Does Sorry Work? The Power of Full Disclosure in the Healthcare Setting

Introduction

To read literature about medical malpractice is to be inundated with tales of basic surgeries and procedures gone horribly wrong. A cancer surgeon who removed a segment of the wrong rib during surgery, a woman who was given twice the recommended dosage of her cancer treatment causing her white blood cell count to soar, a young boy who bled to death of an ulcer following an elective surgery after physicians failed to order a routine blood test that could have detected the problem. What these three stories have in common is that following each of these events the doctors responsible admitted the mistakes to the patients or their families, apologized and were forgiven by the patients, none of whom brought lawsuits. These cases reflect a movement in the healthcare industry away from a “deny and defend” culture and towards policies of full disclosure and apology following a medical mistake. In addition to reducing the frequency and cost of medical malpractice litigation, these policies may prove to be more satisfying to both patients and physicians than the traditional litigation model because they provide an opportunity for open and honest communication.

This paper explores the emergence and effectiveness of full disclosure and apology policies in the medical setting. Section one discusses the historic role of full disclosure and apology following medical mistakes. Section two summarizes the role of “I’m sorry” legislation

2 Judith Graham, Doctors Try New Word: Sorry; Admitting Mistakes Not Just the Right Thing to do, Medical Community Finds it May Prevent Malpractice Suits, CHICAGO TRIBUNE, Aug. 18, 2007.
3 Id. One of the patients reported that she wasn’t angry, explaining that “he admitted it, and you know that isn’t easy. . . . I’m glad he did it.” Another reported “We felt better. He was an honest man.” Id.
in the full disclosure movement. Section three explores the comprehensive full disclosure and apology program developed by the Sorry Works! Coalition.

I. The Role of Apology in Medicine

The American Medical Association (AMA) Code of Medical Ethics, which lays out guidelines of professional conduct for the medical community, states that “when a patient suffers significant medical complications that may have resulted from the physician’s mistake or judgment, the physician is ethically required to disclose to the patient all the facts necessary to ensure understanding of what has occurred”. The guidelines go on to state that “a physician’s concern about legal liability that might result from full disclosure should not affect his or her decision to deal candidly with a patient.” The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) also requires that “unanticipated outcomes” be disclosed. These requirements have been interpreted by the medical community in a very general way, which leaves the physician wide discretion regarding when disclosure is required. Neither the AMA nor the JCAHO expressly imposes a duty to apologize following a medical mistake. However, despite this, the absence of an apology when disclosing a medical error can be conspicuous and awkward, making it difficult for physicians to fulfill their disclosure obligations without apologizing as well.

4 Flauren Fagadau Bender, “I’m Sorry” Laws and Medical Liability, 9 Virtual Mentor, 300, 300 (2007).
5 Id.
8 Id.
Despite these standards, lawyers and risk managers routinely advise health care providers not to accept responsibility or apologize for medical errors. Instead, these providers are advised to adopt a “deny and defend” approach to adverse medical events. Under this approach, doctors release only controlled and coached information to patients and families following an event. The two primary factors cited for physicians’ failure to fully explain and apologize for an adverse medical event are fear of litigation and the culture of medicine which bestows an aura of infallibility on physicians. This culture within the medical field makes it difficult for open discussions about mistakes to occur.

This deny and defend system takes a toll on both physicians and patients. Even if a physician wants to apologize following a mistake, and feels that it is the right thing to do, they are often advised not to do so by the insurance carrier or told by the hospital administer to keep quiet. Doctors report experiencing “anxiety, sadness, guilt, remorse, fear, and self-doubt” as a result of withholding information from patients and their families.

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10 Bender, *supra* note 4; see also Mayes, *supra* note 6.
12 *Apologizing for Adverse Outcomes, supra* note 9. See also Bender, *supra* note 4 (Citing two national surveys which revealed the fear of litigation is the primary reason for both physicians’ and hospitals’ reluctance to disclose errors and unanticipated outcomes”)
13 *Apologizing for Adverse Outcomes, supra* note 9. See also Graham, *supra* note 2 (“These are folks who were number one in kindergarten. They’re not used to admitting they did something wrong.”)
14 *Id.*
16 *Sorry Works! Interview, supra* note 11.
hospital defense attorney argues that this “non-communicative, dehumanizing, adversarial process [is] at complete odds with the mission of healing.”

Additionally, patients and families are sometimes left feeling frustrated and angry when they are unable to get an explanation from their healthcare provider about the source of their injuries. Feeling shut out by the hospital, these patients often turn to litigation. Studies have shown that the breakdown in the provider-patient relationship was at the root of nearly 75% of malpractice claims of filed against physicians. Further, 91% of those pursuing medical negligence claims reported that their desire for an explanation was the reason for the legal action. These patients want “information, an explanation of what happened, provider accountability and to be sure someone else doesn’t have to go through what they did.” According to malpractice lawyers what encourages patients to sue is “less an error than its concealment, and the victim’s concern that it will happen again.”

In contrast to the “deny and defend” method, full disclosure, apologies, and open communication between doctors and patients pre-empt the fundamental reasons patients sue, allow for human expression of compassion and concern and create a foundation for physicians and hospitals to work with patients to address their needs. Litigation only offers money, but these other issues are often more important to patients than dollars. Additionally, these policies have been shown to decrease litigation costs and the frequency of lawsuits.

17 Id.
18 Id.
19 Apologizing for Adverse Outcomes, supra note 9.
20 Id.
21 Sorry Works! Interview, supra note 11
22 Sack, supra note 1.
23 Sorry Works! Interview, supra note 11
II. Apology Legislation

Recognizing the benefits of physician apology following an adverse event, thirty-six states have enacted legislation that limits liability for health care providers who express sympathy to a patient following an unanticipated event. These laws seek to encourage open communication between patients and health care providers by removing the risk that sympathetic statements will be used against the physician in subsequent litigation. While the laws vary, at the very least they all prevent a hospital or physician’s expression of sympathy following an adverse event from being used against them in court.

State apology laws fall into two basic categories: 1) those that protect apologies but do not protect any accompanying statements of fault; and 2) those that protect apologies and acknowledgements of fault that accompany them. The majority of state apology laws that have been enacted to date fall into the first category. Seventeen state laws are largely similar and apply to any “statements, gestures, or expressions or apology, benevolence, sympathy, or commiseration made by a health care provider to an alleged victim of an unanticipated outcome of the victim’s relative or representative.” Most of these laws require that the statement be

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26 “The hope is that if you can’t use an apology in court to prove that a doctor has been negligent, then there will be more apologies.” Susan Brink, “It’s Never Just One Thing That Leads to Serious Harm”, LOS ANGELES TIMES, Jan. 28, 2008 (arguing that apology is making a “legally protected comeback”).
27 “I’m Sorry laws: Summary of State Laws”, supra note 25. Arizona, Colorado, Connecticut, Georgia, Idaho, Indiana, Iowa, Maine, Montana, Nebraska, North Dakota, Ohio, Oklahoma,
related to the discomfort, pain or death of the alleged victim. 28 Several other states have enacted more narrow laws that cover any “any statements, writings, or benevolent gestures expressing sympathy or general sense of benevolence relating to pain, suffering, or death of a person and made to that person or the person’s family” but do not clearly cover apologies made by the health care providers. 29 Vermont’s law is limited to oral expressions of regret or apology. 30 Illinois’ law is limited to expressions of grief or apology that occur within 72 hours of when the provider knew or should have known the cause of the negative outcome. 31

In contrast to these laws, those in the second category protect statements of fault in addition to expressions of sympathy or apology. 32 For example, the law enacted in Colorado provides that “In any civil action brought by an alleged victim of an unanticipated outcome of medical care . . . any and all statements, affirmations, gestures, or conduct expressing apology, fault, sympathy, commiserations, condolence, compassion, or a general sense of benevolence which are made by a health care provider or an employee of a health care provider to the alleged victim, a relative of the alleged victim and which is related to the discomfort, pain, suffering, injury or death of the alleged victim as the result of the unanticipated outcome of medical care shall be inadmissible as evidence of an admission of liability or an admission against interest.” 33

This stronger protection for health professionals allows for a greater open communication between patients and health care professionals following an adverse event. However, these laws

South Carolina, Utah, Washington, and Wyoming have all enacted laws with these provisions.

Id.
28 Id.
29 Id.
30 Id.
31 Id.
33 Bender, supra note 4.
have been criticized for providing overly broad protection to physician statements.\(^{34}\) One critic claims that the law should be titled the “‘I’m sorry I killed your mother bill,’” arguing that “if a doctor comes out and says something like that, he shouldn’t be able to immunize himself against statements like that by couching it in an apology.”\(^{35}\) Additionally, even in states that have laws protecting doctors against statements of fault, doctors are often encouraged to against issuing apologies that admit guilt.\(^{36}\)

In addition to state Apology Laws, at least seven states have enacted legislation that requires disclosure of medical errors.\(^{37}\) For example, Florida’s law states that “An appropriately trained person designated by each licensed facility shall inform each patient, . . . in person about adverse incidents that result in serious harm to the patient. Notification of outcomes of care that result in harm to the patient under this section shall not constitute an acknowledgement or admission of liability, nor can it be introduced as evidence.”\(^{38}\) While these laws do not explicitly require a doctor to apologize following an adverse event, in practice it is difficult for a physician to disclose an error without expressing regret.\(^{39}\) “A patient who hears a physician (or hospital representative) disclose an error without apologizing may, in his mind, hear the physician saying something like, ‘I made an error that harmed you, but I’m not sorry’” These laws have been


\(^{35}\) Id.

\(^{36}\) Id. For example ProMutual Group, which insures 18,000 doctors, dentists, and health care facilities in the Northeast, advises its clients against apologies that admit guilt. “We encourage physicians to apologize about outcomes, not necessarily for any error that may have occurred. Apology is not about confession.” Id.

\(^{37}\) See Tabler, supra note 7; see also Sack, supra note 1.


\(^{39}\) See Tabler, supra note 7.
criticized due to the difficulty of regulating information that must be disclosed across a wide variety of medical malpractice situations.  

In 2005, Senators Hillary Clinton and Barack Obama introduced the National Medical Error Disclosure and Compensation (MEDiC) Act of 2005. In an article in The New England Journal of Medicine the Senators wrote “Our proposed MEDiC program provides grant money and technical assistance to doctors, hospitals, insurers, and health care systems to implement programs for disclosure and compensations. The MEDiC model promotes the confidential disclosure to patients of medical errors in an effort to improve patient safety-systems. At the time of disclosure, compensation for the patient or family would be negotiated, and procedures would be implemented to prevent a recurrence of the problem.” The proposed law further provided that “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 end without mutually agreed compensation.” The legislation would have required automatic disclosure of a medical error to the patient and provided protection for any apology made by a health care practitioner for such an error. While the legislation was not enacted, its proposal reflects a growing national trend towards disclosure and apology legislation.

41 See Tabler, supra note 7.
42 Hilary Rodham Clinton and Barack Obama, Making Patient Safety the Centerpiece of Medical Liability Reform, 354 NEW ENG. JOURNAL OF MED. 2205, 2205 (2006) (citing studies which show that malpractice suits often result from when an unexpected adverse outcome is met with a lack of empathy from physicians and a perceived or actual withholding of essential information.)
43 Id at 2206.
44 See Tabler, supra note 7.
III. The Sorry Works! Coalition

The protection offered by “I’m Sorry” legislation represents an important step in the transition from a “deny and defend” mentality to a system of full disclosure. By removing the fear that their words of sympathy will be used against them in court, the laws allow doctors to apologize and sympathize freely following an adverse event. However, for many patients, the ability to obtain information from their health care provider about how the event occurred and how similar events will be prevented is just as, if not more, important than receiving an apology for the event. Apology laws are not sufficient to ensure that these needs are met. In order for doctors and patients to communicate effectively following an adverse event it is necessary for hospitals and health care systems to adopt comprehensive full disclosure programs which establish a system through which doctors can give patients the information they need. The Sorry Works! Coalition has established a model of this type of program which has been implemented in numerous hospitals nationwide.

The Sorry Works! Coalition was formed in 2005 to advocate full disclosure and apology following medical errors as a solution to the medical malpractice crisis. The group was founded by Doug Wojcieszak after his brother died as the result of a “gross medical error.” Wojcieszak describes the experience as “just horrible,” explaining that “while my brother was dying on the operating table, his doctor came out, took one look at my mother in the hall and ran, literally ran, the other way.” The Sorry Works! Coalition believes that “apologies for medical errors, along with up-front compensation, reduce anger of patients and families, which leads to a

45 Mayes, supra note 6.
46 Id.
47 Id.
reduction of lawsuits and associated defense litigation expenses”48 Sorry Works! is comprised of doctors, lawyers, insurers, patients, and citizens who work with legislatures, policy experts, the media and lawyers who promote full disclosure and apologies for medical errors.49 While not opposed to “I’m Sorry” legislation, the group advocates for a “much broader approach.”50 The Sorry Work! Coalition seeks to promote full disclose by: 1) educating all stakeholders in the medical liability debate about the effectiveness of full disclosure; 2) serving as an organizing forces for the full disclosure movement; and 3) advocating for legislative incentives, including pilot programs.51

The Sorry Works! Protocol is based on a disclosure program developed at the Veteran’s Administration hospital in Lexington, Kentucky and a similar program implemented in the University of Michigan Health System.52 In 1987, the Lexington KY Veterans Medical Center was involved in a wrongful death case involving a medical error in which the family was not aware that there had been a problem.53 The center decided to “do the right thing” by disclosing the error and offering compensation.54 The case was settled within weeks at a “reasonable cost”.55 Since this first case, the Medical Center has practiced a policy of full disclosure including proactively informing patients who do not suspect that anything has gone wrong. Under the policy, practitioners identify and review potentially compensable incidents to

49 Id.
50 Mayes, supra note 6.
51 Wojciesak, supra note 48 at 347.
52 Id. See also Disclosure Programs and Policies, Sorry Works! Coalition, available at http://www.sorryworks.net/disclosurepolicy.phtml. for a compilation of these and other policies.
53 Steve Kraman, Vice Chairman, Department of Internal Medicine, Victim Compensation Without Litigation: The Lexington Experiment.
54 Graham supra note 2. One of the doctors involved in the decision recalled, “Our team asked, ‘Would we want to know if this was our mother? And the answer was obvious.” Id.
55 Id.
determine if there was a standard of care violation or other medical error.\footnote{Steve Kraman, \textit{supra} note 53.} If it is determined that an error was made, the hospital discloses the error directly and sympathetically, and discusses compensation options with the patient or their family.\footnote{\textit{Id.}} Over the seven year period following the implementation of the program the Center fell to the lowest quartile for settlement and litigation costs among competitive hospitals.\footnote{Wojciesak, \textit{supra} note 48 at 346.} During this time, the center’s average payout was $16,000 per settlement, compared to the national VA hospital average of $98,000 per settlement.\footnote{\textit{Id.}} Over the first thirteen years of the program, the hospital negotiated more than 170 settlements with patients and only went to trial three times.\footnote{Steve Kraman, \textit{supra} note 53. Of these three trials the center won one case, lost one case on the merits, and lost one case in which they had acknowledged responsibility but could not reach a settlement with the plaintiff. \textit{Id.}}

Similarly, the chief risk officer of the University of Michigan Heath System, Richard Boothman, reported that its full-disclosure program, which is modeled closely after the Lexington VA program, has “halved the number of pending lawsuits and reduced the litigation costs per case from $65,000 to $35,000 resulting in annual savings of approximately $2 million in defense litigation bills.”\footnote{Wojciesak, \textit{supra} note 48. Boothman summarizes the UM disclosure program in three points: 1) “we will seek to compensate quickly and fairly when our unreasonable medical care causes patient injuries, 2) We will defend our staff and institution vigorously when our care was reasonable or when we did not cause a patient injury, and 3) We will seek to learn from our mistakes and our patients’ experiences.” \textit{Id.}} The average time it took to settle claims and lawsuits decreased from 20.7 months to 9.5 months.\footnote{Medical Malpractice: Issues Update, \textsc{Insurers Information Institute}, Jan. 2009, http://www.iii.org/media/hottopics/insurance/medicalmal/..} Boothman further reported that doctors, patients and lawyers are happier with the full disclosure system.\footnote{\textit{Id.}} Additionally, the openness and honesty inherent to

\footnotesize{\textsuperscript{56} Steve Kraman, \textit{supra} note 53.  
\textsuperscript{57} \textit{Id.}  
\textsuperscript{58} Wojciesak, \textit{supra} note 48 at 346.  
\textsuperscript{59} \textit{Id.}  
\textsuperscript{60} Steve Kraman, \textit{supra} note 53. Of these three trials the center won one case, lost one case on the merits, and lost one case in which they had acknowledged responsibility but could not reach a settlement with the plaintiff. \textit{Id.}  
\textsuperscript{61} Wojciesak, \textit{supra} note 48. Boothman summarizes the UM disclosure program in three points: 1) “we will seek to compensate quickly and fairly when our unreasonable medical care causes patient injuries, 2) We will defend our staff and institution vigorously when our care was reasonable or when we did not cause a patient injury, and 3) We will seek to learn from our mistakes and our patients’ experiences.” \textit{Id.}  
\textsuperscript{62} Medical Malpractice: Issues Update, \textsc{Insurers Information Institute}, Jan. 2009, http://www.iii.org/media/hottopics/insurance/medicalmal/..  
\textsuperscript{63} \textit{Id.}}
the program has provided the Michigan Health System with information necessary to improve systems and reduce medical errors. 64

The Sorry Works! Coalition advocates for a three-step disclosure program which includes: 1) initial disclosure; 2) investigation; and 3) resolution. 65 In step one “providers say ‘sorry’ but no fault is admitted or assigned. Providers take care of the immediate needs of the patient/family . . . and promise a swift and thorough investigation. The goal is to make sure the patient/family never feels abandoned.” 66 The Coalition recommends apologies such as “We are sorry this happened. We feel bad as we are sure you do too. . . . We are going to do a thorough investigation . . . as we learn things, so will you.” 67 Step two, investigation, “is about learning the truth. Was the standard of care breached, or not? [the coalition] recommend[s] involving outside experts and moving swiftly so the patient/family doesn’t suspect a cover-up. Stay in close contact with the patient/family throughout the process.” 68

Step three, resolution, “is about sharing the results of the investigation with the patient family, and their legal counsel.” 69 If there was no mistake, the provider should meet with the patient/family and their attorney and “explain what happened, apologize, and offer empathy but [] not admit fault or provide up front compensation” 70 Providers are not expected to settle or offer compensation for a non-meritorious claims. 71 If the investigation reveals that there was a

64 Id.
66 Id.
68 Id.
69 Id.
70 Wojciesak, supra note 48 at 344
71 Id at 345. (Explaining that providers are never “sold out” to settle a claim quickly and cheaply).
mistake the provider should set a meeting with the patient/family and their attorney to “apologize, admit fault, explain what happened and how it will be prevented in the future, and discuss fair, upfront compensation for the injury or death.”\footnote{Doug Wojciesak, Sorry Works! Coalition, presentation, \textit{available at} http://www.sorryworks.net. The presentation further explains that the four elements of a “real apology” are “1) sorry – “I am sorry”, 2) Admission of fault – ‘I made a mistake’ … 3) explanation of what happened and how it will be fixed and 4) compensation/fix.” \textit{Id.}} \footnote{Doug Wojciesak, Sorry Works! Coalition, presentation, \textit{available at} http://www.sorryworks.net. The presentation further explains that the four elements of a “real apology” are “1) sorry – “I am sorry”, 2) Admission of fault – ‘I made a mistake’ … 3) explanation of what happened and how it will be fixed and 4) compensation/fix.” \textit{Id.}} Sorry Works! provides tips to medical professionals on apologizing and advises them: 1) “The “s” word: Sorry! Say it!; 2) Admit fault – if you did make a mistake; 3) Explain – slowly – what happened; 4) Ask patients or their families to repeat back to you what you said; 5) Allow patients to vent – remember, it’s not about you! Don’t take it personal; 6) Answer all questions truthfully and honestly; and 7) When anger, shock, and rage have begun to subside with patient and family, respectfully begin to discuss compensation” \footnote{Doug Wojciesak, Sorry Works! Coalition, presentation, \textit{available at} http://www.sorryworks.net. The presentation further explains that the four elements of a “real apology” are “1) sorry – “I am sorry”, 2) Admission of fault – ‘I made a mistake’ … 3) explanation of what happened and how it will be fixed and 4) compensation/fix.” \textit{Id.}}

Since the creation of the Coalition, full disclosure programs have been successfully implemented in hospitals and health care systems throughout the country. For example, The University of Illinois Medical Center moved from a 'deny and defend' policy to a system where their goal is to “investigate, apologize, settle or mediate, and learn from mistakes in 60 days or less.”\footnote{New Disclosure Program at University of Illinois Medical Center in Chicago, \textit{SORRY WORKS! COALITION}, http://www.sorryworks.net/uofi.phtml.} The Center has a system in place to move quickly following an adverse event so they can collect information, determine what happened, and work with the patient/family.\footnote{Doug Wojciesak, Sorry Works! Coalition, presentation, \textit{available at} http://www.sorryworks.net. The presentation further explains that the four elements of a “real apology” are “1) sorry – “I am sorry”, 2) Admission of fault – ‘I made a mistake’ … 3) explanation of what happened and how it will be fixed and 4) compensation/fix.” \textit{Id.}} In the first year of the program the Center disclosed 40 adverse events but only one claim was filed.\footnote{Doug Wojciesak, Sorry Works! Coalition, presentation, \textit{available at} http://www.sorryworks.net. The presentation further explains that the four elements of a “real apology” are “1) sorry – “I am sorry”, 2) Admission of fault – ‘I made a mistake’ … 3) explanation of what happened and how it will be fixed and 4) compensation/fix.” \textit{Id.}} Catholic Healthcare West in San Francisco, California has also implemented a successful full-
disclosure program.\textsuperscript{77} One of the unique elements of the Catholic Healthcare West program is that they were able to convince insurance companies covering doctors who are independent contractors to participate in the full-disclosure program, thereby expanding the program’s coverage.\textsuperscript{78} The program in place at Catholic Healthcare West, a non-profit hospital system, helps to address the concerns of critics who claim that the Sorry Works! protocol is only practical in government hospitals.\textsuperscript{79}

Additionally, all hospitals in the VA system, Stanford University, Harvard Teaching Hospitals, the Kaiser Permanente hospitals, the Children’s Hospitals and Clinics of Minneapolis\textsuperscript{80}, and Catholic Health Initiatives have implemented successful full-disclosure programs based on the Sorry Works! protocol.\textsuperscript{81} In 2005, Illinois became the first state to enact a Sorry Works! pilot program. The program allowed two hospitals to implement Sorry Works! risk-free for a two-year period.\textsuperscript{82} Under the program, the state pledged to cover the difference if liability costs rose as a result of the program’s implementation.\textsuperscript{83} Similar pilot programs have been considered by other states. While the Coalition supports the pilot program, its founder noted that hospitals and doctors don’t need the program to try Sorry Works! but that it “simply provides an extra incentive for hospitals to try this approach.”\textsuperscript{84}

\textsuperscript{77} \textit{Catholic HealthCare West, SORRY WORKS! COALITION}, http://sorryworks.net/catholic.phtml.
\textsuperscript{78} \textit{Id.}
\textsuperscript{79} \textit{Id.}
\textsuperscript{80} \textit{Id.} This program reduced the number of lawsuits in the system by half, a result which is especially notable in a setting with high liability exposure because of its young patients. \textit{Id.}
\textsuperscript{81} Doug Wojciesak, Sorry Works! Coalition, presentation, available at http://www.sorryworks.net
\textsuperscript{83} \textit{Id.}
\textsuperscript{84} \textit{Id.}
Critics of full disclosure programs most often express concern that 1) full disclosure will lead to more lawsuits against doctors and hospitals, 2) apologizing will not work and doctors will have admitted guilt, and 3) the program cannot work in litigious regions. Despite these concerns, the full disclosure has been shown to reduce the occurrence and cost of litigation. Further, proponents of the programs believe that full disclosure and apology will reduce litigation and help doctors to appear as “sympathetic defendants” when claims are pursued. Literature produced by the Sorry Works! Coalition argues that if a doctor apologizes and offers compensation, but the offer is rejected and a suit is initiated, “the doctor will go to court, looking like the person who tried to do the right thing by apologizing . . . but was rebuffed. . . . The jury will become angry, but not at the doctor.”

An additional criticism lodged against Sorry Works! and other full disclosure programs is that the programs, which were developed in a Veterans Administration hospital, can only work in a government or VA hospital setting. In these hospitals the doctors are on the hospital payroll and covered by government insurance. This streamlined system makes it easier to implement a full disclosure system because at these hospitals it is only necessary to get approval from one group of administrators and lawyers versus multiple insurance companies. However, the successful implementation of full disclosure programs in non-profit and private hospitals has shown that full disclosure is possible in non-government systems despite the increased difficulty. Additionally, as more doctors become hospital employees as opposed to

86 Id. (noting that in states that have enacted “I’m sorry” legislation, disclosures made by doctors are not admissible in court).
87 Id.
88 Id.
89 Id.
independent hospital contractors, the implementation of full disclosure programs may become even easier.  

Full disclosure policies create additional concerns when it comes to malpractice reporting. Some critics have claimed that the programs will increase settlements, leading to an increase in reports to the disciplinary board. However, according to the National Practitioner Data Bank, “A payment made as a result of a suit or claim solely against an entity (for example a hospital . . . ) that does not identify an individual is not reportable.” Further, “Medical malpractice payments are limited to exchanges of money and must be the result of a written complaint or claim demanding monetary payment for damages.” Therefore, if a written complaint or claim can be avoided through full disclosure and negotiation, then reporting can be avoided. However, concerns have been raised that this ability of doctors to avoid being reported will lead to full disclosure becoming an “easy out” for bad doctors who will attempt to use the programs to avoid reporting. Patient safety experts are currently in disagreement on the best way to ensure reporting of the worst offenders under a full disclosure system.

**Conclusion**

Following an adverse medical event, a comprehensive full disclosure policy meets many of the needs of doctors, patients, and health care administrators. Patients or families are given the opportunity to obtain information regarding the injury sustained by themselves or their loved

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90 *Id.* (citing the example of the Kaiser Permanente hospitals, which employ and cover their doctors)
91 Wojciesak, *supra* note 48 at 348.
92 *Id.*
93 *Id.*
94 *Id.*
95 *Id.*
96 *Id.*
ones. Doctors are free to explain and apologize for a medical mistake. Health care administrators are benefited by the reduced frequency of litigation and the diminished litigation costs often associated with full disclosure programs. By removing the fear that their sympathetic words or gestures will later be used against them in a lawsuit, state “apology laws” represent an important step in the movement from a “deny and defend” mentality towards a system of full disclosure. However, in addition to these laws, hospitals and health care systems will need to adopt comprehensive full disclosure programs in order to meet the needs of patients and doctors following an adverse event. These programs should provide a system through which a health care professional provide information, apologize, and compensate a patient if it is determined that an adverse medical event is the result of an avoidable mistake. The program should be about “doing the right thing” for the patients. However, this also ultimately means “doing the right thing” for everyone involved - patients, doctors, and hospital administrators.