

# Enough with the White Lie-ability: Decreasing Frivolous Health Care Liability Actions in Tennessee with Time and Transparency

MARY KATHERINE SMITH\*

I. INTRODUCTION .....	503
II. WHY MEDICAL MALPRACTICE LITIGATION IS THE TREND .....	509
A. <i>Justifications for Following Medical         Malpractice Trend</i> .....	512
B. <i>Why Medical Malpractice is Not the Answer</i> .....	514
C. <i>Why Patients Continue to Turn to Medical         Malpractice Litigation</i> .....	516
III. HOW DISCLOSURE PROGRAMS AID IN REDUCING FRIVOLOUS MEDICAL MALPRACTICE LITIGATION .....	518
IV. SUCCESSFUL DISCLOSURE PROGRAMS IMPLEMENTED IN OTHER STATES .....	522
A. <i>Veterans Affairs Medical Center in Lexington,         Kentucky</i> .....	522
B. <i>University of Michigan Health System Approach</i> .....	525
V. PROPOSED AMENDMENT TO TENNESSEE’S SYMPATHY LAW TO PROTECT APOLOGETIC EXPRESSIONS AND FAULT ADMITTING STATEMENTS MADE BY HEALTH CARE PROVIDERS.....	527
VI. PROPOSED AMENDMENT TO EXPAND TENNESSEE’S PRE-SUIT NOTICE PERIOD FOR A HEALTH CARE LIABILITY ACTION .....	538
VII. CONCLUSION .....	542

## I. INTRODUCTION

John Smith, a sixty-year-old male, was admitted to a local hospital in Memphis, Tennessee, for treatment of a recurring bacterial infection, which if not managed, would have ultimately resulted in pneumonia. Smith’s daughter, Nancy, accompanied him to the hospital where they provided the treating nurse with all of

Smith's past and present medical conditions, medical allergies, and insurance information. Smith disclosed that he was highly allergic to all types of sulfonamide ("sulfa") drugs. The nurse gave Smith a red band to wear around his wrist to put other treating physicians and nurses on notice that he had a well-documented, life-threatening sulfa drug allergy. Despite the prevalent warning, the treating physician mistakenly ordered that Smith be administered a sulfa drug for his symptoms. The medical staff did not tell Smith which drug they were ordering him, so he persistently questioned the physician about this particular drug's risks and side effects. Still, the physician failed to disclose this information.

Later that evening, Smith's daughter learned that the treating physician ordered the nurse to monitor Smith for an anaphylactic drug reaction following his first dose of the sulfa drug. Neither Smith nor Nancy was informed of this monitoring plan. Smith did not exhibit any symptoms of an allergic reaction after the first several doses of the drug. However, several hours following his fourth dose, a drug reaction began to cause Smith to experience hypotension, which eventually led to several complications. When Smith and Nancy asked about these complications, the treating physician avoided the questions and denied the possibility that Smith's experiences were a result of the medication the physician administered to him. While still in the hospital, the complications worsened, and Smith soon passed away.

Following her father's passing, Nancy discovered that despite the disclosure of Smith's specific drug allergy, he had been administered a sulfa drug during his stay at the hospital. After this realization, and because Nancy was not provided with any true explanation of her father's death, she confronted the treating physician and asked if her father had been administered a sulfa drug, and if so, was a drug reaction the definitive cause of her father's death. The only responses she received from the physician and hospital representatives were evasive explanations and a denial of any wrongdoing. The treating physician told Nancy that her father's underlying medical condition was the reason for his passing. Further, the physician downplayed the risks of the drug that he administered to Smith. He also refused to admit any fault throughout the entire process. Nancy was unsatisfied with how the physician and hospital representatives handled the medical error that ultimately caused her father's passing. Frustrated and angry about the dishonesty and lack of accountability she witnessed, Nancy

filed a health care liability action against both the individual physician and the hospital for their error in administering Smith a drug in which the doctor knew or had reason to know would cause a devastating allergic reaction.<sup>1</sup>

Medical errors are prevalent, and situations such as John Smith's arise in hospital settings daily. Such medical errors cause patients not only to suffer "unnecessary physical and mental pain" for prolonged periods of time, but sometimes cost patients their lives.<sup>2</sup> Many of these unnecessary outcomes mentioned above are preventable.<sup>3</sup> But, the medical and legal communities together must take action to reform their approaches to combat these medical errors and frivolous malpractice actions. First, it is important to determine what constitutes a medical error within the context of a health care setting. The Institute of Medicine ("IOM") defines a medical error generally as "the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim."<sup>4</sup> Although the IOM definition provides a broad framework

---

\* J.D. Candidate, The University of Memphis Cecil C. Humphreys School of Law, May 2016; The University of Memphis Law Review, Senior Notes Editor, Vol. 46; B.S., Psychology, Mississippi State University, 2013. I am grateful to Lauren Winchell, Professor Amy Campbell, Patrick Quinn, Greg Wagner, and Sarah Smith for their time, guidance, and invaluable insight in assisting me in the drafting and completion of this Note.

1. Although the location, names, and ages of the individuals involved in this fact pattern have been altered for purposes of this Note, this hypothetical is inspired by the facts of an actual event. *Stories About Medical Errors: Father Given Wrong Dosage of Life Threatening Medication*, SAFE PATIENT PROJECT, [http://safepatientproject.org/sys-medical\\_errors.html](http://safepatientproject.org/sys-medical_errors.html) (last visited Jan. 26, 2016).

2. Rebecca Rubel-Seider, *Full Disclosure: An Alternative to Litigation*, 48 SANTA CLARA L. REV. 473, 473 (2008); see Evelyn M. Tenenbaum, *Using Informed Consent to Reduce Preventable Medical Errors*, 21 ANNALS HEALTH L. 11, 11 (2012), <http://lawcommons.luc.edu/cgi/viewcontent.cgi?article=1012&context=annals> (acknowledging the long-standing effects of preventable medical errors).

3. See Randall R. Bovbjerg, *Paths to Reducing Medical Injury: Professional Liability and Discipline vs. Patient Safety—and the Need for a Third Way*, 29 J.L. MED. & ETHICS 369, 369 (2001) ("Many, perhaps even most, injuries are preventable, probably numbering in the hundreds of thousands a year for hospital care alone."); see also Rubel-Seider, *supra* note 2.

4. INSTITUTE OF MEDICINE, *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 1*, (Linda T. Kohn et al. eds., 1999) [hereinafter *TO ERR IS HUMAN*].

for the description of a medical error, each state differs as to how it statutorily defines medical errors.

Because medical errors have the potential to result in life-threatening outcomes, they also have the effect of fueling costly and time-consuming medical malpractice litigation. In the state of Tennessee, litigation that stems from medical negligence was previously referred to as a medical-malpractice claim, but is more recently recognized as a health care liability action.<sup>5</sup> A health care liability action is defined as

any civil action, including claims against the state or a political subdivision thereof, alleging that a health care provider or providers have caused an injury related to the provision of, or failure to provide, health care services to a person, regardless of the theory of liability on which the action is based.<sup>6</sup>

Preventable medical errors play a large role in frivolous medical malpractice litigation. This litigation may be avoided by encouraging transparency and communication within the health care setting via hospital-implemented disclosure policies and programs. However, encouraging the co-existence of transparent disclosure programs with the threat of potential medical malpractice litigation looming in the background is no easy task. Both medical malpractice litigation and patient safety disclosure programs aim to reduce medical errors in the health care arena.<sup>7</sup> Although the end goals are corresponding, the policies behind these two movements

---

5. In 2011, the Tennessee General Assembly passed the Tennessee Civil Justice Act, which replaced the term “medical malpractice action” throughout the Tennessee Code with the term “health care liability action.” See 2011 Tenn. Pub. Acts 510, § 9. For purposes of consistency throughout this Note, I will refer to Tennessee’s “health care liability action” as a “medical malpractice action.”

6. TENN. CODE ANN. § 29-26-101(a)(1) (2012 & Supp. 2015).

7. See Stanton N. Smullens et al., *Regulating for Patient Safety: The Law’s Response to Medical Errors: Article: Pennsylvania’s Approach to Reducing Medical Error: The Story of the Patient Safety Authority*, 12 WIDENER L. REV. 39, 40 (2005); see also Bovbjerg, *supra* note 3 (discussing the two competing views that society uses to both define and respond to medical errors).

are in conflict.<sup>8</sup> Unlike patient safety disclosure programs, the medical malpractice approach is considered reactive and punitive in nature, blaming the individual physician for his or her lapse in professional judgment and care.<sup>9</sup> This approach is justified on the grounds that if a physician is penalized for his or her mistakes, the incurred punishment will prevent similar mistakes from happening again in the future.<sup>10</sup>

On the other hand, patient safety disclosure programs are part of a relatively new movement.<sup>11</sup> Disclosure programs use a proactive approach in attempting to reduce both medical errors and litigation by focusing on the individual patient, identifying any potential medical errors, and “fostering an atmosphere that is open to discussing [those] errors.”<sup>12</sup> Physicians and medical providers are encouraged to communicate transparently and honestly with their patients and patient’s families, especially following a medical error.<sup>13</sup> In effect, this approach seems to alleviate the “name and blame” policy driving medical malpractice, and supports the idea that medical errors are a result of a possible system failure rather than the result of incompetent physicians.<sup>14</sup>

When handling medical errors, the conflict between these two approaches makes it difficult to not only achieve quality

---

8. See generally Smullens et al., *supra* note 7 (explaining the divergent interests between medical malpractice litigation and the patient safety movement).

9. See *id.*; see also David M. Studdert et al., *Medical Malpractice*, 350 *NEW ENG. J. MED.* 283, 287 (2004) (stating that medical malpractice litigation seeks to single out individual physicians in order to allocate fault and compensation based on evidence of negligence).

10. See Smullens et al., *supra* note 7; see also Studdert, *supra* note 9, at 283 (“Theoretically, lawsuits deter physicians by reminding those who wish to avoid the emotional and financial costs of litigation that they must take care.”).

11. See Smullens et al., *supra* note 7.

12. *Id.*

13. For a general discussion regarding the role of transparent communications within the health care setting following a medical error, see generally Joanna C. Schwartz, *A Dose of Reality for Medical Malpractice Reform*, 88 *N.Y.U. L. REV.* 1224 (2013).

14. *Id.* The patient safety movement recognizes that physicians and other health care providers make mistakes because it is inherent in human nature and not because they lack adequate training or competency. See also Bovbjerg, *supra* note 3, at 370.

care,<sup>15</sup> but also inhibits the possibility of reducing frivolous malpractice claims. As part of the patient safety movement, physicians and health care providers are urged to be open and transparent about their medical errors, reporting them to patients, fellow practitioners, and regulators, to openly address future methods of prevention.<sup>16</sup> In order to foster openness and honesty from medical providers, experts emphasize that most medical errors are a result of system failures and not unskilled or incompetent physicians.<sup>17</sup> Conversely, the medical malpractice approach is strikingly contrary because it targets individual physicians by assigning blame and encouraging providers to keep hidden information surrounding a medical error.<sup>18</sup> The fear of being exposed to litigation may override physicians' interests in patient safety disclosure methods. Further, reluctant physicians feel that there is little to no legal protection when they are transparent about medical errors, which could ultimately lead to litigation or difficulty in obtaining medical malpractice insurance.<sup>19</sup> Due to the conflict between these two approaches, not only are physicians less willing to disclose medical errors to their patients, but they are also deterred from communicating openly with their patients about potential mistakes.<sup>20</sup>

In support of the goal of reducing frivolous health care liability actions in Tennessee, this Note proposes that the Tennessee

---

15. See Smullens et al., *supra* note 7, at 40.

16. *Id.* at 40–41. Initiated in response to a report issued by the IOM in 1999, which disclosed the severity of recurring medical errors, the patient safety movement focuses on identifying errors pro-actively by encouraging an open discussion of those errors. *Id.* at 40.

17. See Studdert, *supra* note 9, at 287.

18. *Id.*

19. *Id.*

20. See Lisa I. Iezzoni et al., *Survey Shows That at Least Some Physicians Are Not Always Open or Honest with Patients*, 31 HEALTH AFF. 383, 388 exhibit 2 (2012), <http://content.healthaffairs.org/content/31/2/383.full.pdf>. In a 2009 research survey that addressed physicians' attitudes and behavior regarding the disclosure of medical errors to patients, researchers found that a significant number of physicians deviated from a policy of complete honesty. *Id.* Nearly 65.9 percent of survey respondents agreed that physicians should "disclose all significant medical errors to affected patients." *Id.* However, 19.9 percent of survey respondents failed to fully disclose actual errors to their patients due to the fear of a potential malpractice suit. *Id.*

legislature amend two current statutes that would, in effect, provide greater protection for physicians' apologies following a medical error, and expand the pre-suit notice period before filing a health care liability action. These proposed amendments will encourage health care providers and hospital systems within the state to adopt patient-centered disclosure programs that mandate transparency and communication when handling medical errors.

Part II of this Note discusses why medical malpractice litigation remains the default response to medical errors, and how this response inhibits the implementation of full disclosure programs throughout Tennessee. Part III recognizes the benefits of full disclosure programs and how they aid in reducing frivolous medical malpractice litigation. Part IV then offers an overview of successful disclosure programs that have been implemented in other states, and analyzes the benefits of these programs. Part V suggests amending Tennessee Rules Evidence section 409.1(a) by adding a provision that protects apologetic expressions, including fault-admitting statements, made specifically by health care providers following a medical error. Part VI proposes to amend Tennessee Code Annotated section 29-26-121(a)(1) by expanding the pre-suit notice period prior to filing a health care liability action. Part VII concludes the analysis and offers brief closing remarks.

## II. WHY MEDICAL MALPRACTICE LITIGATION IS THE TREND

Traditionally, endeavors to reduce medical errors have been addressed predominantly through medical malpractice litigation.<sup>21</sup> A period of an abundant increase in medical errors within the health care arena revealed, however, that persistent medical malpractice actions are not the end-all, be-all solution. In November 1999, the IOM released an alarming report that ignited controversy within the medical community.<sup>22</sup> The IOM's report, *To Err is Human*, announced that preventable medical errors had become a leading cause of mortality in the United States, estimating these

---

21. See Smullens et al., *supra* note 7, at 39; see also Alan G. Williams, *The Cure for What Ails: A Realistic Remedy for the Medical Malpractice "Crisis,"* 23 STAN. L. & POL'Y REV. 477, 481–83 (2012). Between the 1950s and 1980s, America considered itself to be facing a medical malpractice crisis. *Id.* at 480.

22. See *TO ERR IS HUMAN*, *supra* note 4.

errors were responsible for as many as 98,000 deaths per year.<sup>23</sup> Another study found that a projected three to five percent of hospital patients have suffered an injury as a result of their health care.<sup>24</sup> Comparing the past medical error crises to an epidemic, the IOM further estimated that preventable medical errors potentially cost between \$17 billion and \$29 billion per year.<sup>25</sup> The report also acknowledged that the prevalence of medical errors not only results in the unnecessary loss of human life and costly expenses, but also depletes patients' trust in the healthcare system, resulting in dissatisfaction for both patients and medical professionals alike.<sup>26</sup> The IOM concluded that a majority of the medical errors that occur in hospital settings are largely due to system failures and faulty conditions rather than individual negligence or incompetence.<sup>27</sup> After addressing the serious consequences of medical errors, the report then offered solutions to aid in the prevention of future medical errors in order to increase patient safety, acutely focusing on transparent disclosure.<sup>28</sup>

---

23. *Id.* at 1; Charles M. Key, *Toward a Safer Health System: Medical Injury Compensation and Medical Quality*, 37 U. MEM. L. REV. 459, 461 (2007); Rubel-Seider, *supra* note 2, at 473.

24. *See* Bovbjerg, *supra* note 3, at 369 (discussing the role of negligent medical care in causing patient injuries).

25. TO ERR IS HUMAN, *supra* note 4, at 1–2; *see also* Lee Taft, *Apology and Medical Mistake: Opportunity or Foil?*, 14 ANNALS HEALTH L. 55, 56 (2005)

<http://lawecommons.luc.edu/cgi/viewcontent.cgi?article=1203&context=annals> (attributing these preventable costs to a variety of factors).

26. *See* TO ERR IS HUMAN, *supra* note 4, at 2.

27. *See id.* at 49. The majority of medical errors do not result from individual recklessness or the actions of a particular group—this is not a “bad apple” problem. Medical errors are more commonly, the result of systems, processes, and conditions that lead physicians or nurses to make mistakes. *Id.* *But see* Bovbjerg, *supra* note 3, at 369 (stating that nearly one-third to one-half of patient injuries that transpire during hospital visits are due to negligence or an otherwise preventable error).

28. *See* TO ERR IS HUMAN, *supra* note 4, at 23. *But see* H. T. Stelfox et al., *The “To Err Is Human” Report and the Patient Safety Literature*, 15 QUALITY SAFETY HEALTH CARE 174, 174 (2006), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2464859/pdf/174.pdf>. Although the IOM gained mostly positive attention from both the public and health care providers, critics of the IOM report suggested that the release of the report did more harm than good. *Id.* For example, critics argue that, “by focusing undue attention on accidental deaths



In order to combat the pervasiveness of medical errors, the IOM recommended a framework of specific approaches to help reduce the occurrence of these avertable mistakes.<sup>29</sup> In 2001, the IOM report quickly proved to be a facilitator of change in the health care industry when the Joint Commission for the Accreditation of Hospitals (“JCAHO”) published new patient safety standards, which included regulations requiring the disclosure of unanticipated outcomes following medical care.<sup>30</sup> However, concerns with medical errors and malpractice litigation were well known even before the publication of the IOM report.

Studies conducted in the early 1990s confirmed that the recent concerns about preventable medical errors were material and in desperate need of a solution.<sup>31</sup> A 1991 study indicated that 3.7 percent of hospitalizations in New York resulted in adverse events, and 13.6 percent of those adverse events resulted in death.<sup>32</sup> Further, a 1992 study conducted in Utah and Colorado concluded that 2.9 percent of the states’ hospitalizations resulted in adverse events, while 6.6 percent of those instances led to mortality.<sup>33</sup> These two late studies collectively provided the foundation and ultimate motivation for the IOM’s 1999 report’s push for change.<sup>34</sup>

---

which are difficult to study and prevent, limited resources are being drawn away from other important quality improvement initiatives.” *Id.*

29. See TO ERR IS HUMAN, *supra* note 4, at 6. This framework included methods such as, establishing a national focus to create leadership and enhancing knowledge on patient safety; developing a nationwide public mandatory reporting system while also encouraging the implementation of separate voluntary reporting systems; creating and raising performance standards and expectations; and implementing safety systems to ensure safe practices. *Id.*

30. See Taft, *supra* note 25, at 56.

31. See Smullens et al., *supra* note 7, at 41.

32. *Id.*; see also Troyen A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I*, 324 NEW ENG. J. MED. 370, 370 (1991) (defining an adverse event as an injury that is caused by the medical management rather than the underlying disease and results in either a prolonged hospital stay or a disability).

33. Smullens et al., *supra* note 7, at 41; see Eric J. Thomas et al., *Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado*, 38 MED. CARE 261, 261 (2000).

34. Smullens et al., *supra* note 7, at 41.

A. *Justifications for Following Medical Malpractice Trend*

Although the early IOM report encouraged change in several facets of the health care industry, including how to efficiently deal with medical errors, deference to malpractice litigation continued to be the norm. This is because the “‘deny and defend’ culture of malpractice litigation is fundamentally opposed to the culture of openness and transparency advocated by the [IOM].”<sup>35</sup> Over the last several decades, efforts toward transparency, disclosure, and improving patient safety have successfully made a debut into the health care arena. However, the “deny and defend” approach continues to be the prevailing response of many health care providers when faced with a medical error and patient injury.<sup>36</sup> There are numerous fears plaguing both physicians and hospital representatives that dissuade these individuals from speaking openly and honestly with their patients about medical mistakes or sometimes even non-negligent complications.<sup>37</sup> Some of these fears include “a natural aversion to confronting angry” patients or families, “concerns that disclosure might invite a [malpractice] claim that otherwise would not be asserted,” “anxiety that the discussion will compromise [] defenses” that may be viable in the future, and “fear[s] that the conversation may lead to loss of malpractice insurance or higher premiums.”<sup>38</sup>

Generally, medical professionals assert that their fear of being transparent with patients derives from the adversarial nature of the legal profession.<sup>39</sup> A study conducted in 2008 surveyed physi-

---

35. Schwartz, *supra* note 13, at 1227.

36. Richard C. Boothman et al., *A Better Approach to Medical Malpractice Claims? The University of Michigan Experience*, 2 J. HEALTH & LIFE SCI. L. 125, 127, 131 (2009), <http://www.med.umich.edu/news/newsroom/Boothman%20et%20al.pdf> (“Transparency seems to be gaining currency as a concept, but individual physicians, hospitals, insurers, and defense lawyers still cling to ‘deny and defend’ as a comfortable, safe response to claims, despite its drawbacks.”).

37. *Id.* at 128.

38. *Id.*

39. William M. Sage, *Medical Malpractice Insurance and the Emperor’s Clothes*, 54 DEPAUL L. REV. 463, 464 (2005) (“For over a century, American physicians have regarded malpractice suits as unjustified affronts to medical professionalism, and have directed their ire at plaintiffs’ lawyers—whose wealth

icians about their attitudes regarding methods of communication that take place following a medical error and found that “[p]hysicians were ‘concerned about the confidentiality and legal discoverability of the error information they report.’”<sup>40</sup> Hospitals and healthcare providers seem to tailor their programs and policies in response to a perceived exposure to legal liability, regardless of whether that perception actually materializes.<sup>41</sup> This perception serves as a barrier that tends to discourage physicians from disclosing medical errors to their patients since disclosure would seem contrary to implemented policies.<sup>42</sup> Additionally, apologies made by physicians to injured patients also play an important role in the disclosure process. However, a significant reason why physicians abstain from making such apologies, or even initiating the disclosure process in the first place, is due to the realistic fear of impending lawsuits and their potentially devastating consequences.<sup>43</sup> When physicians realize that apologies or expressions of sympathy may be used against them to prove liability, or that such actions may jeopardize their ability to obtain insurance coverage in the

---

and reputation seem inversely proportional to their own—and the legal system in which they operate.”).

40. See Boothman et al., *supra* note 36, at 129; see also Jane Garbutt et al., *Lost Opportunities: How Physicians Communicate About Medical Errors*, 27 HEALTH AFF. 246 (2008), <http://content.healthaffairs.org/content/27/1/246.full.pdf>. Physicians’ concerns regarding disclosure are understandable due to the malpractice system’s tendency to focus only on provider fault and the limited obtainability of malpractice insurance. *Id.*

41. See Carol Brass, *A Proposed Evidentiary Privilege For Medical Checklists*, 2010 COLUM. BUS. L. REV. 835, 842–43 (2010).

42. See *id.* at 846; see also Emily R. Carrier et al., *Physicians’ Fears of Malpractice Lawsuits Are Not Assuaged by Tort Reforms*, 29 HEALTH AFF. 1585, 1591 (2010), <http://content.healthaffairs.org/content/29/9/1585.full.pdf> (“It is likely that physicians’ assessment[s] of their risk is driven less by the true risk of malpractice claims or the cost of malpractice insurance, and more by the perceived arbitrary, unfair, and adversarial aspects of the malpractice tort process . . .”).

43. Robin E. Ebert, *Attorneys, Tell Your Clients to Say They’re Sorry: Apologies in the Health Care Industry*, 5 IND. HEALTH L. REV. 337, 342 (2008). However, it is suggested that that many physicians may not have access to correct information regarding “their absolute risk of being sued.” Carrier et al., *supra* note 42, at 1591.

future, they are less likely to be forthcoming and apologetic with their patients.<sup>44</sup>

The constant anticipation of a lawsuit following some type of medical error generates an atmosphere of secrecy and mistrust among health care providers.<sup>45</sup> As a result, a physician or hospital representative's failure to disclose mistakes causes unsatisfied and fearful patients to sense that their only option is to file suit.<sup>46</sup> These reasonable concerns of litigation instill fear in the minds of medical providers about the no-defect medical culture, which is impossible to obtain and ultimately results in the practice of defensive medicine and increased health care costs for the remainder of society.<sup>47</sup>

### *B. Why Medical Malpractice is Not the Answer*

The “deny and defend” method is an ineffective and costly way to respond to a patient who has been affected by a medical error.<sup>48</sup> When physicians and hospitals resort to this method, patients are left with unanswered questions and plausibly feel that their only way to hold the providers accountable is to seek recourse through the adversarial system. Although litigation has long been the answer for patients who suffer as a result of a medical error, physician liability alone has failed to solve these problems and prevent these mistakes from recurring.<sup>49</sup> When patients choose to resort to litigation following a medical error, the process often proves to be inefficient and time consuming, leaving the patient uncompensated and experiencing unwanted outcomes, such as un-

---

44. See Ebert, *supra* note 43, at 342.

45. Barbara Phillips-Bute, *Transparency and Disclosure of Medical Errors: It's the Right Thing to Do, so Why the Reluctance?*, 35 CAMPBELL L. REV. 333, 336 (2013).

46. *Id.*

47. *Id.* The idea of defensive medicine stems from physicians' looming fear of potential lawsuits, which leads them to “prescribe medicines and order tests” that they know are not reasonably necessary under the circumstances, but do so anyway for the sole purpose of shielding themselves from liability. Frederick H. Davis, *Medical Liability and the Disclosure-Offer Approach: Transforming How Arkansans Should Think About Medical Malpractice Reform*, 64 ARK. L. REV. 1057, 1069 (2011).

48. See Boothman et al., *supra* note 36, at 129. The “deny and defend” approach is financially and emotionally costly. *Id.*

49. See Bovbjerg, *supra* note 3, at 377.

foreseen injuries associated with the medical error.<sup>50</sup> Accordingly, in the rare case that a patient is granted compensation following a medical malpractice action, the patient typically does not receive a monetary award until a much later date.<sup>51</sup> It is estimated that patients do not receive payment until roughly five years following the relevant incident that caused the harm.<sup>52</sup> Further, if the patient actually receives compensation, it is generally only half of the patient's true award due to the reduction of attorney fees and litigation expenses.<sup>53</sup>

The costs incurred from malpractice litigation are tremendous.<sup>54</sup> According to one study, overhead costs stemming from malpractice litigation are "exorbitant," and "for every dollar spent on compensation, 54 cents went to administrative expenses," such as attorney fees, experts' compensation, and court costs.<sup>55</sup> Comparably to the lack of adequate compensation experienced by affected patients involved in malpractice suits, litigation also does not always allow patients' questions or injuries to be fully addressed because the physicians are focused on relieving themselves of potential liability.<sup>56</sup> Because physicians' malpractice suits remain defensive, they are less incentivized to openly explain the circum-

---

50. *Id.* at 335; see also David M. Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 NEW ENG. J. MED. 2024, 2025 (2006) (asserting that costly, frivolous medical malpractice claims are a substantial waste of time and resources in both the legal and medical systems).

51. See Phillips-Bute, *supra* note 45, at 335.

52. See *id.*; Studdert et al., *supra* note 50, at 2031 (disclosing the findings of a study that indicated an average time of five years between when the injury stemming from a medical error occurred and when the resolution process was complete).

53. See Phillips-Bute, *supra* note 45, at 335.

54. See Charles Kolodikin & Paul Greve, *Medical Malpractice: The High Cost of Meritless Claims*, IRMI (Jan. 2007), <http://www.irmi.com/expert/articles/2007/kolodkin01.aspx>.

55. Studdert et al., *supra* note 50, at 2026. For a discussion of how the liability process is slow in resolution, disregards a majority of claimed injuries, and fails to pay out consistent amounts, even among similar cases, see Randall R. Bovbjerg, *Beyond Tort Reform: Fixing Real Problems*, 3 IND. HEALTH L. REV. 1, 13 (2006).

56. See Phillips-Bute, *supra* note 45, at 337.

stances surrounding a medical error.<sup>57</sup> Due to this defensive practice, physicians may make judgment calls or take action based on their perceived personal legal benefit as opposed to a patient's clinical benefit.<sup>58</sup> Additionally, although the effects of medical errors can be potentially detrimental to both patients and their families, the subsequent effects of litigation can take a devastating toll on the physician as well.<sup>59</sup> This leads many physicians to sometimes experience depression, alienation, and financial instability after being sued.<sup>60</sup> Even though these barriers are tremendous, many patients feel that litigation is their only means of recourse.

### *C. Why Patients Continue to Turn to Medical Malpractice Litigation*

It is suggested that patients who resort to malpractice litigation following an injury caused by a medical error do so as a result of the physician's reluctance to disclose or explain to the patient what actually happened.<sup>61</sup> Accordingly, following a medical error,

---

57. See Richard C. Boothman et al., *Nurturing a Culture of Patient Safety and Achieving Lower Malpractice Risk Through Disclosure: Lessons Learned and Future Directions*, FRONTIERS HEALTH SERV. MGMT., Spring 2012, at 13, 15, <http://www.med.umich.edu/news/newsroom/Boothman-ACHE-Frontiers.pdf> (“The medical community more often views a complaint as a threat, not an opportunity to reach an understanding based on honesty and openness.”). The defensive process of malpractice litigation persuades physicians to distance themselves from “acknowledg[ing] mistakes and to avoid talking to an injured patient at all.” Phillips-Bute, *supra* note 45, at 336.

58. Bovbjerg, *supra* note 55, at 11. “Some of [these actions are] characterized as negative defensive medicine, that is, not doing ethically or clinically indicated things for legal reasons—like seeing charity patients or providing obstetrical care to high risk patients.” *Id.* However, there are many more instances of positive defensive medicine in practice. Examples of positive defensive medicine include “ordering extra tests, doing unneeded procedures, or adding layers of documentation, because those things are perceived to lower risk of lawsuit or facilitate defense if claims are brought.” *Id.* at 11–12.

59. Phillips-Bute, *supra* note 45, at 336–37 (“Symptomatic reactions are common among physicians who have been sued for malpractice . . .”).

60. See Alicia Gallegos, *Life After Lawsuit: How Doctors Pick Up the Pieces*, AMERICAN MEDICAL NEWS (May 16, 2011), <http://www.amednews.com/article/20110516/profession/305169939/4/>.

61. Boothman et al., *supra* note 36, at 133; e.g., Ebert, *supra* note 43, at 343 (“[A] patient who does not receive the response he or she was expecting may leave feeling resentful and more likely to desire taking legal action against

patients are motivated to turn to the courts because they feel as if they have not been fully advised about their outcomes, the physician or hospital has failed to take responsibility for the accident, or the patient reasonably believes a same or similar mistake will occur in the future during another patient's care.<sup>62</sup> One study surveyed patients who had been affected by a medical error and found that 24 percent of those patients filed suit because "the physician had failed to be completely honest with them about what happened, allowed them to believe things that were not true, or intentionally misled them."<sup>63</sup>

Generally, patients have reasonable expectations of trust when visiting a hospital or health care provider. Patients expect that when they go in for treatment, surgery, or a simple diagnosis, the providing physician will possess the knowledge and ability to assist them. These same patients also expect that if something were to go wrong while they were under the physician's care, the physician would honestly and willingly explain the situation, regardless of the outcome. A considerable gap exists, however, between current disclosure practices and a patient's expectation that he or she will be notified of a medical error.<sup>64</sup> Therefore, if an in-

---

the physician."); Rubel-Seider, *supra* note 2, at 476 ("Patients who experience medical errors seek litigation as a way to hold the hospital responsible for its mistake . . .").

62. Boothman et al., *supra* note 36, at 133 (citing Charles Vincent et al., *Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action*, 343 LANCET 1609, 1609–13 (1994)).

63. *Id.* (citing Gerald B. Hickson et al., *Factors that Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries*, 267 JAMA 1359, 1361 (1992)). Out of the 127 families who responded to the survey, another 24 percent filed suit because they needed compensation, 33 percent filed because they were advised by an individual outside of the patient's family to take action, another 23 percent of the families filed suit because they were informed by medical personnel that they suffered from poor medical care, 20 percent filed because they realized that as a result of the medical error their child had no future, and 19 percent filed suit out of revenge. FRANK A. SLOAN ET AL., *SUING FOR MEDICAL MALPRACTICE* 64–65 (1993).

64. See Anna C. Mastroianni et al., *The Flaws in State "Apology" and "Disclosure" Laws Dilute Their Intended Impact on Malpractice Suits*, 29 HEALTH AFF. 1611, 1616 (2010), <http://content.healthaffairs.org/content/29/9/1611.full.pdf> (noting that disclosure requirements are more commonly being codified into state laws). The circumstances surrounding a medical error may be vague, allowing physicians to be uncertain as to what information necessitates

jured patient does not receive a reasonably anticipated forthcoming response from his or her treating physician, the patient is left feeling angry, resentful, and more likely to turn to the adversarial system to compensate for the harm he or she suffered.<sup>65</sup>

### III. HOW DISCLOSURE PROGRAMS AID IN REDUCING FRIVOLOUS MEDICAL MALPRACTICE LITIGATION

Although historically many health care systems discouraged the disclosure of medical errors for fear of liability, there has recently been a continuous push by the health care industry toward the implementation of full disclosure programs that emphasize transparency.<sup>66</sup> Accordingly, there continue to be prevalent concerns that increased transparency, coupled with apologetic statements made by physicians following a medical error, will result in

---

disclosure, essentially adding to the gap between patients' expectations and a provider's actual disclosure. See also Thomas H. Gallagher et al., *Choosing Your Words Carefully: How Physicians Would Disclose Harmful Medical Errors to Patients*, 166 ARCHIVES INTERNAL MED. 1585, 1585 (2006), <http://archinte.jamanetwork.com/article.aspx?articleid=410785>.

65. Ebert, *supra* note 43, at 343. Patients who have been affected or injured by a medical error desire a detailed explanation about what happened, an apology acknowledging that the medical error had an impact on the patient, and a compensation to cover expenses that would not have incurred but for the error. Virginia L. Morrison, *Heyoka: The Shifting Shape of Dispute Resolution in Health Care*, 21 GA. ST. U. L. REV. 931, 947 (2005). "Studies document that the failure to meet these expectations, or poor communications in meeting them, can be perceived as measures of disrespect and may inflict as much or more pain than the injury, serving as the catalyst for taking legal action." *Id.*

66. Phillips-Bute, *supra* note 45, at 337 ("While the health care system has traditionally discouraged disclosures, there is, nonetheless, a steady momentum toward programs that promote transparency and full disclosure of medical errors in the United States and in other western countries."); see generally Kelly Bogue, Note, *Innovative Cost Control: An Analysis of Medical Malpractice Reform in Massachusetts*, 9 J. HEALTH & BIOMEDICAL L. 87, 100-03 (2013) (discussing the successes of the disclosure programs that are in effect within New Hampshire and Michigan); Doug Wojcieszak et al., *The Sorry Works! Coalition: Making the Case for Full Disclosure*, 32 JOINT COMMISSION J. ON QUALITY & PATIENT SAFETY 344 (2006), [http://www.jointcommission.org/assets/1/18/Sorry\\_Works.pdf](http://www.jointcommission.org/assets/1/18/Sorry_Works.pdf) (promoting the implementation of full disclosure programs and physician apologies in the event of a medical error).



amplified litigation and greater malpractice premiums.<sup>67</sup> These concerns, however, have shown to be unfounded. Research suggests that a provider's reluctance to provide transparent disclosure to a patient injured by a medical error actually increases the frequency of litigation, especially if the patient believes his or her questions have not been answered or that the provider is avoiding accountability for his or her mistake.<sup>68</sup> One study indicated that 37 percent of the patients interviewed who resorted to legal action would have refrained from doing so if they had been provided with an explanation and apology from the physician following the medical error, while another 25 percent of injured patients would have refrained from pursuing a malpractice claim if the physician corrected his or her mistake.<sup>69</sup> Not only does transparent disclosure serve the goal of decreasing frivolous medical malpractice claims, but "[a] system that encourages medical disclosure and transparency through a safe, supportive, and highly effective process that addresses both the needs of the patients and the needs of the physician can also serve the broader goals of increased patient safety."<sup>70</sup>

---

67. See Troyen A. Brennan, *The Institute of Medicine Report on Medical Errors—Could it do Harm?*, 342 NEW ENG. J. MED. 1123, 1125 (2000); see also Phillips-Bute, *supra* note 45, at 338.

68. Phillips-Bute, *supra* note 45, at 337–38 (citing Vincent et al., *supra* note 62, at 1609); see Rubel-Seider, *supra* note 2, at 485 (highlighting that a patient is less likely to file a malpractice suit if the patient feels decreased anger towards a physician); see also Wojcieszak et al., *supra* note 66, at 344 (explaining that when patients' emotions and concerns are properly addressed, compensation becomes an ancillary issue). The Sorry Works! Coalition is "an organization of doctors, lawyers, insurers, and patient advocates that is dedicated to promoting full disclosure and apologies for medical errors as a 'middle-ground solution' to the medical malpractice crisis." *Id.*

69. Vincent, *supra* note 62, at 1612 tbl.5. The same study also indicated that 17 percent of the patients affected by medical errors would have refrained from resorting to litigation if physician or hospital would have paid the patient compensation for the inflicted injury. *Id.* A similar study found that 24 percent of patients who have encountered a medical error filed suit because the treating physician was dishonest about their mistake, or the patient felt that the physician had intentionally misled them about their injury. See Jennifer K. Robbennolt, *Apologies and Medical Error*, 467 CLINICAL ORTHOPAEDICS & RELATED RES. 376, 377 (2009), [http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2628492/pdf/11999\\_2008\\_Article\\_580.pdf](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2628492/pdf/11999_2008_Article_580.pdf) (citing Hickson, *supra* note 63, at 1359–63).

70. Phillips-Bute, *supra* note 45, at 337.

Along with full disclosure, an apology can play an important role in fulfilling the patient's expectations and avoiding outrageous medical and insurance costs.<sup>71</sup> It is suggested that there are three essential responses that patients desire following a medical error: (1) information about what happened; (2) a sincere apology; and (3) the assurance that measures to prevent the error from happening to another patient have been taken.<sup>72</sup>

There are several benefits derived from implementing a full disclosure program within a health care system. For example, the medical community is likely to observe improved communications between health care providers and their patients, which aids in mending the physician-patient relationship after a medical error has occurred due to the reinstatement of trust between the parties.<sup>73</sup> Full disclosure programs also have the potential to provide patients with a remedy more quickly than if patients chose to participate in extensive litigation.<sup>74</sup> But, these programs also allow patients to retain the right to sue should negotiations not satisfy their de-

---

71. Rubel-Seider, *supra* note 2, at 480; *see also* Thomas H. Gallagher et al., *Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors*, 289 [J]AMA 1001, 1003 (2003), [http://www.mitsstools.org/uploads/3/7/7/6/3776466/gallagher\\_patientphysicianattitudestowardsdisclosureofmedicalerrors.pdf](http://www.mitsstools.org/uploads/3/7/7/6/3776466/gallagher_patientphysicianattitudestowardsdisclosureofmedicalerrors.pdf) (discussing the conflicting views between patients and physicians regarding the necessity of an apology following a medical error). Apologies have also been used as an important and effective dispute resolution tool in other legal settings such as mediation. *See* Deborah L. Levi, *The Role of Apology in Mediation*, 72 N.Y.U. L. REV. 1165, 1208 (1997) (recognizing that a sincere, remorseful apology may aid in satisfying conflict, but cautioning against overestimating the power of a simple "I'm sorry").

72. Phillips-Bute, *supra* note 45, at 338; *see also* Taft, *supra* note 25, at 63–64. ("In the face of medical error, the physician must first take time to identify what went wrong and why, a process that must take place before communicating with the patient or the patient's family. This is a time not only for internal reflection but also a time for communications with the medical team, mentors, and colleagues."). These steps are imperative because not only do they "equip[] the physician to communicate with clarity," they also prepare the physician to communicate the information through an authentic apology. *Id.* at 64.

73. Rubel-Seider, *supra* note 2, at 486. Healing for the patient begins once the injury is disclosed and an apology is made by the physician, but the nondisclosure of an error "interrupts the essential ingredient of trust" in a doctor patient relationship. Taft, *supra* note 25, at 66.

74. Rubel-Seider, *supra* note 2, at 486.

mands.<sup>75</sup> By departing from the “deny and defend” approach and heeding the benefits of a full disclosure program, physicians and hospitals are able to focus on moving forward with their patients’ anticipated care.<sup>76</sup>

Due to the importance of transparent disclosure and genuine apologies following a medical error, medical schools are beginning to “incorporate training about error disclosure and apologies into the curriculum.”<sup>77</sup> Perhaps the most important reasons to encourage the teaching of patient safety and error disclosure policies to medical students are to prevent future error and improve a patient’s quality of care.<sup>78</sup> However, despite the fact that some medical schools have implemented a curriculum that teaches students to both disclose medical errors and apologize to patients, medical students still find it difficult to disclose their mistakes because they are “less sure of their skills” and are especially concerned about tarnishing their reputations as physicians.<sup>79</sup> Because errors are an inevitable part of medicine, it is essential that medical professionals are trained and mentored early on in their medical career so that they will learn how to properly disclose errors to

---

75. *Id.* For example, New Hampshire recently implemented a statutory early offer and disclosure program in which, following an adverse event, allows patients to either pursue litigation or “enter into an early offer process,” which entails the patient sending a “written notice of injury” to the provider, and requires the patient to waive certain legal rights, such as, the right to receive payment for non-economic damages. Bogue, *supra* note 66, at 103; *see also* N.H. REV. STAT. ANN. § 519-C:2 (Supp. 2012). The provider has ninety days to respond to the written notice with a financial offer, and the patient subsequently has sixty days to either accept the provider’s offer by signing a waiver or request a hearing. Bogue, *supra* note 66, at 103.

76. Bogue, *supra* note 66, at 101. Physicians should be able to focus on providing the best care to their patients based on their past training and education rather than deciphering ways to avoid liability in the case of a medical error. *Id.* at 93.

77. Robbennolt, *supra* note 69, at 380.

78. Joseph L. Halbach & Laurie L. Sullivan, *Teaching Medical Students About Medical Errors and Patient Safety: Evaluation of a Required Curriculum*, 80 ACAD. MED. 600, 600 (2005).

79. Dhruv Khullar, *When Medical Students Make Errors*, N.Y. TIMES (May 15, 2014, 10:35 AM), [http://well.blogs.nytimes.com/2014/05/15/when-medical-students-make-errors/?\\_r=0](http://well.blogs.nytimes.com/2014/05/15/when-medical-students-make-errors/?_r=0).

their patients.<sup>80</sup> This early training will prove beneficial because transparent disclosures and sincere apologies are characteristics embedded in current hospital disclosure programs today.<sup>81</sup>

#### IV. SUCCESSFUL DISCLOSURE PROGRAMS IMPLEMENTED IN OTHER STATES

##### A. *Veterans Affairs Medical Center in Lexington, Kentucky*

The Veterans Affairs Medical Center (“VA”) in Lexington, Kentucky, has implemented a landmark disclosure program<sup>82</sup> that consists of high standards for transparency and disclosure—a different approach to medical errors than most hospitals have chosen to adopt.<sup>83</sup> Its program is inherently proactive as it emphasizes extreme honesty when handling medical errors.<sup>84</sup> The driving force behind the implementation of the VA’s policy “was to maintain a care-giving relationship toward the patient following medical error rather than adopting an adversarial one.”<sup>85</sup> The VA’s disclosure program is comprised of several practical steps.

First, once a patient experiences a harmful medical error, the hospital encourages providers to report those errors to its risk management committee (“the Committee”).<sup>86</sup> After the error is reported, the Committee immediately investigates the mistake and attempts to determine its root cause.<sup>87</sup> The Committee considers

---

80. See *id.*; see also Darrell G. Kirch & Philip G. Boysen, *Changing the Culture in Medical Education to Teach Patient Safety*, 29 HEALTH AFF. 1600, 1601 (2010), <http://content.healthaffairs.org/content/29/9/1600.abstract> (“To achieve the culture change necessary to improve patient safety, medical schools and clinical practices must work together more effectively.”).

81. But see Kirch & Boysen, *supra* note 80, at 1600 (“Medical education alone cannot accomplish this shift [in advancing patient safety].”).

82. In 1987, after losing two colossal malpractice claims costing upward of \$1.5 million, the VA decided that it was time for a change in the way the institution dealt with medical errors, thus implementing a full disclosure program. See Phillips-Bute, *supra* note 45, at 339–40.

83. Rubel-Seider, *supra* note 2, at 487.

84. *Id.* The VA is so proactive in their disclosure that they are known to “call families after discharge to explain that an error occurred.” *Id.*

85. Jonathan R. Cohen, *Apology and Organizations: Exploring an Example From Medical Practice*, 27 FORDHAM URB. L. J. 1447, 1451 (2000).

86. See *id.* at 1452.

87. *Id.*

the possibility of both a “systemic” error and individual negligence on behalf of the providing physician.<sup>88</sup> Once it is determined that the patient has suffered harm, the physician fully informs the patient of the medical error.<sup>89</sup> After the disclosure is made, the Committee discusses avenues available to the hospital that will assist the affected patient through further medical treatment, including necessary compensation.<sup>90</sup> Once a the Committee develops a plan of action, the providing clinicians and Committee members set up a face-to-face meeting with the patient, his or her family, and the patient’s legal counsel.<sup>91</sup> If the Committee’s investigation indicates that the hospital or its physicians are at fault, the patient is afforded an apology.<sup>92</sup> If the Committee finds that the hospital or its employees are to blame for the patient’s injuries, the Committee offers the patient both a fair settlement offer and an apology.<sup>93</sup>

Because the approach taken by the VA implicates the necessary elements of a full disclosure program,<sup>94</sup> the hospital has had the ability to minimize its exposure to litigation because patients and their families are not as angry when learning of a medical error.<sup>95</sup> The VA experienced financial improvement after the new disclosure program took effect.<sup>96</sup> These improvements were con-

---

88. *Id.* If the hospital’s risk management committee finds that a systemic error caused the harm, efforts to prevent similar, future systemic mistakes are taken. *Id.*

89. *Id.* The physician must disclose the error to patient regardless whether the patient has knowledge of the harm. *Id.*

90. *See id.* at 1453.

91. *Id.*

92. *Id.* During the meeting, the physicians alongside the committee members discuss with the patient different approaches that could be taken to further aid the patient medically, and also consider any benefits to which the patient may be entitled. *Id.*

93. *Id.*

94. *Id.*

95. *See id.* at 1449 (“By going out of its way to be open and honest with patients and their families, the [VA] hospital has found that it is minimizing its legal exposure because families are not as angry when they learn of a medical error.”).

96. *Id.* at 1453 (“From 1990 through 1996, the hospital paid an average of only \$190,113 per year in malpractice claims, with an average (mean) payment of \$15,622 per claim.”).

sidered substantial when compared to the previous \$1.5 million malpractice verdicts rendered against the VA from 1985 through 1986.<sup>97</sup> The VA's financial improvements placed it in the lowest quartile of comparable VA hospitals for malpractice payments during a seven-year period.<sup>98</sup>

However, the VA system possesses a distinctive feature that has contributed to its success. Contrary to many private hospitals that carry third-party liability insurance, the VA is a self-insured organization that directly bears its liability costs.<sup>99</sup> When an employer hospital becomes self-insured, the hospital pays for "individual employee health claims out of cash flow rather than as a monthly fixed premium to a health insurance carrier."<sup>100</sup> Being self-insured potentially promotes the affording of apologies to patients while third-party insurers may possibly "give little weight to some . . . benefits of [an] apology that an organization may value."<sup>101</sup> Further, being self-insured allows the VA more control in how a hospital decides to handle medical errors.<sup>102</sup> This is because most third-party insurance contracts impose a duty on the insured hospital to comply with the third-party insurance policy once involved with the defense of a claim.<sup>103</sup>

---

97. *Id.*

98. *Id.* "The Lexington VA's average payout was \$16,000 per settlement, versus the national VA average of \$98,000 per settlement, and only two lawsuits went to trial during a 10-year period." Wojcieszak et al., *supra* note 66, at 346.

99. Wojcieszak, *supra* note 66, at 346; see also Greg Bordonaro, *Hospitals Battle Medical Malpractice Costs*, HARTFORDBUSINESS.COM (Apr. 28, 2014), <http://www.hartfordbusiness.com/article/20140428/PRINTEDITION/304249935/hospitals-battle-medical-malpractice-costs> ("Being self-insured . . . also gives hospitals greater control over malpractice premiums, which could also impact total expenses.").

100. Joseph Berardo, Jr., *Understanding Benefits of Self-Insurance and Role of Hospitals in Helping Employers Lower Claims Costs*, BECKER'S HOSPITAL REVIEW (Dec. 31, 2013), <http://www.beckershospitalreview.com/strategic-planning/understanding-benefits-of-self-insurance-and-role-of-hospitals-in-helping-employers-lower-claims-costs.html>. Additionally, when a hospital becomes self-insured, it is afforded greater flexibility in setting strategic goals, increased financial control, maximized internal resources, and improved decision-making. *Id.*

101. Cohen, *supra* note 85, at 1471.

102. *Id.*

103. *Id.*

*B. University of Michigan Health System Approach*

The University of Michigan Health System (“UMHS”) has implemented perhaps one of the most compelling disclosure program models in the country.<sup>104</sup> UMHS’s disclosure policies, fashioned closely after those of the VA system, involve several stages. Following the occurrence of a medical error or near miss,<sup>105</sup> the physician communicates openly and directly with the patient or his or her medical representative.<sup>106</sup> The risk management team reviews the complaint made by the patient in order to determine what happened.<sup>107</sup> If the affected patient has retained legal counsel, the risk management team offers to meet with both parties to review the patient’s care and to answer any questions.<sup>108</sup> If through an investigation the risk management team determines that the patient’s care was unreasonable, the institution admits its mis-

---

104. When the program was implemented in 2001, three principal goals molded the institution’s response to patient injuries following medical errors: (1) compensate quickly and fairly when unreasonable care causes injury; (2) defend medically reasonable care vigorously; and (3) reduce patient injuries (and therefore claims) by learning from patients’ experiences. Boothman et al., *supra* note 36, at 139; *see also* Richard Boothman & Margo M. Hoyler, *The University of Michigan’s Early Disclosure and Offer Program*, BULL. AM. C. SURGEONS (Mar. 2, 2013), <http://bulletin.facs.org/2013/03/michigans-early-disclosure/#> (“The UMHS model has been generally well-received in Michigan and elsewhere. . . . Nationally, the model has been covered by major newspapers and newsmagazines.”).

105. The term “near miss” is “used to describe any process variation that did not affect an outcome but for which a recurrence carries a significant change of a serious adverse outcome.” COMPREHENSIVE ACCREDITATION MANUAL FOR LABORATORY AND POINT-OF-CARE TESTING, JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS at SE-4 (2011), [http://www.jointcommission.org/assets/1/6/2011\\_CAMLAB\\_SE.pdf](http://www.jointcommission.org/assets/1/6/2011_CAMLAB_SE.pdf).

106. *The Michigan Model: Medical Malpractice and Patient Safety at UMHS*, U. MICH., <http://www.uofmhealth.org/michigan-model-medical-malpractice-and-patient-safety-umhs> (last visited Feb. 5, 2016).

107. *Id.* This step includes a peer review process, which involves professionals in similar practices. *Id.* The risk management team also acknowledges any opportunities for improvement that would prevent a similar event in the future. *Id.*

108. *Id.* This step is taken regardless of whether the parties provided the institution with a notice of intent to file suit. *Id.*

take and apologizes to the patient.<sup>109</sup> If the team's investigation concludes that the patient's care was medically reasonable, the team still extends an offer to meet with the patient and his or her counsel to explain the situation.<sup>110</sup> If a patient responds by filing suit, the risk management team vigorously defends its position throughout the litigation process.<sup>111</sup>

Similar to the VA, UMHS has several advantages over other health care systems, which ultimately aid in its program's efficiency. UMHS is a self-insured health system, "which allow[s] for consistency and alignment of ethical and financial motivation between the hospitals, care providers, and insurer."<sup>112</sup> Further, Michigan law encourages hospitals and health care institutions to respond proactively to patient injuries by communicating with the affected patients and managing the consequences of a medical error as quickly and efficiently as possible.<sup>113</sup> Accordingly, UMHS benefits from Michigan's statutory six-month pre-suit notice period, which allows the facility time to investigate the alleged claims and engage the patient and the patient's family in possible settlement negotiations, if appropriate.<sup>114</sup> Despite speculation that transparency increases malpractice claims, UMHS data suggests

---

109. *Id.* If the patient was injured as a result of an error, the team works with the patient and his or her legal counsel to reach a mutual agreement about a resolution. *Id.* This does not imply a settlement is going to occur, but if it were to occur, the institution compensates quickly and fairly. *Id.* UMHS views care as reasonable when it meets professional and institutional expectations, and such a determination is fundamentally clinical rather than legal. Boothman et al, *supra* note 57, at 21.

110. *See The Michigan Model, supra* note 106. It is not required, but many times the providing physician will participate in the mutual discussion. *Id.* The physician can aid in explaining to the patient the care they received. *Id.*

111. *See id.* ("No matter what happens: We will seek to learn from the experience, educate our staff, and make changes to the systems and processes that were involved in the care that prompted the complaint.").

112. *See* Boothman et al., *supra* note 36, at 137 (highlighting the benefits of maintaining a self-insured facility).

113. *See id.* ("Michigan laws encourage proactive responses to patient injuries and claims.").

114. *See id.* Under Michigan law, before filing a medical malpractice suit, a plaintiff must serve the potential defendants with written specifics of the claim he or she intends to file at least 182 days before the action is commenced. MICH. COMP. LAWS § 600.2912b (2015).



that its disclosure policies have led to a substantial decrease in litigation.<sup>115</sup> After the implementation of the program, the number of new claims against the hospital system fell from 136 in 1999 to 61 in 2006.<sup>116</sup> Additionally, claims were resolved more quickly with processing times shifting from an average of 20.3 months to 8 months overall, while litigation expenses were also cut in half.<sup>117</sup> Patients' satisfaction with UHMS's policy of explanatory disclosure and an apology following a medical error is perhaps an explanation as to why the number of lawsuits against the health system continues to decrease.<sup>118</sup> These policies coupled with Michigan's favorable malpractice laws may be the key to fixing the broken medical malpractice system.

V. PROPOSED AMENDMENT TO TENNESSEE'S SYMPATHY LAW TO PROTECT APOLOGETIC EXPRESSIONS AND FAULT ADMITTING STATEMENTS MADE BY HEALTH CARE PROVIDERS

Designing and implementing an entirely new statutory scheme in order to mandate the implementation of full disclosure programs for hospitals and health care providers within Tennessee is a daunting task. Instead, Tennessee can aid in encouraging and incentivizing its health care providers and hospital systems to implement full disclosure programs by amending its existing law to create an environment that is conducive to the existence of such programs. The proposed amendment would give health care providers and hospital systems in Tennessee a greater incentive to engage in full disclosure programs by protecting apologetic expressions and statements of fault made specifically by health care

---

115. See Boothman et al., *supra* note 36, at 145 ("Although singular factors giving rise to decreased claims cannot be identified precisely, clearly, transparency at UMHS has not been the catastrophe predicted—and it has yielded unquestionable benefits that enable UMHS and its staff to deliver safer and better care.").

116. *Id.* at 143.

117. Phillips-Bute, *supra* note 45, at 341. *But see* Boothman et al., *supra* note 36, at 144 (discussing that transparency alone is not responsible for the downwards trend of medical malpractice claims).

118. Tina Reed, *University of Michigan's Policy Admitting Medical Errors Reduced Costs, Study Finds*, THE ANN ARBOR NEWS (Aug. 16, 2010, 6:22 PM), <http://www.annarbor.com/news/university-of-michigans-medical-error-policy-effectively-cut-costs-study-finds/>.

providers following a medical error. This statutory amendment would provide physicians and hospitals greater protections and work to decrease frivolous medical malpractice lawsuits.

In 2002, the Tennessee legislature originally enacted statutory disclosure requirements applicable to all physicians and medical facilities following the occurrence of an “unusual event,” which was Tennessee’s term for medical error.<sup>119</sup> The statute defined “unusual event” as “an unexpected occurrence or accident resulting in death or life-threatening or serious injury to a patient that is not related to a natural course of the patient’s illness or underlying condition.”<sup>120</sup> The statute required that “[t]he affected patient and the patient’s family, as may be appropriate, shall also be notified of the [unusual] event or incident by the facility.”<sup>121</sup> Thus, if during a

---

119. TENN. CODE ANN. § 68-11-211(d)(1) (2007) (amended 2009).

120. *Id.* § 68-11-211(c)(7). “An unusual event also includes an incident resulting in the abuse of a patient.” *Id.*

121. *Id.* § 68-11-211(d)(1). In order to provide guidance to medical providers, the statute listed examples of situations that could result in unusual events:

The following represent circumstances that could result in an unusual event that is an unexpected occurrence or accident resulting in death or life-threatening or serious injury to a patient, not related to a natural course of the patient’s illness or underlying condition. The circumstances that could result in an unusual event include, but are not limited to:

- (A) Medication errors;
- (B) Aspiration in a non-intubated patient related to conscious or moderate sedation;
- (C) Intravascular catheter related events, including necrosis or infection requiring repair, or intravascular catheter related pneumothorax;
- (D) Volume overload leading to pulmonary edema;
- (E) Blood transfusion reactions, use of wrong type of blood or delivery of blood to the wrong patient;
- (F) Perioperative or periprocedural related complications that occur within forty-eight (48) hours of the operation or the procedure
- ...
- (G) Burns of a second or third degree;
- (H) Falls resulting in radiologically proven fractures, subdural or epidural hematoma, cerebral contusion, traumatic subarachnoid hemorrhage, or internal trauma, but does not include fractures resulting from pathological conditions; and

patient's treatment, the physician or member of the treating team made a mistake that ultimately resulted in a medical error, the patient was entitled to be informed of such event. In 2009, the Tennessee legislature amended the statute, and disclosures of "unusual events" are no longer mandatory.<sup>122</sup> Currently, the statute only requires a medical facility to notify a patient and a patient's family about incidents of "abuse, neglect, and misappropriation."<sup>123</sup>

Although the Tennessee legislature removed the statutory requirement that medical providers disclose medical errors to their patients, transparency will still be encouraged if the legislature amends Tennessee's apology law to include statements of fault made by health care providers following a medical error. This strategy would encourage disclosure of medical errors to affected patients and their families without having to recreate a coercive mandatory disclosure statute. Such amendment would also cultivate broader protection for health care providers and ultimately create an environment that incentivizes a more transparent and honest disclosure following a medical error.

A sincere apology offers several advantages in the health care arena.<sup>124</sup> An apology has positive emotional and psychological effects on both the wrongdoer and the victim.<sup>125</sup> Although an

---

(I) Procedure related incidents, regardless of setting and within thirty (30) days of the procedure and includes readmissions

*Id.* § 68-11-211(d)(1)(2).

122. TENN. CODE ANN. § 68-11-211 (2012).

123. *Id.* § 68-11-211(c).

124. The value of an apology is not a recent revelation in the health care industry. Many medical organizations have emphasized the importance of honest communications and apologies between patients and physicians. See Nicole Saitta & Samuel D. Hodge, Jr., *Efficacy of a Physician's Words of Empathy: An Overview of State Apology Laws*, 112 J. AM. OSTEOPATH ASS'N 302, 302 (2012), <http://jaoa.org/article.aspx?articleid=2094499>. For example, section 2 of the American Osteopathic Association's Code of Ethics states, "The physician shall give a candid account of the patient's condition to the patient or to those responsible for the patient's care." *AOA Code of Ethics*, AM. OSTEOPATH ASS'N, <http://www.osteopathic.org/inside-aoa/about/leadership/Pages/aoa-code-of-ethics.aspx> (last visited Dec. 22, 2014).

125. See Nicole Marie Saitta & Samuel D. Hodge, Jr., *Is it Unrealistic to Expect a Doctor to Apologize for an Unforeseen Medical Complication?—A Primer on Apologies Laws*, 82 PA BAR. ASS'N. Q. 93, 94 (2011); see also Beverly Engel, *The Power of Apology*, PSYCHOL. TODAY, July 1, 2002,

apology alone cannot undo the wrongful act itself, an apology has the effect of placating an individual's anger toward the wrongdoer by lessening the negative effects of that action.<sup>126</sup> Frequently, apologies work as efficient dispute resolution tools because forgiveness often depends on an apology.<sup>127</sup> If a physician or hospital representative offers a sincere apology to the patient for harm they caused, the patient has an opportunity to forgive. Additionally, ethical and professional duties urge physicians and hospital representatives to take responsibility for their actions, regardless of the impending consequences.<sup>128</sup> A physician's fault-admitting statement may help prevent future, similar medical mistakes.<sup>129</sup> In order to understand the root cause of a medical error and prevent a future occurrence, an open and honest discussion of the error must first take place.<sup>130</sup> Further, a fault admitting statement made by a physician to a patient aids in decreasing the patient's anger towards the physician for his or her mistake.<sup>131</sup>

It stands to reason that if a patient has the opportunity to forgive the physician for injuries they experienced, the likelihood of the patient filing a frivolous malpractice suit decreases.<sup>132</sup>

---

<http://www.psychologytoday.com/articles/200208/the-power-apology> (“[An apology] is an important ritual, a way of showing respect and empathy for the wronged person.”).

126. See Saitta & Hodge, Jr., *supra* note 125, at 94.

127. See Rubel-Seider, *supra* note 2, at 481.

128. See Aviva A. Orenstein, *Apology Excepted: Incorporating a Feminist Analysis into Evidence Policy Where You Would Least Expect It*, 28 SW. U. L. REV. 221, 264 <http://www.repository.law.indiana.edu/cgi/viewcontent.cgi?article=1554&context=facpub> (“By disclosing and apologizing, a doctor is able to fulfill the physician's ethical responsibility of being truthful and loyal.”).

129. If an honest, fault-admitting statement is made to a patient, the hospital may use that information following a medical error to prevent it from occurring down the road, ultimately increasing patient safety. Ebert, *supra* note 43, at 358.

130. 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).

131. See Ebert, *supra* note 43, at 358.

132. See Saitta & Hodge, Jr., *supra* note 124, at 303 (“Monetarily, an apology decreases the financial consequences that result from litigating a medical malpractice claim.”); see also Jennifer K. Robbennolt, *Apologies and Legal Settlement: An Empirical Examination*, 102 MICH. L. REV. 460, 485–86 (2003). Following a survey study conducted in order to examine the effects of sincere

However, the manner and tone of a health care provider's apologetic statement to a patient is critical; an apology that truly accepts responsibility for past actions is considered more effective than a statement simply acknowledging empathy.<sup>133</sup> Generally, there are three essential elements to an effective apology: an expression of sympathy for the challenges or sufferings that the patient is experiencing, an admission of fault, and an expression of remorse or regret.<sup>134</sup>

Still, laws among the states vary widely regarding the evidentiary protections afforded to physicians and hospital representatives for apologetic statements made to patients following a medical error.<sup>135</sup> One of the primary variations among state laws is

---

apologies on a patient's willingness to accept a settlement offer following a medical error, the results suggested that when provided a full apology, 73 percent of surveyed patients were inclined to accept the offer, while only 52 percent would accept in the absence of an apology. *Id.*

133. See Saitta & Hodge, Jr., *supra* note 125, at 94.

134. See Rubel-Seider, *supra* note 2, at 481; see also Robbennolt, *supra* note 132, at 486 (acknowledging that apologies can be defined in various ways and consist of various elements).

In its fullest form, the apology has several elements: expression of embarrassment and chagrin; classification that one known what conduct had been expected and sympathizes with the application of negative sanction; verbal rejection, repudiation, and disavowal of the wrong way of behaving along with vilification of the self that so behaved; espousal of the right way and an avowal henceforth forth to pursue that course; performance of penance and the volunteering of restitution.

*Id.* However, other definitions of an effective apology require fewer, simpler elements. For instance, Nicholas Tavuchis proposes that an apology must at least consist of an "acknowledgement of the legitimacy of the violated rule, admission of fault and responsibility for its violation, and the expression of genuine regret and remorse for the harm done." NICHOLAS TAVUCHIS, *MEA CULPA: A SOCIOLOGY OF APOLOGY AND RECONCILIATION* 3 (Stanford Univ. Press ed., 1991). Despite its effectiveness, it is clear that not every definition of an effective apology requires an admission of fault on behalf of the wrongdoer.

135. Although many state apology laws are catalogued under a particular state's rules of evidence relating to medical errors, some states protect apologies irrespective of whether such statements pertain to a medical malpractice claim. Saitta, *supra* note 124, at 306. Tennessee's apology law applies broadly across all industries and is not just limited to statements made by medical providers. See TENN. R. EVID. 409.1(a). Along with Tennessee, ten other states have adopted an apology law with general applicability, including: California, Flori-

whether a state's statutory protections for apologetic gestures also include safeguards for a physician's statements of fault.<sup>136</sup> A fault-admitting statement includes language such as, "I am sorry about what happened, this was my fault." A majority of states have enacted statutory protections for *apologies* made by physicians and hospital representatives, but most of these states do not protect a medical provider's *admissions of fault*.<sup>137</sup> This is the case even if an admission of fault is integrated into a physician's sincere expression of sympathy.<sup>138</sup> Thus, it is important that physicians know what types of empathetic statements are protected under the laws of their state so that they may avoid misspeaking and inadvertently increasing the likelihood of liability following a medical error. Currently, only a few states have enacted apology laws protecting medical providers' statements of fault from being used in malpractice actions. These states include: Arizona,<sup>139</sup> South Caro-

---

da, Hawaii, Indiana, Iowa, Massachusetts, Missouri, Nebraska, Texas, and Washington. See Mastroianni, *supra*, note 64, at 1619 n.37.

136. See Jonathan R. Cohen, *Legislating Apology: The Pros and Cons*, 70 U. CIN. L. REV. 819, 820 (2002) (discussing the ability of fault admitting apologies to alter the outcome of malpractice litigation if not afforded protection); see also Saitta & Hodge, Jr., *supra* note 124, at 303 (explaining that patients have greater respect for physicians when their apologies contain admissions of fault, thereby increasing patients' willingness to settle).

137. See *Davis v. Wooster Orthopedics & Sports Med., Inc.*, 952 N.E.2d 1216 (Ohio Ct. App. 2011) (holding that the term "apology" as used in the Ohio statute barring admissions of a health care provider's apologies for an unanticipated outcomes of medical care does not include admissions of fault); see also *Lawrence v. MountainStar Healthcare*, 320 P.3d 1037, 1051 (Utah Ct. App. 2014) (holding that Utah's apology law does not bar statements of fault made by a medical provider following an unanticipated outcome of medical care); see also Ebert, *supra* note 43, at 357.

138. See Ebert, *supra* note 43, at 357.

139. In full, Arizona's full apology law protects, [A]ny statement, affirmation, gesture or conduct expressing apology, *responsibility*, liability, sympathy, commiseration, condolence, compassion or a general sense of benevolence that was made by a health care provider or an employee of a health care provider to the patient, a relative of the patient, the patient's survivors or a health care decision maker for the patient and that relates to the discomfort, pain, suffering, injury or death of the patient as the result of the unanticipated outcome of medical care is inadmissible as evidence of an admission of liability or as evidence of an admission against interest.

lina,<sup>140</sup> Connecticut,<sup>141</sup> Georgia,<sup>142</sup> Washington,<sup>143</sup> and Colorado.<sup>144</sup> These particular states reward those medical professionals

---

Ariz. Rev. Stat. § 12-2605 (West Supp. 2012) (emphasis added). Arizona's statute is one relating specifically to unanticipated outcomes of a patient's medical care. *Id.*

140. South Carolina's apology statute is construed as a full apology law, protecting,

[A]ny and all statements, affirmations, gestures, activities, or conduct expressing benevolence, regret, apology, sympathy, commiseration, condolence, compassion, mistake, error, or a general sense of benevolence which are made by a health care provider, an employee or agent of a health care provider, or by a health care institution to the patient, a relative of the patient, or a representative of the patient and which are made during a designated meeting to discuss the unanticipated outcome shall be inadmissible as evidence and shall not constitute an admission of liability or an admission against interest.

S.C. CODE ANN. § 19-1-190(D) (West Supp. 2012). Thus, both apologies and statements of fault made by medical providers following unanticipated medical outcomes are not admissible to prove that the physician is liable.

141. Connecticut has adopted a full apology law, covering both apologies and statements of fault. The relevant statutes reads,

[A]ny and all statements, affirmations, gestures or conduct expressing apology, *fault*, 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 a result of the unanticipated outcome of medical care shall be inadmissible as evidence of an admission of liability or as evidence of an admission against interest.

CONN. GEN. STAT ANN. § 52-184d(b) (West 2013) (emphasis added).

142. Georgia is also considered to have implemented a full apology law, protecting,

[A]ny and all statements, affirmations, gestures, activities, or conduct expressing benevolence, regret, apology, sympathy, commiseration, condolence, compassion, mistake, error, or a general sense of benevolence which are made by a health care provider or an employee or agent of a health care provider to the patient, a relative of the patient, or a representative of the patient and which relate to the unanticipated outcome shall be inadmissible as evidence and shall not constitute an admission of liability or an admission against interest.

who hold themselves accountable for their actions by shielding them from liability based solely on their fault admitting statements.<sup>145</sup> For example, according to the clear language found in Colorado's apology law, which strictly applies to expressions made by medical providers, statements of fault are inadmissible as later evidence of liability.<sup>146</sup> Colorado's statute reads:

[A]ny and all statements, affirmations, gestures, or conduct expressing apology *fault*, sympathy, commiseration, condolences, 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 an alleged victim, or a representative of the alleged victim and

---

GA. CODE ANN. § 24-3-37.1(c) (2014). Although Georgia's statute does not explicitly address statements of fault, a Georgia state appeals court previously held that a physician's statement, "this was my fault," clearly fell within the language and scope of the statute's protections. *See Airasian v. Shakk*, 657 S.E.2d 600, 602 (Ga. Ct. App. 2008).

143. The state of Washington has also adopted a full apology law, protecting both apologetic expressions and statements of fault made by health care providers following a medical error. The statute protects, "(i) Any statement, affirmation, gesture, or conduct expressing apology, fault, sympathy, commiseration, condolence, compassion, or a general sense of benevolence." WASH. REV. CODE § 5.64.010(2)(b)(i) (2014).

144. COLO. REV. STAT. ANN. § 13-25-135(1) (2014). *See* David Doyle, *Apologizing for Medical Missteps: Whether it's a Mistake for Physicians*, PHYSICIANS PRACTICE (Feb. 22, 2014), <http://www.physicianspractice.com/blog/apologizing-for-medical-missteps-whether-its-a-mistake-for-physicians>. Many states have enacted partial apology laws, protecting only statements of "compassion, commiseration, condolence, or sympathy." *Id.* However, states that have implemented full apology laws protect against all types of statements, such as, "statements of fault, errors, liability, or mistake." *Id.*

145. There are four overlapping reasons supporting the contention that fault-admitting statements should be statutorily protected. First, it encourages parties to settle, avoiding the costly expenses of litigation. Second, apologies admitting fault promote open, honest, and direct communication with the patient after the injury. Third, fault-admitting statements allow the physician or hospital to express sympathy and acknowledge their willingness to admit that a mistake was made. Finally, protecting fault admitting encourages individuals to engage in morally correct behavior by apologizing after they have injured a patient. *See* Cohen, *supra* note 136, at 841.

146. COLO. REV. STAT. ANN. § 13-25-135(1) (2014).



which relate to the discomfort, pain, suffering, injury or death of the alleged victim as the result of the unanticipated outcome of a medical care shall be inadmissible as evidence of an admission of liability or as evidence of an admission against interest.<sup>147</sup>

Colorado's statutory language is precise, leaving physicians unable to speculate as to what types of apologetic statements and conduct are protected. This certainty of protection is likely to make physicians more willing to provide a patient affected by a medical error with a sincere apology, owning responsibility and mending the physician-patient relationship.

Statutory clarity in apology laws is important because if the language is ambiguous, the physician could, for example, mistakenly convey an admission of fault to the affected patient and that statement could potentially be used against them as evidence of liability if not protected by the state's applicable apology statute. Further, if physicians have to concern themselves with "the exact phrasing necessary to avoid a lawsuit," many physicians will decide to suspend or omit an apology completely.<sup>148</sup>

Tennessee adopted a partial apology law with general applicability, protecting only expressions of sympathy and benevolence in all civil settings and not specifically statements made by medical providers.<sup>149</sup> Tennessee's current statute has the potential

---

147. *Id.* (emphasis added). Connecticut has a similar full apology law that also expressly protects statements of fault, making it a clear and concise model that could be referenced by the Tennessee legislature when broadening Tennessee's apology law. See CONN. GEN. STAT. ANN §52-184(d) (2014).

148. See Maria Pearlmutter, *Physician Apologies and General Admissions of Fault: Amending the Federal Rules of Evidence*, 72 OHIO ST. L.J. 687, 702 (2011); see also William M. McDonnell & Elizabeth Guenther, *Narrative Review: Do State Laws Make it Easier to Say "I'm Sorry?"*, 149 ANNALS INTERNAL MED. 811, 812 (2008) ("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 physicians disclosure an apology.").

149. TENN. R. EVID. 409.1(a) (2014); see Stephen E. Raper, *No Role for Apology: Remedial Work and the Problem of Medical Injury*, 11 YALE J. HEALTH POL'Y L. & ETHICS 269, 318 (2011). Contrary to a full apology, "[a] 'partial apology' is one in which the offending party expresses sympathy and hope for rapid recovery, but does not accept responsibility for the accident causing the injury." Michael B. Runnels, *Apologies All Around: Advocating Federal*

to cause physicians and medical providers to be skeptical about delivering apologies to affected patients for fear of inadvertently saying something that may be used against them in a later lawsuit. Since the absence of an apology can lead to angered patients and the increased likelihood of frivolous malpractice actions being filed against the physician or hospital, the Tennessee legislature should amend Tennessee's existing partial apology law by adding a separate, full apology provision, similar to Colorado's apology law. This provision should specifically provide protections to health care providers' apologetic and fault-admitting statements. By broadening Tennessee's apology law, hospitals and medical providers within the state would likely be more willing to implement full disclosure programs within their facilities due to the enhanced protections of statements made during communication with affected patients. As written, the current Tennessee apology law reads as follows:

That portion of statements, writings, or benevolent gestures expressing sympathy or a general sense of benevolence relating to the pain, suffering or death of a person involved in an accident and made to such person or to the family of such person shall be inadmissible as evidence of an admission of liability in a civil action. *A statement of fault that is part of, or in addition to, any of the above shall not be inadmissible because of this Rule.*<sup>150</sup>

Because Tennessee's current apology law is one of general applicability to all individuals in various types of civil actions, the Tennessee legislature should amend the statute by adding a separate provision specifically addressing statements made by medical providers. The language within this provision should protect not only benevolent gestures, but also apologetic expressions and statements of fault in order to eliminate the gray area and encourage a fuller, more honest disclosure process. Patients and physicians in Tennessee would gain significant benefits from the addi-

---

*Protection for the Full Apology in Civil Cases*, 46 SAN DIEGO L. REV. 137, 149 (2009).

150. TENN. R. EVID. 409.1(a) (2014) (emphasis added).

tion of a full apology provision as compared to the current partial apology law. In effect, this provision would help create an environment that encourages the implementation of disclosure programs within Tennessee's medical facilities.<sup>151</sup> The following section to the Tennessee apology statute should be added:

(b) That portion of statements, writings, or benevolent gestures expressing apology, fault, sympathy, commiseration, condolences, or compassion, which are made by a health care provider or an employee of a health care provider to a patient or to a patient's family and which relate to the pain, suffering, injury, or death of that person shall be inadmissible as evidence of an admission of liability in a civil action.

Adding this additional, separate provision addressing only statements made by health care providers creates differentiation between protections afforded in the general civil setting and those made by a health care provider in a medical setting. With the additional amendment, the Tennessee statute still provides protection for sympathetic statements and benevolent gestures in general civil actions, but also provides greater protection for health care providers' statements following a medical error, allowing physicians more leeway when providing a genuine, full apology, thus decreasing the likelihood of litigation.<sup>152</sup> This broader apology law will support the initiative that hospitals and health care facilities within Tennessee adopt full disclosure programs.

---

151. See Pearlmutter, *supra* note 148, at 697 ("A full apology was seen as more moral and regretful, and the giver of such an apology was perceived to be less likely to offend in the future."); see also Jennifer K. Robbennolt, *Apologies and Legal Settlement: An Empirical Examination*, 102 MICH. L. REV. 460, 487 (2003) (explaining the findings of a study that showed full apologies were more sufficient than a partial apology which only expressed sympathy).

152. But see Mastroianni et al., *supra* note 64, at 1616 (explaining that even after a sincere apology, some patients will still choose to file suit, especially if the "injury entails large economic losses and there is no offer of compensation").

## VI. PROPOSED AMENDMENT TO EXPAND TENNESSEE'S PRE-SUIT NOTICE PERIOD FOR A HEALTH CARE LIABILITY ACTION

In 2008, the Tennessee legislature amended the late Tennessee Medical Malpractice Act<sup>153</sup> by enacting a new pre-suit notice statute. This statute requires a plaintiff patient in a health care liability action to give the defendant health care provider pre-suit notice of his or her claim at least 60 days prior to filing the initial complaint with the court.<sup>154</sup> If a plaintiff complies with the requirements of this statute, the plaintiff's statute of limitations for his or her claim is extended by 120 days.<sup>155</sup> The pre-suit notice period is occasionally referred to as a "cooling off period" because it allows both the plaintiff and the defendant time to analyze and investigate the issue at hand while also encouraging a possible settlement.<sup>156</sup> During this "cooling off period" the plaintiff may become less angered and have the opportunity to process the situation rationally. A longer statutory pre-suit notice period before filing suit allows physicians and health care providers to more thoroughly review reported claims and hold disclosure meetings without the

---

153. During a tort reform in 2011, the Tennessee Medical Malpractice Act was replaced with the Tennessee Civil Justice Act of 2011. The Tennessee Civil Justice Act currently governs all health care liability actions within the state of Tennessee that accrued on or after June 16, 2011. The initial 60 day pre-suit notice requirement established in the Medical Malpractice Act is still currently in effect. *See Myers v. AMISUB (SFH), Inc.*, 382 S.W.3d 300, 308-09 (Tenn. 2012).

154. TENN. CODE ANN. § 29-26-121(a)(1) (2014). The statute further sets forth what information the pre-suit notice must include:

- (A) The full name and date of birth of the patient whose treatment is at issue;
- (B) The name and address of the claimant authorizing the notice and the relationship to the patient, if the notice is not sent by the patient;
- (C) The name and address of the attorney sending the notice, if applicable;
- (D) A list of the name and address of all providers being sent a notice; and
- (E) A HIPPA complaint medical authorization permitting the provider receiving the notice to obtain a complete medical records from each other provider being sent a notice.

*Id.* § 29-26-121(a)(2).

155. TENN. CODE ANN. § 29-26-121(c) (2014). The statute also delineates how the notice may be delivered to the defendant via personal delivery or mail in order to qualify for the extended statute of limitations. *Id.* at § 29-26-121(3).

156. *See Bogue, supra* note 66, at 104.

pressure of a pending lawsuit and deadlines. Accordingly, an amendment to expand Tennessee's pre-suit notice period would decrease frivolous medical malpractice litigation because it would encourage hospitals and health care providers to implement full disclosure programs based on transparency and honest communication with their patients.

A majority of states have enacted legislation requiring plaintiffs to provide defendants with statutory pre-suit notice of their intent to file a medical malpractice claim.<sup>157</sup> The length of mandatory pre-suit notice periods among states varies largely, ranging from a short 30 days to lengthier 182 days.<sup>158</sup> Tennessee falls in the middle of the spectrum with a 60 day pre-suit notice period, meaning that a plaintiff must provide a defendant with his or her intent to file suit at least 60 days before actually filing a health care liability complaint with the court.<sup>159</sup> The Tennessee statute reads, in full:

(a)(1) Any person, or that person's authorized agent, asserting a potential claim for medical malpractice shall give written notice of the potential claim to each health care provider that will be a named defendant at least sixty (60) days before the filing of a complaint based upon medical malpractice in any court of this state.<sup>160</sup>

Although Tennessee's pre-suit notice period is not considered short when compared to some other states' notice periods,<sup>161</sup> 60 days does not provide considerable time to investigate claims

---

157. See Haavi Morreim, *Malpractice, Mediation, and Moral Hazard: The Virtues of Dodging the Data Bank*, 27 OHIO ST. J. DISP. RESOL. 109, 142 (2012) (highlighting the length of various states' pre-suit notice periods).

158. *Id.*

159. TENN. CODE ANN. § 29-26-121(a)(1) (2014). To receive an explanation regarding the purpose behind Tennessee's statutory 60 day notice period, see *Myers v. AMISUB (SFH), Inc.*, 382 S.W.3d 300, 309 (2012) ("The essence of Tennessee Code Annotated section 29-26-121 is that a defendant be given notice of a medical malpractice claim before suit is filed.").

160. TENN. CODE ANN. § 29-26-121(a)(1) (2014).

161. In order to file a medical malpractice action in West Virginia, the Plaintiff must provide the medical provider with thirty-days notice. W. VA. CODE § 55-7B-6(b) (2014).

and communicate with patients as would a longer statutory period. As discussed above, in order for successful disclosure programs to run efficiently, hospitals and medical providers need more time to properly evaluate each step that leads to patient injuries.<sup>162</sup> For example, both Michigan's<sup>163</sup> and Massachusetts's<sup>164</sup> pre-suit notice

---

162. *See supra* Part IV.

163. MICH. COMP. LAWS ANN. § 600.2912b(1) (West 2014). The legislative purpose behind the 182 day notice requirement “was to provide a mechanism for ‘promoting settlement without the need for formal litigation, reducing the cost of medical malpractice litigation, and providing compensation for meritorious medical malpractice claims that would otherwise be precluded from recovery because of litigation costs. . . .’” *Bush v. Shabahang*, 772 N.W.2d 272, 283 (Mich. 2009) (quoting Senate Legislative Analysis, SB 270, August 11, 1993). Additionally, the Michigan statute allows the 182-day notice period to be lessened to 91 days if the following conditions are satisfied:

(3) The 182-day notice period required in subsection (1) is shortened to 91 days if all of the following conditions exist:

(a) The claimant has previously filed the 182-day notice required in subsection (1) against other health professionals or health facilities involved in the claim.

(b) The 182-day notice period has expired as to the health professionals or health facilities described in subdivision (a).

(c) The claimant has filed a complaint and commenced an action alleging medical malpractice against 1 or more of the health professionals or health facilities described in subdivision (a).

(d) The claimant did not identify, and could not reasonably have identified a health professional or health facility to which notice must be sent under subsection (1) as a potential party to the action before filing the complaint.

MICH. COMP. LAWS ANN. § 600.2912b(3) (West 2010).

164. MASS. GEN. LAWS ANN. ch. 231, § 60L(a) (Westlaw through Ch. 95 of 2015 1st Ann. Session). Similar to Michigan, the Massachusetts statute also allows its 182-day notice period to shorten to 90 days if one of two requirements is met. The statute reads, in pertinent part:

(c) The 182-day notice period in subsection (a) shall be shortened to 90 days if:

(1) the claimant has previously filed the 182-day notice required against another health care provider involved in the claim; or

(2) the claimant has filed a complaint and commenced an action alleging medical malpractice against any health care provider involved in the claim.

*Id.* ch. 231, § 60L(c) (Westlaw through Ch. 95 of 2015 1st Ann. Session).

statutes state that a plaintiff who intends to file suit against a defendant is required to provide a notice of intent not less than 6 months (182 days) before actually filing the malpractice complaint. Longer pre-suit notice periods allow plaintiff patients significant time to analyze the strength of their potential claims and decide whether they plan to continue to pursue litigation.<sup>165</sup> Further, an expansive pre-suit notice period allows defendant health care providers to investigate the alleged claims and offer the plaintiff alternative remedies or settlement figures.<sup>166</sup> With a longer notice period, the parties can take the time to review and exchange information pre-litigation, which saves time, money, and unnecessary expenses.<sup>167</sup> Disclosing important information up front that will eventually be revealed during discovery promotes efficiency and provides the opportunity to minimize or eliminate litigation.<sup>168</sup> An extended pre-suit notice period encourages increased transparency and communication between the parties without patients sacrificing their right to bring suit at a later date.<sup>169</sup>

Tennessee would benefit from an extended pre-suit notice period because it would create an environment that encourages the adoption of full disclosure programs by health care facilities across the state. Institutions within the state of Michigan have shown success in using its prolonged notice period to both analyze the potential claims and engage the patient or family during the process.<sup>170</sup> If Tennessee were to amend its current 60 day notice period to 182 days, it would encourage the implementation of full disclosure policies and programs within hospitals and other facilities throughout the state. In effect, this amendment would allow time

---

165. See Bogue, *supra* note 66, at 104.

166. See *id.*; Boothman et al., *supra* note 36, at 137–38.

167. See Bogue, *supra* note 66, at 104.

168. See *id.*; Dwight Golann, *Dropped Medical Malpractice Claims: Their Surprising Frequency, Apparent Causes, and Potential Remedies*, 30 HEALTH AFF. 1343, 1346 (2011), <http://content.healthaffairs.org/content/30/7/1343.full.pdf> (stating that the information gained while investigating claims in the course of litigation is a primary reason that plaintiff's decide to abandon their claims).

169. See Bogue, *supra* note 66, at 104.

170. See *id.* (“Because Michigan already requires a 182-day notice period, UMHS took advantage of this built-in six-month period to have their committee thoroughly review claims and hold the disclosure meetings, without the added pressure on both parties of an already-pending lawsuit.”).

for health care providers to investigate alleged claims, allow greater opportunity for providers to communicate with the affected patients, and ultimately engage the parties to participate in settlement discussions, effectively decreasing frivolous health care liability actions. To extend the pre-suit notice period, the relevant Tennessee statute should read:

(a)(1) Any person, or that person's authorized agent, asserting a potential claim for medical malpractice shall give written notice of the potential claim to each health care provider that will be a named defendant at least 182 days before the filing of a complaint based upon medical malpractice in any court of this state.

Ultimately, in conjunction with a broader apology law discussed in Part V, an amendment to expand Tennessee's pre-suit notice period would decrease frivolous litigation because hospitals and health care providers would have a greater incentive to implement full disclosure programs that emphasize honesty and communication within their facilities.<sup>171</sup>

## VII. CONCLUSION

Preventable medical errors play a large role in frivolous medical malpractice litigation. These malpractice actions may be avoided by simply encouraging transparency and communication within the health care setting. If health care providers engaged in more transparent disclosure and provided affected patients with a sincere apology that acknowledged responsibility, patients would feel less of a need to turn to the courts for redress. Additionally, longer pre-suit notice periods allow both physicians and patients to participate in a more effective communication process due to the requirement that patients provide health care providers with their intent to file a potential malpractice claim during a certain extended time period before his or her claim is actually filed with the court. Many states have statutes that provide the necessary protections for physicians to have the opportunity to engage in these

---

171. *See supra* Part V.



types of discussions.<sup>172</sup> Many hospitals within these states that have implemented successful disclosure programs are self-insured institutions.<sup>173</sup> These self-insured hospitals retain many benefits that third-party insured hospitals do not enjoy, such as greater control over malpractice premiums and vast discretion in deciding how to handle medical errors.<sup>174</sup>

Furthermore, effective communication between physicians and patients allows for questions to be answered and anger to be diffused, potentially decreasing frivolous malpractice litigation and increasing patient safety. Several effective disclosure programs implemented in other states emphasize the idea of transparent communication, apologies, and cooling off periods.<sup>175</sup> Currently, Tennessee has a statute of general applicability that protects expressions of benevolence made in civil suits from being used to prove liability.<sup>176</sup> In order for health care providers to express a sincere apology and acknowledge responsibility for their mistake, a separate provision that specifically protects apologies and statement of fault made by health care providers must be added to Tennessee's statute. Additionally, Tennessee would benefit from a longer pre-suit notice period for the same reasons. Currently, Tennessee has a pre-suit notice period of 60 days. A longer notice period would allow for more effective communication and investigations in order for patients and health care providers to determine the strength of the potential claim. Thus, Tennessee's pre-suit notice statute should be amended to require patients to afford health care providers with their intent to file a claim at least 182 days before the actual complaint is filed with the court. The ultimate goal of amending these two Tennessee statutes is to increase patient safety and encourage health care providers and hospital systems in Tennessee to implement full disclosure programs so as to decrease the number of frivolous health care liability actions that arise from preventable medical errors.

---

172. See *supra* Parts V and VI.

173. See *supra* Part IV. Both UMHS and the VA are self-insured institutions that have implemented successful full disclosure programs.

174. See Bordonaro, *supra* note 99; Cohen, *supra* note 85, at 1471.

175. See *supra* Parts IV and VI.

176. TENN. R. EVID. 409.1(a) (2014).