report, tort liability was still touted as important in putting pressure on doctors to improve safety. [FN 22] A closed case review by the American Society of Anesthesiologists (ASA) is cited as an example of tort liability triggering process improvements. [FN 23] The ASA, however, is the only instance of process improvement resulting from a compilation of data from liability cases. Other medical specialties have not collected and categorized analogous data, precluding wide realization of the deterrent benefit of tort liability. [FN 24]

As the malpractice crisis deepened, so did the culture of silence, further diminishing the deterrent value of tort liability. The risk of litigation, "disclosure means exposure," dissuaded physicians and hospitals from embracing voluntary disclosure. Defense attorneys perpetuated this concern, advising clients against admissions, disclosures, and apologies. [FN25] Yet, no published evidence suggests disclosure of errors dramatically increases liability. [FN 26] Many patients decide to litigate simply to learn more about their situation, [FN 27] or because of a perceived lack of communication with their doctor. [FN28] Multiple survey studies have shown that error disclosure reduces patients' intention to file a lawsuit, and that apologies may help promote settlements of suits filed. [FN 29]

The threat of tort liability from isolated errors alone cannot result in the health care delivery system safeguards advocated by the IOM Report. Neither can tort reforms, such as artificial caps on general damages. Caps may reduce insurance premiums, but do not promote disclosure or advance patient safety practices. Sporadic closed-case data collected by some insurance carriers, not compiled for use in advancing error avoidance, is also of no benefit. Instead, mounting evidence suggests disclosure does not increase the likelihood of lawsuits. Coupled with an effective reporting system, disclosure has the potential for actually realizing the systemic improvement goals of the IOM Report.

Two innovative approaches to tort law may play important roles in promoting patient safety. First, in the spirit of tort reform, state legislatures could consider adopting caps on non-economic damages only for institutions or individuals participating in a voluntary disclosure program. [FN 30] Second, the IOM Report suggested development of standardized definitions for use in reporting. [FN31] The National Quality Forum, which produces consensus standards for health care delivery, responded by publishing a list of preventable adverse medical events, [FN32] and added disclosure of error to the list of safe practices. [FN33] Error reporting and analysis are also part of JCAHO accreditation requirements. [FN 34] Plaintiff attorneys may argue that hospitals failing to implement voluntary disclosure as a NQF safe practice [FN 35] or meet JCAHO requirements are negligent for not meeting an industry standard of care.

ii. The Role of Legislation

Not only is tort law evolving to embrace voluntary disclosure, federal and state legislatures are considering or instituting recommendations of the IOM Report. In 2005, the National Medical Error Disclosure and Compensation (MEDiC) Bill was introduced in the US Senate. Explaining the purpose of the Bill in a NEJM article, the co-authors stated, "[t]o improve both patient safety and the medical liability climate, the tort system must achieve four goals: reduce the rates of preventable medical injuries, promote open communication between physicians and patients, ensure patient access to fair compensation for legitimate medical injuries, and reduce liability insurance premiums for health care providers." [FN 36] The authors recognized the benefit of integrating disclosure and reporting systems into current tort law practices to achieve these goals. Commensurate with IOM Report suggestions, MEDiC proposed several actions: creation of an Office of Patient Safety and Health Care Quality charged with development of a national error reporting database; federal grant support and technical assistance for institutions developing disclosure programs; institutional designation of a patient safety officer to review errors and receive notices of related legal actions; mandatory disclosure of recognized error to an injured patient with offer of negotiated settlement; and protection of any apology offered during disclosure from use in any subsequent legal proceeding as an admission of guilt. The bill died in committee.

Several states have adopted disclosure and apology laws containing variable requirements for reporting and protections of apologies. [FN 37] In 2004, Michigan passed legislation creating the State Commission on Patient Safety. In 2005, 25 Commission members from varied backgrounds produced an extensive report (MI Report) [FN 38] and proposed a model act establishing a statewide center for patient safety leadership, information and advocacy. In 2006, bills introduced in the house of representatives addressing some MI Report recommendations, including development of a standardized data collection tool and establishment of an adverse health care event reporting system, expired with the legislative session and were never reintroduced. [FN 39]

C. Business and Financial Implications of Voluntary Disclosure

i. The Cost of Error

The health care system not only has an ethical and legal obligation to consider implementation of voluntary disclosure, but an economic incentive as well. The IOM Report estimated economic losses due to medical error at a startling $17 to $29 billion. Half of these costs are attributable to prolonged hospitalizations necessary to treat complications. The remainder represents lost income, productivity, and disability costs. [FN 40] Any system that decreases error rates has the potential to generate enormous cost savings. Voluntary disclosure of error and reporting to an accessible databank enables dissemination of experiences that may

correct delivery system errors and prevent similar injuries by other practitioners. A decreased error rate would in turn occasion lower liability insurance rates, helping curb the malpractice crisis. The MEDiC proposal recognized this, and the authors suggested cost savings could fund the national databank in budget-neutral fashion. Proportionate savings would be realized by statewide systems as well.

Another financial consequence of the current liability system is the practice of "defensive medicine," performance of superfluous tests in avoidance of threatened liability, by some estimates accounting for as much as 16% of physician-ordered services. [FN 41] In a transparent environment, physicians will not perceive potential liability from making diagnostic choices. Elimination of redundant testing may be another source of funds for a disclosure program.

ii. The Price of Litigation

The monetary impact of error is not limited to the medical domain alone. Malpractice litigation is traditionally a lengthy and expensive process for all parties and, according to the Harvard Medical Practice study; the majority of injured patients do not receive compensation. [FN42] The experience of three institutions who used disclosure principles to achieve more efficient compensation for patients actually injured by medical error are instructive.

Beginning in 1987, the Lexington, Kentucky Veterans Affairs Medical Center implemented a disclosure and settlement policy for appropriate cases of medical error. Early settlement resulted in substantially lower payments and litigation costs compared to cases before 1987 and to other Veterans Affairs facilities. [FN 43] Although significant litigation and compensation differences exist between the Veterans system under the Federal Tort Claims Act and civil tort liability actions, principles of voluntary disclosure and early settlement are equally applicable.

In 2001, the University of Michigan Health System ("UMHS") adopted a "principled approach" [FN 44] to malpractice claims. Under the UMHS plan, responding to a claim, the "reasonableness of care" is assessed through internal investigation. Findings are shared with patients and their attorneys. The UMHS then elects to defend the claim or to offer a settlement. [FN 45] Of equal importance, facts regarding discovered or reported errors are disseminated among the medical staff to circumvent future injuries. This approach has won favor with both faculty physicians and the plaintiff's bar and has reduced both average processing time for claims and litigation costs by more than half.

While the UMHS system realizes a strategic advantage from shared malpractice coverage for physicians and institutions [FN 46] not present in private practice, private sector institutions are beginning to focus on the advantages of disclosure as well. COPIC, the largest malpractice insurer in Colorado, developed a program called "3Rs" (recognize, respond, resolve) that provides compensation for patients' direct economic losses without attaching fault to the provider. [FN 47] The program operates to resolve claims without litigation. Clear cases of physician negligence or patient representation by an attorney are not eligible for the 3Rs program. Participation does not preclude later pursuit traditional litigation if resolution cannot be reached. In furtherance of the program, 3Rs offers disclosure training for physicians, and case management for patients. From January 2000 through October 2006, over 2,800 physicians participated and the program processed 3,200 events. Twenty-five per cent of patients received payments averaging $5,400. Seven paid and 16 unpaid cases proceeded to litigation, eight of which received tort compensation. [FN48] The 3Rs program is presently unique to Colorado, but insurance companies in Maryland and West Virginia are embarking on similar programs. [FN49] The experiences of COPIC, Lexington Veterans, and UMHS all demonstrate advantages of disclosure principles over traditional quality assurance processes not just financially, but in subjectively satisfying feelings for participants.

iii. The Possible Reimbursement Benefit of Voluntary Disclosure

In addition to cost savings through efficiency, a voluntary disclosure program may be a source of additional institutional revenue. Under the Medicare Modernization act, the Centers for Medicare and Medicaid Services (CMS) launched experimental pay for performance demonstration projects that may lead to changes in reimbursement allocations. [FN 50] Institutions high in safety achievement may receive remuneration bonuses for their performance. Since disclosure programs improve safety, hospitals will have a financial incentive to participate.

The Leapfrog Group, a coalition of large health care purchasers, "works with it members to encourage transparency and easy access to health care information as well as rewarding hospitals that have a proven record of high quality care". [FN51] Hospitals representing over one-half of all inpatient beds voluntarily submit data to Leapfrog. The data is analyzed by Leapfrog and published on the coalition's website where hospitals receive comparative ratings. Leapfrog currently uses pay-for-performance schemes based on NQF safe practice guidelines. Performance scores for disclosure will soon be available with other specific outcome measurements used for rating and reimbursing hospitals. [FN 52]

II. Application of Voluntary Disclosure Doctrine to a Community Hospital

The Lexington Veterans, UMHS, and COPIC programs all successfully implemented disclosure principles as part of a larger strategy for improving patient safety and treatment outcomes, achieving additional benefits of participant satisfaction and financial gain. Common to these programs is central administration and policy execution. Community hospitals are not similarly structured. Hospital administrators are responsible to a governing board, medical staff may be employed or in private practice, and support staff and ancillary services may work under myriad contracts or agreements. This heterogeneity makes complete implementation of voluntary disclosure difficult, but integrating disclosure principles into existing policies offers a variety of benefits.

Hospitals exist to serve and care for the community. Transparency and shared decision making amongst providers and patients and families is becoming the hallmark of quality in health care delivery. Hospitals claiming excellence must embrace disclosure of medical error as morally right and ethically correct. A supportive, conciliatory environment that endorses learning from mistakes and avoiding their repetition must replace the culture of silence, shame, and embarrassment.

Collaboration with the medical staff is necessary for promulgation of a disclosure policy. I recently surveyed the medical staff at my hospital. Of the responders, 97% agreed that physicians had an ethical responsibility to disclose errors to patients, 84% would support institution of a formal policy, and 83% would participate in voluntary disclosure. Unfortunately, 90% of responders were unaware that a formal policy, "Disclosure of Unanticipated Outcomes," [FN 53] was implemented more than two years previously. Resolving this incongruity between hospital administration and medical staff through educational programs will be of vital importance in the growth of voluntary disclosure. An implementation team with quality assurance, risk management, educational and ethical backgrounds should be created, trained in disclosure communication and charged with increasing awareness and use of hospital policy.

Once a cooperative environment of disclosure is created, establishing and implementing an objective, physician-approved reporting system of errors is vital to the success of any program. This is a reasonable extension of quality assurance and peer review procedures familiar to all hospital practitioners. The Society of Thoracic Surgeons ("STS") developed a uniform reporting system that community hospitals can look to for guidance and emulation. In 1989, the STS standardized a database for tracking outcomes of coronary artery bypass surgery ("CABG"). In 1996, using this database, the Michigan Society of Thoracic and Cardiovascular Surgeons

("MSTCVS") implemented a system of peer review and quality improvement now partially funded by a cooperative venture with Blue Cross and Blue Shield of Michigan. All 33 sites performing adult cardiac surgery in Michigan participate in this project. Compliance with strict definitions of complications and confidentiality of data assures completeness and accuracy. Quarterly meetings review and analyze collected data. Best practice models developed from programs achieving superior results are disseminated statewide. Underperforming programs receive assistance with process upgrades, including site visits from geographically non-competitive teams. The MSTCVS effort has produced a statewide CABG mortality below the national average, and noteworthy improvements in other important postoperative quality metrics, all enhancing patient safety. [FN 54] The success of this program derives from physician acceptance of a defined database, as well as institutional and private sector cooperation.

The potential success of an error disclosure system must have an analogous foundation. In cooperation with the medical staff, hospitals can use available guidelines, or create a tailored categorization of reportable events. Analysis of the data collected can facilitate delivery system improvements to prevent repetition of error. The quality assurance process can use the data to educate physicians in error avoidance. Sharing data between hospitals will amplify this benefit.

A voluntary disclosure program can also generate legal benefits. The traditional, protective roles for risk managers in community hospitals, preventing or minimizing financial loss due to accident, injury or medical malpractice, must be expanded to include principles of voluntary disclosure. Community hospitals and their practitioners do not usually share representation, and strategic disagreements in responding to claims may hinder negotiation. When collaboration regarding claims is possible, disclosure principles such as sharing findings regarding the cause of injury, apology, and offer of compensation, remain applicable. Community hospitals should consider the recommendation of MEDiC and appoint a Patient Safety Officer (PSO) to support the risk manager in this added responsibility. The PSO would work with the hospital's quality assurance structure and the medical staff to institute and monitor an error reporting system, and assist the risk manager in resolving identified cases and claims. Additional duties might include evaluating system deficiencies responsible for the error, analyzing and classifying reports for educational and preventative value, and coordinating system improvements. Facilitating patient and family disclosures, organizing disclosure training for physicians and hospital personnel, and updating the governing body on these activities are all appropriate functions for a PSO.

The lack of government leadership is a significant impairment to implementing disclosure. Community hospitals, medical staff, employees, and their patients should all become more politically active, and urge legislators to develop a statewide reporting system recommended by the IOM Report, the MI Report, the MEDiC Bill, JACHO, and the NQF. Benefits of a standardized, accessible statewide databank in improving patient safety is clear, as demonstrated by the MSTCVS quality improvement project. Legislators should also be urged to enact laws preventing plaintiffs from using disclosures or apologies in litigation. This would encourage practitioners to have open, honest, and healing conversations with patients.

In a competitive health care market, fiscal efficiency is essential to survival and growth. Diminishing reimbursement and rising costs are significant financial challenges. Voluntary disclosure policies can help in this area as well. Reducing errors, attendant treatment costs, and length of stay is central to any hospital operations budget. Reducing exposure and liability compensation is essential to durable strategic planning budgets. A disclosure program complete with case review and system improvement will advance both of these financial concerns.

Of paramount importance for a community hospital is attracting and preserving a highly qualified medical staff. Creating a professionally and personally satisfying environment for physicians is important. Lowering insurance costs and liability exposure also promote loyalty to the institution. Disclosure programs have been shown to accomplish both these goals. Collaborating with physicians and insurers in the development of plans similar to COPIC, even

considering underwriting insurance policies or supplementing existing policies may be another basis of retention. No innovative stone should be left unturned in the search for the financial viability necessary for a community hospital to continue its vital services.

CONCLUSION

Americans are dying at alarming rates from unacceptable causes in health care institutions. The culture of concealing error, denying the opportunity of understanding and avoiding repetition, must submit to the age of transparency. Medical educators must include ethics education in their curriculum and certifying boards must test to assure appropriate knowledge, as is the practice in law schools and bar examinations. Professional societies must provide educational and training opportunities for practitioners to learn the necessary communication skills for appropriate disclosure and apology. Health care institutions must create an atmosphere of expectation yet security for practitioners to disclose and discuss errors in an educational, non-punitive manner. Liability insurers must recognize the value of voluntary disclosure, perhaps discounting premiums to institutions and practitioners where programs are in effect. Third party payers should incentivize institutions meeting objective improvement standards of patient safety with performance premiums. Plaintiff representatives must negotiate in good faith with institutions and individuals practicing voluntary disclosure in the alternative dispute resolution setting. Legislative bodies must protect disclosures and apologies from evidentiary admission in formal litigation. Finally, establishment of a comprehensive, objective, educational, and accessible reporting and monitoring system for practitioners and institutions will support avoidance of replication of mistakes.

For doctors, in the ever-increasingly complex and technologically advancing practice of medicine, to err is human. Voluntary disclosure and apology is ethically and morally correct.

For the harmed, to accept apology is noble and just compensation is appropriate.

For society, to create an environment where both are possible is essential to economic efficiency in an era of limited resources, and ultimately, in advancing patient safety and the saving of lives.

EPILOGUE

The attending surgeon I most admired in my residency once operated on a young man with lung cancer. During the procedure, he treated some minor bleeding near the vertebral column with packing. The patient awoke paraplegic from a hematoma compressing the spinal cord. Swift reoperation and evacuation of the hematoma failed to reverse the patient’s neurologic injury, or the surgeon’s desolation. Long before the revelation of voluntary disclosure, apology, and just compensation, my mentor courageously sat with his patient and family, described the operation, and treatment of the bleeding. He recommended the patient file suit to achieve some hollow monetary recompense for the disability he now faced.

Some years later, the surgeon I most admired fought with equal courage the cancer he taught others to cure. He lost his battle. Our community lost an unparalleled leader. His is the legacy I try to follow in my professional career and personal life…without apology.

FOOTNOTES

[FN a1] University of Detroit Mercy School of Law. MD, Wayne State University School of Medicine. Fellow American College of Surgeons, Medical Director Government Relations, Henry Ford Macomb Hospital.

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[FN 4] Id at 4.

[FN 5] Leape LL, Berwick DM, *Five Years After To Err Is Human: What Have We Learned*, JAMA 2005;293(19):2384, 2384.

[FN 6] Taft L, *Apology and Medical Mistake: Opportunity or Foil?*, 14 Annals Health L. 55, 62 citing Minn. Hosp. Assn. *Communicating Outcomes to Patients 2* (2002).

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[FN 8] Am. Coll. Of Surgeons, *Statement on Principals, Code of Professional Conduct*, (available at http://www.facs.org/fellows_info/statements/stonprin.html#anchor116209 (2004) last visited 7/26/08).

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[FN 16] "Authentic" apology implies a precise three-step formula. Taft L, *Apology and Medical Mistake: Opportunity or Foil?*, 14 Annals Health L. 55, 64 (Winter 2005).

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[FN 23] Id. at 1063,1064.

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[FN 25] Tabler supra note 13 at 23.

[FN 26] Gallagher et al supra note 11 at 1821.

[FN 27] Id. at 1820.

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[FN 35] See Annas GJ, *The Patient's Right to Safety—Improving the Quality of Care through Litigation against Hospitals*, N. Engl. J. Med. 2006;354(19):2063.

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[FN 45] See Id.

[FN 46] R. Boothman, personal communication.

[FN 47] Gallagher et al supra note 11 at 1821.

[FN 48] Gallagher et al supra note 9 at 2717.

[FN 49] Id.

[FN 50] Leape supra note 5 at 2389.

[FN 51] See http:// www.leapfroggroup.org .

[FN 52] Gallagher et al supra note 9 at 2715.

[FN 53] Henry Ford Macomb Hospital, *Disclosure of Unanticipated Outcomes* (available at http://henry.hfhs.org/body.cfm?xyzpdqabc=0&id=41&action=listpolicycache&ck=1d980fd1%2D1adb%2D4e3e%2Da2a9%2Db8ad2b779f8a%5FOF%5F0&nPPP=50, last visited 7/26/08).

[FN 54] Proprietary data, MSTCVS, used with permission, submitted for publication.