



Will Saying “I’m Sorry” Prevent a Malpractice Lawsuit?

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The Case

On a Saturday evening, a 68-year-old woman complaining of cough, difficulty in breathing, and fever entered the emergency department of a local community hospital. The emergency physician on duty examined the patient, and although she found no specific abnormality, she nonetheless ordered chest radiography. After reviewing the radiographs herself and finding them to be within normal range, the emergency physician discharged the patient with a diagnosis of upper respiratory infection and instructed the woman to contact her private physician if her symptoms did not abate. The physician elected not to consult with the on-call radiologist who was at home but available by telephone.

The following morning, the radiologist on duty for the weekend interpreted the radiographs and dictated a report that stated, “Chest is most likely normal. However, there is a small ill-defined density in the right upper lobe, most likely representing a scar. If no previous films are available for comparison, CT scan should be considered for further evaluation.” At the time he rendered his interpretation, the radiologist had access to a form indicating that the emergency physician had interpreted the films as normal.

A year later, the patient was referred by her primary care physician to the hospital’s outpatient radiology department for chest radiography because of a persistent cough. The same radiologist who had interpreted the chest radiographs a year earlier reviewed the new study. It disclosed a 2.5-cm round lesion in the patient’s right upper lobe, similar in location to where the radiologist had seen the density on the previous study. Moderate mediastinal lymphadenopathy was also present. The findings were clearly suspicious for carcinoma, and indeed the diagnosis of non-small cell carcinoma was confirmed 3 days later, after bronchoscopy.

Concerned that the patient might not have been told about the questionable abnormality reported on the initial chest radiographs obtained a year earlier, the radiologist consulted the department chair, who then contacted both the chair of the emergency department and the patient’s private physician. They quickly discovered that the written report issued by the radiologist on the day after the patient’s emergency visit had been inserted in the patient’s emergency department chart long after the patient had been discharged, and thus a physician apparently had never interpreted it. The name of the patient’s primary care physician was not listed either on the original radiology requisition form or the subsequently issued report. A copy of the written report of the chest radiography therefore had never been sent to the physician.

Because it now became obvious that the patient had never been informed of the questionable abnormality present on her original chest radiographs, the question immediately arose whether the patient should be informed of the now-apparent failure of communication. A conference among the reading radiologist and his chair, the chair of the emergency department, the attending physician, and the hospital’s risk manager was quickly convened to discuss the matter. They agreed unanimously that the patient should be informed of the communication failure and both the chair of the departments of emergency services and radiology should meet with the patient, who by now had been admitted as an inpatient to the hospital.

The following day the two chairs met with the patient and her husband. They informed the couple of the failure to communicate the results of the initial radiographs obtained a year earlier, attempted to explain why the failure had occurred, and offered their apologies for the breakdown.

Soon afterward, the patient underwent a thoracotomy, during which the right upper lobe

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was resected and a biopsy was taken of the mediastinal lymph nodes, which later were found to be involved with metastases. After discharge from the hospital, the patient underwent chemotherapy at the hospital and continued to have periodic follow-up chest radiographs.

Six months later, the patient filed a medical malpractice lawsuit against the hospital, the emergency department physician, and the radiologist who had interpreted the initial chest radiographs, alleging negligence by their failure to communicate to her the possibility of lung cancer, which would have "resulted in there being a 90% probability of cure."

Malpractice Issues

The ensuing legal discovery process revealed a hospital policy stipulating that if radiologic examinations obtained after hours are interpreted by an emergency department physician, a radiologist should review those studies and interpret them officially the following day. If the radiologist discovered a discrepancy between the two interpretations, the radiologist should "personally" communicate it to emergency department personnel. In this particular case, no record indicated that the radiologist had contacted either a physician or any other person in the emergency department the following morning to notify them of a discrepancy. The written report had found its way to the patient's chart, but the chart had languished in the hospital's medical records department unread until the cancer was discovered a year later. When questioned in his deposition about whether he had personally communicated the questionable abnormal lung finding to either a physician or a nurse in the emergency department on the day he rendered his interpretation, the radiologist replied that he "thought he had called the emergency physician on duty at the time, but could not remember for sure."

A radiology expert witness retained by the plaintiff testified in a discovery deposition that the defendant radiologist had breached the standard of care by failing to communicate directly the potential abnormality in the chest radiograph to an emergency department physician. A radiology expert witness retained by the defense testified that although direct communication by the radiologist "would have been helpful, it was not required" because the defendant radiologist "had every reason to believe that emergency department personnel would have discovered the discrepancy."

The attorneys and professional liability insurance claims managers representing the var-

ious codefendants concluded that the lawsuit could not be defended successfully, and, with the approval of the defendant physicians and hospital, they began settlement negotiations with the plaintiff. The lawsuit was eventually resolved with a total payment to the plaintiff of \$1 million, with the emergency physician and hospital each paying \$200,000 and the radiologist paying the balance of \$600,000.

Postscript to the Settlement: Effect of "The Apology"

After the settlement, the patient continued to undergo treatment and periodic diagnostic testing at the hospital until her death 2 years later. During this period, the risk manager of the hospital arranged a meeting with the patient and her husband to discuss her illness and the subsequent lawsuit and settlement. The patient and her husband said that they were at first dismayed and then angry when they were told about the failure in communicating to them the results of the original chest radiographs. They said they "appreciated" that the department chairs of both emergency services and radiology had informed them and expressed their "sorrow" about the delay in communication. But after discussing the matter with their children and other relatives, the couple became convinced they were victims of medical malpractice and were thus "entitled" to be compensated. They then consulted a personal injury attorney who later filed the lawsuit. They acknowledged that had the emergency and radiology chairs not told them about the error regarding the failure to communicate the original chest radiography results, they in all likelihood would never have discovered the mistake and thus would not have had any reason to file a malpractice lawsuit. Throughout the entire legal proceeding including the settlement negotiations, both the patient and her husband continued to think the "hospital and its doctors" were "doing a good job" and thus felt no compunction to look elsewhere for medical care.

Discussion: To Tell or Not to Tell

For many months during discovery proceedings and even after the lawsuit was resolved through settlement, the defendant radiologist ruminated over and over again about whether he had done the "right thing" by bringing the matter of the failed communication to the radiology department chair. "I knew when I saw the cancer on the follow-up chest radiograph that I had screwed up by not calling the emergency department physician

on the day I read the initial film," confided the radiologist. "My dilemma was," he continued, "whether I should simply report the cancer on the second film and say nothing to anybody about the first reading in hopes that the error would never be discovered or should I go ahead and report the error." The radiologist opted to report the communication failure to his chair, who then, as already described, took the matter to the emergency department chair and the hospital's risk manager.

The temptation not to report a medical error should not be underestimated. One published study [1] disclosed that only 50% of house staff physicians who admitted making serious clinical errors disclosed their errors to medical colleagues, and only 25% disclosed them to the patients or their families. In another published survey of laypersons, only a third of respondents who had experienced medical error said that the physicians involved in the error had informed them about it [2]. Still another survey asking European physicians whether they would disclose a medical error to patients found that although 70% responded that physicians should provide details of such an event, only 32% would actually disclose the details of what happened [3]. A similar percentage of American physicians, 77%, echoed the same opinion [2].

A British researcher explains this reluctance to disclose by pointing out that physicians who commit medical errors frequently question their own competence and fear being discovered; they know they should confess but "dread the prospect of potential punishment" [4]. These reactions are "reinforced during medical training; the culture of medical school and residency implies that mistakes are unacceptable and point to a failure of effort or character."

Why physicians may choose to cover up rather than disclose an error was illustrated in a letter to the editor published in the *Journal of the American Medical Association* [5]. The letter described an incident in which a medical resident's employment in a Chicago hospital was summarily terminated after he voluntarily reported committing an error that led to the accidental exposure of a patient to HIV. The letter writer speculated that the resident's career would have remained intact and unblemished had he chosen to remain silent about the error and voiced concern that this incident would encourage an atmosphere that rewards lying. Certainly, many physicians believe that admitting mistakes invokes the so-called shame and blame mentality [6].

thereby precipitating medical malpractice litigation [7–9] and leading to loss of referrals, hospital admitting privileges, preferred provider status, and even licensure [10, 11]. Other researchers [12] have emphasized that being subjected to a malpractice lawsuit is “an extremely powerful punishment that strikes at the heart of the professional’s self-image as a caring and competent physician.”

The question of whether mistakes or errors committed by physicians should be disclosed to patients affected by them is no longer debatable. The preponderance of legal opinion, regulations of federal and state agencies, and policies of professional organizations all favor the physician’s complete disclosure of all facts and information relevant to a patient’s health, including complications of medical procedures and iatrogenic errors and injuries [13–16]. But the question of what physicians should say to patients as part of the disclosure of an error—in other words, whether they should apologize and, if so, what that apology should include—warrants further discussion.

Disclosure–Apology–Compensation: A New Algorithm

When one person has injured or wronged another, Judeo-Christian tradition prescribes a three-stage process by which people “right” the “wrong” they have committed: confession, which includes disclosure and apology; repentance, which includes the actions that a person who has harmed another undertakes to compensate for the error; and forgiveness, through which the person who has been harmed is adequately compensated [17]. For many years, medical organizations and ethicists have advocated the disclosure to patients of complications or medical errors. The concept of offering apologies, however, is of more recent origin.

In 1987, the management of the Veterans Affairs Medical Center (VAMC) in Lexington, Kentucky, took the practice of disclosing medical errors to patients one step further. The VAMC offered an apology and compensation for injury if it determined that error resulted in a physical or an earning-capacity loss [18]. The VAMC implemented a procedure by which patients were not only notified that an error had been committed, but in addition the patient or next of kin was told all the details of the error, including the identities of persons involved in the incident; was offered expressions of “regret of the institutions and personnel involved”; and was given compensation for the injury. This practice has been

quite successful. Before the initiation of the policy, the VAMC was among the nation’s Veterans Affairs hospitals that paid the most in claims; it is now among those that pay the least [19–21]. A similar “disclose–apologize–compensate” algorithm has been successful in achieving reductions in payments for patient injuries resulting from medical errors at other institutions, including the Dana Farber Cancer Institute in Boston [21, 22], University of Michigan Health System in Ann Arbor [21, 23], Johns Hopkins University in Baltimore [24], and Children’s Hospital in Minneapolis [22].

Interestingly, when in 2001 the Joint Commission for the Accreditation of Health Care Organizations included as a patient safety standard the disclosure to patients and families of unanticipated outcomes, it discussed the possibility of requiring apologies. It abandoned the idea, however, because of concerns that apologies could be used against physicians and hospitals in a court of law [20, 21].

States Legislate Immunity for Apologies

Fear that an apology offered by a physician could be used as incriminating evidence against the physician in court energized states to take legislative action that would provide legal immunity for expressions of apology or regret. In 1986, Massachusetts became the first state to adopt an immunity law when its legislature passed a statute that provides [21]

Statements, writings, or benevolent gestures expressing sympathy...relating to the pain, suffering, or death of a person...and made to such a person or to the family of such a person shall be inadmissible as evidence of an admission of liability in a civil action.

Thirteen years later, Texas passed a similar law, and as the 21st century unfolded, similar statutes were enacted in California, Florida, and Washington [21, 25]. By the end of 2005, apology-immunity statutes had been passed in 19 states [26, 27]. In Illinois, the recently passed legislation has been termed the “Sorry Works” law [28]. Senators Hillary Rodham Clinton of New York and Barack Obama of Illinois have introduced federal legislation that would include, among other measures, immunity for apologies [27, 29]. The trend to protect the statements of doctors legally who say they are “sorry for what has happened” from being used as self-incriminating evidence has spread

to England, where the United Kingdom National Patient Safety Agency has recently announced the “Being Open” policy, which it hopes to fully implement by mid 2006 [30].

Extrajudicial Admissions of Fault

The legal term “extrajudicial admission” is defined as a statement that an individual makes voluntarily outside the courtroom or legal proceeding that is against one’s own interest. A judge or jury can consider such admissions as evidence [21]. They are considered to be credible because it is assumed that one would not make a statement against one’s own interest unless that statement was true. The legal literature is replete with cases in which physicians have, in essence, acted as expert witnesses against themselves by having voluntarily “confessed” to patients who have sustained an adverse event by making comments like “I made a mess of things,” “What has happened is all my own fault,” “I should have run that test before the operation,” “This is a terrible thing I have done,” “I just made a mistake and got over too far [with the scalpel],” “I obviously messed up on the first one, and another surgery has to be done to repair the damage,” and “I am to blame for this” [16]. Although most state apology-immunity laws protect statements expressing sympathy from admissibility, they do not protect statements that admit fault. For example, the Florida statute states,

The portion of statements, writings, or benevolent gestures expressing sympathy...relating to the pain, suffering, or death of a person...made to that person or the family of that person shall be inadmissible as evidence in a civil action. A statement of fault, however, which is part of, or in addition to, any of the above shall be admissible [25].

The single exception to “immunity-for-apologies-but-not-for-admissions-of-fault” state laws is the statute that Colorado passed in 2003. This statute declares,

In any civil action brought by an alleged victim of an unanticipated outcome of medical care...any and all statements, affirmations, gestures, or conduct expressing apology, fault, sympathy, commiseration, condolence, compassion, or a general sense of benevolence which are made by a health care provider...related to the discomfort, pain, suffering, injury,

or death of the alleged victim as the result of the unanticipated outcome of medical care shall be inadmissible as evidence of an admission of liability [31].

One legal observer has criticized the Colorado statute as having gone “too far” in pushing the pendulum to protect the physician—at the expense of the patient [21]. The statute, the observer points out, permits a physician to admit to the patient outside the courtroom that an error is the physician’s fault and due to negligence, but then, later, in the courtroom, allows the physician to deny the admission of fault and disclaim any degree of liability.

Offering an Apology “The Safe Way”

An article published in 2005 advised physicians how to discuss adverse events or complications with their patients to “maximize our efforts to avoid litigation” [32]. “Express regret in a sincere way, without an admission of wrongdoing, but still be both empathetic and sympathetic,” suggested the authors. A journalist writing in a medical magazine proposed the following:

Express your sympathy without accepting the blame, or blaming other physicians. Avoid using words like ‘mistake,’ ‘error,’ or ‘accident.’ Instead, you might say, ‘I’m sorry things turned out this way’ [33].

Yet another medical legal researcher suggested that “trained error disclosure teams” should meet with patients who have experienced a medical error to offer an explanation and apology in the form of a “sincere expression of empathy” [34]. The researcher advised using a phrase such as “We are so sorry that this event has occurred to you,” rather than a less appropriate “I’m sorry that I made a mistake that injured you” because the former “reflects system accountability.” As discussed next, one legal researcher calls “emphatic disclosures that admit no wrongdoing,” such as those just described, “botched apologies” [21].

The Authentic Apology

Lee Taft, a former trial attorney and now an ethicist and expert on apology, believes that for an apology to be “authentic,” it must contain the following ingredients: an acknowledgment that a rule has been violated; an admission of fault for its violation; an expression of genuine remorse and regret for any harm caused by the violation; and an explicit offer of restitution and promise of re-

form [21]. Taft further points out that the rendering of an authentic apology demands great courage from the party who has erred because that individual must not only acknowledge wrongdoing but also subject himself or herself to the consequences that result from the admission, including potential litigation. An apology that includes only an expression of sympathy without an admission of wrongdoing and offer of compensation is not an authentic apology. Rather, according to Taft, it is an “apologia,” a term defined in the modern business environment as “a strategic communication designed not only to convey information, but more importantly, to neutralize the potential negative ramifications that might otherwise result from the information given.”

An apologia, in other words, is simply a “full justification of one’s position coupled with a defensive strategy.” An authentic apology must include repentance, which encompasses two essential elements: the expression of sorrow and the admission of wrongdoing. The absence of either, concludes Taft, renders the apology incomplete and thus transforms it into a “botched apology.” Indeed, the botched apology not only fails to inspire forgiveness but instead may create even further harm and fuel bitter vengeance.

How the Law Views Apologies

Our legal adversary system traditionally has avoided apology [35]. In the context of litigation, apology is often seen as an admission of guilt. In the eyes of the defense, apologies are discouraged because they tend to put the blame on the defendants and the jury often construes them as tantamount to the defendants convicting themselves of the alleged act of wrongdoing. Plaintiffs’ attorneys are not favorably disposed toward apologies either because they see the purpose of the legal system as providing a means to award monetary compensation—not an apology—to a harmed party. To defense and plaintiff attorneys alike, litigation is a process played out in a legal arena where defendants have the right not to incriminate themselves but rather to defend themselves as best they can, whereas plaintiffs, in contrast, have the right to pursue compensation for wrongs they have suffered [35].

One Boston plaintiff’s attorney states that his job is much more difficult if the physician has offered an authentic apology.

The hardest case for me to bring is the case where the defense has admitted error and apologized to the injured patient. If

you have no conflict, you have no story, no debate, and it doesn’t play well [20].

A Chicago plaintiff’s attorney voiced additional criticisms:

A well-timed apology can take advantage of a family when it’s most vulnerable. If you were real nice, maybe they won’t hire a lawyer and won’t know what their rights are. Is the point of apologizing to be nice, or to avoid legal accountability? The injured party will get offers of settlement that will be insulting. I’ve yet to know anyone who got a fair offer without filing a lawsuit [36].

How Patients View Apologies

Surveys of patients disclose that a full or authentic apology that expresses both sympathy for the patient’s injuries and acceptance of responsibility for those injuries leads to forgiveness and results in the injured parties looking more favorably on settlement offers [25] with a possibly decreased inclination to pursue malpractice litigation [37]. Conversely, patients saw partial so-called botched apologies, those that did not include admission of wrongdoing, as being no better, or possibly even worse, than not offering any apology. Partial apologies did not consistently convey to recipients that the offender had accepted responsibility or regretted his or her behavior, and thus they generated considerably more anger.

Will a physician’s offering an authentic apology reduce the likelihood of an injured patient’s filing a medical malpractice lawsuit? Research studies have found that apologies to patients subjected to medical errors help deter legal action [38]. These studies have also shown that payments in medical malpractice litigation are often higher if an error has not been disclosed and an apology given. Note that no published evidence suggests that more open disclosure of errors and rendering of apologies increases liability dramatically.

A published survey in 2005 disclosed that 99% of parents wanted physicians to tell them about an error involving their children, no matter the severity [39]. Although 36% indicated they were less likely to seek legal action if they were informed of the error by the physician, it is noteworthy that 63% of the parents stated that disclosure by the physician that a serious error had been committed would not change the likelihood of their undertaking legal action.

How Patients View Physicians Who Make Errors: A Caveat

A survey taken of a group of patients who had filed medical malpractice lawsuits against physicians, on one hand, and a group of physicians who had been sued for malpractice, on the other hand, revealed very different opinions about the reasons lawsuits were filed [40]. Ninety-six percent of the patients responded that they filed suit because the defendant physician had made a mistake; only 22% stated that they filed suit to be compensated financially. The responses of the sued physicians were almost the reverse. Only 22% believed the suits were filed because they had made a mistake, and 83% believed the primary reason for filing the suit was to reap a financial reward. Responses to the question of whether state medical licensing boards should take stronger punitive action against physicians who committed errors followed similar lines: 79% of sued patients answered affirmatively compared with only 19% of sued physicians.

Other surveys have shown similarly divergent opinions between patients and physicians [2]. When asked whether suspending medical licenses of physicians is an effective way to reduce medical errors, only 3% of physicians answered affirmatively, in contrast to 50% of the public. In another survey taken by a Massachusetts group of researchers, 39% of patients whose doctor made a mistake would want that doctor's medical license placed on probation, suspended, or revoked [41]. A total of 64% wanted their doctor to be "reprimanded by an authority." When asked about whether disclosure of error by their physician would influence their decision to seek legal recourse, 49% indicated they would if no disclosure was made. Full disclosure of the error by physicians reduced this percentage only modestly, to 38%. These researchers concluded that although complete disclosure of errors by physicians did not increase the likelihood of patients seeking legal advice, physicians should not assume that full disclosure guarantees a positive response by patients; in fact, in some circumstances full disclosure had "little effect."

Summary: Will Saying "I'm Sorry" Prevent a Malpractice Lawsuit?

Patients who are injured by medical errors do not look kindly on physicians who commit them. A substantial percentage of such patients believe malpractice litigation is warranted and that disciplinary action should be imposed on the errant physician.

Radiologists or other physicians who recognize they have committed a medical error that adversely affects the health of a patient can choose to follow one of five possible alternative courses of action. They may keep the error hidden from the patient; they may divulge the error to the patient; they may divulge the error to the patient, adding at the same time a partial apology such as, "I am sorry this has happened to you"; they may divulge the error to the patient, adding at the same time not only a partial apology but also an admission that the error was their fault; or they may divulge the error to the patient, adding at the same time not only a brief apology and admission of wrongdoing but also an offer of compensation.

Ethical standards, moral values, and mandates of the Joint Commission for the Accreditation of Health Care Organizations and professional societies call for the second course of action: full disclosure of medical errors to patients affected by them. Nevertheless, many radiologists and other physicians are reluctant to divulge errors because of potential repercussions ranging from simple embarrassment and loss of face or professional standing to malpractice litigation and possible restriction of clinical privileges and loss of malpractice insurance. Some errors thus are never divulged or discovered. In this scenario, obviously, a malpractice lawsuit will never be filed.

Some errors not divulged by the radiologist or physician are discovered later. In this scenario, patients are likely to become angrier because of the nondisclosure, and thus they are more favorably disposed toward filing a malpractice lawsuit, one that is more likely to result in a higher-than-average settlement or jury verdict [16, 25].

Some errors are not only divulged to patients, but the radiologist or other physicians who divulge them also include a "partial" apology, sometimes with an added admission of wrongdoing and sometimes with an additional offer of compensation. Are patients less likely to file medical malpractice lawsuits in these scenarios? The answer is unclear.

A partial apology that does not include an admission of fault has been shown in some studies to diminish the likelihood of a patient's filing a lawsuit if the resultant injury is minor. If patient injury is substantial, however, surveys suggest that the likelihood of a malpractice lawsuit is unchanged.

A radiologist's admission of wrongdoing or fault can be considered as an "extrajudicial admission" that can be used against the radi-

ologist in a court of law. Thus far, 19 states have passed legislation that grants immunity to physicians' apologies—for example, the use of phrases such as "I am sorry," "I regret," or "I sympathize with what has happened." However, in 18 of the 19 states, statements that can be interpreted as admissions of fault remain admissible as potential evidence against the physician. Only Colorado grants immunity to admissions of fault.

Some medical facilities, for example, a veteran's administration hospital in Kentucky and the University of Michigan, have reduced malpractice expenditures by implementing a program in which physicians and hospital management not only disclose errors but also admit fault and offer compensation. Two caveats must be considered with regard to these "divulge-admit-compensate" programs. First, these medical facilities report a reduction in dollars paid to claimants and associated legal expenses and possibly the number of malpractice lawsuits. Admission of fault and offer of compensation do seem to decrease defense and court costs and the average compensation paid to patients for a given injury. However, whether these types of programs decrease other adverse consequences affecting doctors who have made medical errors, enumerated earlier, has not been documented.

Second, the facilities that have instituted the divulge-admit-compensate programs are those at which a single entity pays all medical malpractice expenses. Physicians are employed by the medical facility, and thus little or no conflict of interest exists between the physicians and the facility. One voice can speak for all actual or potential codefendants.

In most hospitals in the United States, radiologists and nonradiologic physicians are independent contractors. Hospitals have professional liability insurance underwritten by one carrier, radiologists may have insurance underwritten by another carrier, and other physician groups may have insurance underwritten by yet another carrier. In this scenario, differences of opinion regarding strategies and tactics are inevitable. One insurer may promote the concept of apologizing; another insurer may exhort its insureds not to offer apologies. One insurer may be inclined to offer compensation to the patient; another insurer may refuse to do so. In such instances, it would seem difficult, perhaps impossible, to bring the various potential codefendants and their insurers together to effect a unified position before the institution of full-fledged malpractice litigation.

Let us return to the question of whether saying "I'm sorry" will prevent a malpractice lawsuit. Although ethical and moral considerations enjoin physicians to make apologies, the reality is that radiologists would be prudent to consult their hospital risk manager or a representative of their insurance carrier for guidance as to whether they should offer an apology and, if so, what should be included in the apology.

Saying "I'm sorry" may diminish the patient's pain, assuage the radiologist's guilt and recrimination, and strengthen the physician-patient relationship. The extent to which it will prevent a malpractice lawsuit, however, is yet to be determined.

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