

Chapter 28

Disclosure of Adverse Outcome and Apologizing to the Injured Patient

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“To err is human.” And it might be said with equal conviction when error leads to injury that *to apologize is also human*. Certainly this is true in medicine, in which the problems of an illness or the complications of a procedure are often unanticipated because our knowledge is always incomplete, and our human imperfections are inescapable. When, in the course of medical treatment, a patient suffers harm, apologizing would seem natural. But, in the arena of medical care, an apology takes on a powerful legal dimension in which the acknowledged benefits of apologizing are unfortunately accompanied by serious risk.

All successful apologies have certain characteristics in common and finding one that is artful or adequate is rare. For example, on September 11, 1998, President Bill Clinton appeared before a gathering of religious leaders at a White House prayer breakfast and said the following:

I don't think there is a fancy way to say that I have sinned. It is important to me that everybody who has been hurt know that the sorrow I feel is genuine: first, and most important, my family; also my friends; my staff; my Cabinet; Monica Lewinsky and her family, and the American people. I have asked all for their forgiveness. But I believe that to be forgiven, more than sorrow is required, at least two more things. First, genuine repentance: a determination to change and to repair breaches of my own making. I have repented. And if my repentance is genuine and sustained and if I can maintain both a broken spirit and a strong heart, then good can come of this for our country as well as for me and my family.¹

Now there's a *real* apology, a work of art!! All the elements are there: contrition and sincere remorse; acceptance of responsibility; and a desire to atone and build for the future.

This dynamics of apology in this chapter will be organized around the following categories: (1) background; (2) the benefits and risks of apologizing; (3) “safe” apologies; (4) the legal significance of apologizing; and (5) procedural rules for apology.

BACKGROUND

The role of apology in a world of 6.5 billion constantly interacting humans is forbiddingly complex to say the least, for the following reasons:

1. Culturally, apology is the norm in some societies such as Japan where it is expected, and virtually mandated. In some respects, it balances parties as to pain and power, thereby restoring evenness, harmony, and functionality to a relationship.
2. Apology is a basic to all ethical religions, the central principle being that a recognized wrong requires acknowledgement, acceptance of responsibility, and restitution.
3. Psychologically, apology is healing. Submission to an overarching rule of conduct purges the unhealthy qualities of selfishness, arrogance, and thoughtlessness.
4. Practically, an apology, given sincerely, can deflate anger to the point of making negotiations, settlement, and compensation possible.

The one thesis that seems reasonably secure is that the situations from which an apology from doctor to patient might be expected are shockingly frequent. In its major study published in 1999, *‘To Err Is Human,’* the Institute of Medicine (IOM) estimated that the numbers of patients annually dying from medical errors ranges between 44,000 and 98,000.² It must be concluded that medical errors do occur, that they are commonplace, that they are often terribly harmful, and that when treatment results in harm to a patient, an apology from the attending physician as a matter of empathy would be entirely natural. However, because not all disagreements are capable of an easy solution that comes with saying “I’m sorry,” and because legal confrontation becomes the final avenue for resolving many of these disputes, the legal implications of a physician’s apology become critically relevant.

THE BENEFITS AND RISKS OF APOLOGIZING

Although the results of apologizing are varied and unpredictable, for the patient, the benefits can be immediate,

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striking, and sometimes encouraging in a way that becomes important in the patient's recovery.

After suffering an adverse event from treatment, patients are predictably worried, anxious, confused, and filled with questions such as "What went wrong? Was I at fault? Was my injury part of the inherent risk of treatment or did someone commit an error? Can I recover, what is my future, and what do I do next? Can you help me?" Having the attending physician compassionately explain what happened, why and how it occurred, how it now can be handled, and what results can be anticipated can be enormously comforting to a patient beset with both pain and uncertainties. Filling that breach with warm, sympathetic support can be a powerful act of understanding and caring in a moment of despair.

For the physician, benefits may be equally impressive. When physicians are sincerely able to say to an injured patient, "I'm sorry," good things begin to occur for both parties, spiritually, psychologically, and perhaps even legally. Patients have at least some of their questions answered and are reassured by their doctor's continuing support. Physicians feel ethically uplifted and positively buoyed by salvaging what may have been a longstanding, warm relationship. After all, most physicians still see themselves as their patient's friend. In recent years, the benefits of physicians apologizing have been the subject for much commentary, in both lay and professional publications.

The 1999 paper by the VA Medical Center in Lexington, Kentucky, describing their novel program encouraging prompt, full disclosure of all injurious medical adverse effects to the patient, has been repeatedly referred to as evidence demonstrating both the value of apology and its failure to generate noticeable increases in malpractice payments.³ The University of Michigan reported a similar experience.⁴ In fact, some plaintiffs *claim* they wouldn't have sued at all if they had only received an apology. For example, in both the case against the Catholic Diocese of Dallas for failing to protect eleven boys from sexual abuse by a priest and the Kent State University tragedy in which four students were killed by the Ohio National Guard, a demand for apology and its precedence over legal solutions became issues stalling those settlements.⁵ But, once the litigious format has been set, abandonment of the suit by the plaintiff is seldom seen.

The one thing that seems agreed upon is that full disclosure is increasingly encouraged and favored. In order to have control of their life, patients have a right to informed consent prior to treatment and to full disclosure of adverse events after treatment. To do otherwise would constitute culpable deception, a conclusion embedded in the law⁶ promulgated by the Institute of Medicine's 1999 report, adopted by the JCAHO⁷ and the subject of several commendable law reviews.⁸ Since treatment often directly involves physicians, the connection between the concept of full disclosure and that of physician apology becomes an obvious one.

However, the pitfalls and hazards of apologizing are not borne equally by both patient and doctor. They tend to fall disproportionately on the physician, have serious implications for the doctor's professional future, and are always unpleasant. Some to consider include the following:

1. Psychologically, physicians often find apologizing humbling, even humiliating, a slur on them personally and professionally.
2. If the apology is mistakenly interpreted as legal weakness, a sincere, compassionate apology can sometimes transform an indecisive, uncommitted plaintiff into a resolute, aggressive opponent who senses an easy victory.
3. There is a possibility of conflict with an insurance carrier for breach of contract when the contractual wording expressly forbids the physician from assuming responsibility without the company's consent.
4. The legal implications of a physician apologizing can be dire. Simply put, an apology entered into evidence is considered to be an admission, an admission of wrongdoing that can be turned against the physician. Herein is the crux of why most physicians are reluctant to apologize and why most attorneys, who see themselves less as healers and more as advocates protecting their client, usually admonish their clients, "Whatever you do, don't apologize."

"SAFE" APOLOGIES

In those instances in which a patient has been harmed by treatment, but when it appears that apology is both what the patient desires and what the physician would like to do but fears the evidentiary consequences, is it possible to express genuine remorse in apologizing to a patient without being exposed unnecessarily to legal reprisal? Are there some relatively safe havens? The answer is yes. Some are the outgrowth of legal form while others are intrinsic to the apology itself.

State Law

State laws are changing and states are increasingly entering the fray with legislation that attempts to isolate an apology from adverse legal consequences. Some 18 states now either have or are actively considering legislation that incorporates language of "*sympathy and benevolence*."⁹ For instance, California Evidence Code 1160, which is typical of many state provision, reads: "The portion of statements, writing, 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 . . . shall be inadmissible as evidence of liability in an action." However, the exculpatory provision is limited to sympathy and benevolence. To date, no state has enacted a statute that excludes from evidence a fault-admitting apology. Our rules of evidence still make it difficult for doctors to apologize to angry, hurt patients, even though doing so could be positively beneficial.

Mediation

Mediation is an extraordinarily versatile and effective means of barring apologies from admissibility. Federal Rule of Evidence (FRE) 501 provides that ". . . a claim or defense . . . shall be determined in accordance with State law." In this regard, California Evidence Code 1119(a) provides

that “No evidence of anything said or admission made. . . for the purpose of. . . a mediation. . . is admissible. . . in any. . . civil action. . .” And 1119(c) provides that “All communications, negotiations, or settlement discussions. . . between participants in the course of a mediation. . . shall remain confidential.”¹⁰

Exclusion by Mutual Agreement

Next, the parties themselves may agree to exclude an apology, or may voluntarily submit to mutually agreeable arrangements for confidentiality, but confidentiality agreements are often limited by statutory provisions and, if the agreement serves to preclude a court from hearing evidence, it is often disregarded as contrary to public policy.

ELEMENTS COMMON TO SUCCESSFUL APOLOGIES

Genuineness

An apology that bears the trace marks of insincerity, by word or manner, is a drawn bow, almost certain to provoke distrust and anger. Not everyone is adept at communication. In the potentially explosive situation of harm having been done to a patient, such things as tone of voice, speed of words, appearing distracted or uninterested, and failing to look directly at the injured party receiving the apology can all convey the wrong message and, in doing so, impair or nullify the apology.^{11,12}

Apology Appropriate to the Circumstance

How severe was the injurious act and how angry is the injured party? Was the damage merely a medicinally induced rash or was the wrong breast removed? After the injury occurred, was the attending physician responsive and available? Do patient and doctor desire a continuing relationship?

Who Should Apologize

Should the attorney or the physician bear the olive branch? The attorney is likely to be more circumspect in choosing proper words but unfortunately often has the undesired effect of spawning victim suspicion. The physician’s appearance is far more likely to be viewed as caring and genuine, thereby refocusing attention to reconciliation rather than legal defense. Strangely, even though physicians deal regularly with patients on a close, personal basis, many of them are deficient in communication skills and can unwittingly exacerbate the patient’s misgivings in the setting of an adverse event.

How the Apology Should Be Transmitted

Written apologies generate a needed paper trail and certainly allow a cautious position, but the spoken word is far more

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powerful and influential. However, emphasis must be placed on sincerity. Any appearance of attempted manipulation can be terribly inflammatory.

When the Apology Should Be Made

The sooner it comes after the injury, the more satisfying to most patients. When a medical mishap occurs, most physicians ordinarily examine or visit a patient shortly afterwards. If an apology is forthcoming, that moment is a natural one for it. But physicians should understand that the safeguards of FRE 408 apply only *after* the compromise settlement negotiations have begun. And since negotiations for compromise settlement are not usually underway during that initial doctor–patient conversation, an apology given at this time would fall outside the umbrella of FRE 408 protection

To Whom the Apology Should Be Given

Friends tolerate painful honesty better than strangers. If the relationship is new or tenuous, apologizing becomes more risky. If the relationship is firm, warm, and steadfast, the patient is far more likely to accept it generously.

Wording of Apology

This is a critically important ingredient. It is important to appreciate the fact that at least two people are involved in these matters—the physician, who presumably knows his or her own feelings, and the patient, who is forming impressions from both the words and demeanor of the physician. There is a lot of room for misunderstanding.

Here are some examples of how words can influence the risk of apology, beginning with innocent expressions of sympathy and ending with admitted culpability:

1. “I’m sorry about the reaction you had to this medication. I know it’s been uncomfortable.” Was the physician’s statement only an expression of sympathy and regret for the victim’s suffering, the empathy one human being feels for another but without any allusion to responsibility?
2. “I’m sorry about your reaction to the medication I prescribed.” Might this apology have been intended only as regret for a poor result of treatment, regrettable but without any imputation of physician negligence? Here, although there’s an implication of *some*, but *not much*, involvement, there is no suggestion of wrongdoing.
3. “So sorry you experienced that reaction. My choice of antibiotic turned out to be a real mistake.” Even though the reason for the mistake in antibiotic choice is unapparent and there is no suggestion of the standard of care having been violated, does the wording of this apology suggest an escalation in the level of responsibility by admitting a personal error, a flaw of medical judgment? “Mistake” is terminology for “it wasn’t supposed to happen,” and as such is commonly linked to implications of wrongdoing. Here, through the choice of terms such as

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“My choice of antibiotic” and “mistake,” the apologizing physician is moving beyond regret and introducing an insinuation of responsibility for wrongdoing.

4. Finally, “So sorry you experienced that reaction. In retrospect, the choice of that particular antibiotic was a poor one and if I had it to do over again, I would do it differently.” In this blatant admission of wrongdoing, there is not much doubt about a confessional line having been crossed.

Treacherous Expressions

It is entirely possible to express regret and remorse, and to be genuine in doing it, without masochistically proclaiming fault. But in apologizing, it is essential to shun unnecessarily incriminating expressions such as “I regret that we didn’t anticipate . . .” or “I wish that we had done . . .” Also in the category of risky disclosures are “My weekend coverage didn’t know that you had been taking blah, blah. . .,” or “My nurse didn’t understand that you had been told. . .,” Especially incendiary are expressions that sound like an admonishment, such as “Why didn’t you let us know . . .” To patients, these sound accusatory and tend to be interpreted as the physician’s ploy to shift blame away from himself or herself on to the patient, inciting anger and resentment.

Remember, even when the apology is a little too exuberant and fault is unequivocally admitted, there still may be no malpractice for lack of other elements of tort. A physician’s professional performance can fall below his or her personal expectations without necessarily violating the standard of care.

THE LEGAL SIGNIFICANCE OF APOLOGIZING

An apology is ordinarily viewed in law as an “*an admission*” and must be seen in that light. But, depending on the wording, the legal weight of an apology can fall on a continuum ranging from innocent expressions of sympathy to overt, highly probative admissions of wrongdoing.¹³ Choice of words in the apology is central. A surgeon’s statement saying “I’m sorry that the gynecologic operation we did resulted in the loss of your kidney” could as easily be interpreted as only remorse for a bad result as for an admission of a negligent act. Cases on this point are plentiful, distinguishing an apology from a clear admission of liability. In *Phinney v. Vinson*, the plaintiff argued that the apology alone was sufficient evidence of liability, but the Supreme Court of Vermont concluded that, probative though it is, an apology is *not* the automatic equivalent of legal liability for wrongdoing.¹⁴

In an Oklahoma case, *Sutton v. Calhoun*,¹⁵ the court declined to rule that the defendant doctor’s statement that he had made a “mistake” in cutting the patient’s common bile duct at surgery could be considered an equivalent of an admission of negligence. And in *Senesac v. Associates in Obstetrics & Gynecology*,¹⁶ an alleged statement by the

defendant doctor to the effect that she had “made a mistake and she was sorry, and that it had never happened before” was held not sufficient to establish the standard of care of its breach.

However, a contrary result was reached in *Greenwood v. Harris*,¹⁷ in which the defendant doctor mistakenly operated on the pregnant plaintiff’s enlarged uterus, thinking it was an intra-abdominal tumor. After the surgery, the defendant physician was reported to have said “. . . this is a terrible thing I have done. I wasn’t satisfied with the lab report. She did have signs of being pregnant. I should have had tests run again. I should have made some other tests. . . I’m sorry.” In this case, the court held that it was not possible to interpret the defendant’s statements other than an admission of the defendant’s failure to use and apply the customary and usual degree of skill exercised by physicians in the community.

These cases make abundantly clear the premise that legal culpability must take into account other elements such as scope, standard of care, and causality. Mistake, error, and a bad result are predominantly *medical* concepts, requiring *medical* judgments, whereas fault, negligence, and culpability are *legal* concepts, defined by legal standards. There is case law to support the contention that occasionally even poor judgment, mistake, and error can fall within the purview of “usual, acceptable care” as defined by the standard of care. Examples are available to show that the courts have gone both ways on this subject.

PROCEDURAL RULES FOR APOLOGY

First, consider those rules under which an apology might be *admissible* as evidence at trial.

Common Law

Under existing American law and under common law, fault-admitting apologies are ordinarily admissible to prove liability, and at common law all statements made in course of settlement negotiations, including an apology, can be admitted into evidence except when excluded by narrow exceptions, such as (a) apologies framed as a hypothetical as in “Assume for the sake of this inquiry that the defendant were to have said the following . . .” or “This is hypothetical. . .”; and (b) apologies preceded by exclusionary words such as “Without prejudice to any of his legal rights, the defendant admits. . .” Since both (a) and (b) are heavily dependent on legal formalisms, the certainty of protection may be tenuous. Even when the apology is protected and not admissible as evidence, to be valid it must have taken place as part of the compromise settlement discourse, not merely the business discussion.

Federal Rules of Evidence

It is immediately apparent that a policy of admitting apologies as evidence drastically dampens enthusiasm for

openness in compromise discussions, thus significantly curtailing chances for settlement. It was to overcome this impediment that FRE 408 was implemented. In most jurisdictions, common law rules of evidence have been supplanted by the Federal Rules of Evidence, which serve in many states as a template for their state Code of Evidence.

FRE 801(c) defines hearsay as “statements other than one made by the declarant while testifying at the trial or hearing, that are offered in evidence to prove the truth of the matter,” while *FRE 802* makes hearsay testimony inadmissible unless an exception can be invoked. To fall within *FRE 801*, an apology need not be an overt admission but only a statement.

But the same rule, *FRE 801(d)*, then proceeds to carve out complete exclusions from the hearsay rule when dealing with the testimony from prior statements from a testifying declarant or from prior admissions given by a party opponent.¹⁸ Thus, in an action against a physician, testimony from the family alleging that a nurse told them that the doctor was overheard to say, “I’m sorry that I chose that particular medication,” would conventionally be excluded as hearsay under *FRE 801(c)* but becomes admissible under *FRE 801(2)* as an admission by a party-opponent.

FRE 803 contains a long list of statements that ordinarily might be inadmissible as hearsay under *FRE 801* but that are designated “exceptions to the Hearsay Rule.” The availability of the declarant is immaterial. Included are statements about present sense impressions, excited utterances or spontaneous statements, the declarant’s then existing mental, emotional, or physical condition, statements about reputation or a person’s character, and statements made by the declarant for the purpose of medical diagnosis or treatment.¹⁹ The rule then enlarges the scope of applicable exceptions by referring to *FRE 807*, which allocates great latitude to the court in deciding what testimony might qualify as a hearsay exception.

FRE 804 defines the concept of “unavailability” and enlarges the field of exceptions to hearsay by making admissible those statements ordinarily considered hearsay, such as former testimony given as a witness at another hearing, a statement under belief of impending death, a statement against economic or legal interest, and statements of personal or family history such as birth, adoption, marriage, divorce, and ancestry.

FRE 807 is a catch-all rule through which exceptions to *FRE 801* hearsay restrictions on admissibility virtually disappear. It declares that statements not specifically covered by Rule 803 or 804 but judged to be equally trustworthy are not excluded by the hearsay rule, if the court determines that (a) the statement is offered as evidence of a material fact, (b) the statement is more probative on the point in question than any other reasonably procured evidence, and (c) the general interests of justice will best be served by admitting the statement into evidence. In effect, the court is given final discretion in matters of hearsay admissibility.

Next, consider some rules making apologies *inadmissible* as evidence.

FRE 407 pertains to efforts at Subsequent Remedial Measures and makes inadmissible corrective measures taken after an injury that would have made the injury less likely if taken previously. Although apology may not fall neatly into the definition of a remedial measure, it is possible to envision circumstances in which a physician has attempted to ameliorate some harm that has befallen the patient, only to have these efforts interpreted subsequently as the equivalent of an apology, as might be the case when a second surgical procedure is performed in an attempt to improve on the first one.

FRE 408 (Rule on Compromise and Offers to Compromise) states that “Evidence of furnishing. . . or accepting. . . a valuable consideration in compromising. . . a claim, . . . disputed as to either validity or amount, is not admissible to prove liability. . . .”²⁰ Through this wording, *FRE 408* shields apologies from admissibility and, in doing so, blunts the common law tendency that stifles compromise by making admissible virtually all statements and conduct made in settlement negotiations.

However, the many exceptions to *FRE 408* make it a porous shield and its protection against admissibility is easily lost. Here are some to consider.

The apology must be an integral part of the settlement negotiation. If it can be successfully argued that the apology is separate from the settlement negotiations, then the apology as an admission of fault will not be protected by *FRE 408*. For example, if, in the course of negotiations, a physician apologizes by saying “I’m sorry that medication I prescribed resulted in damage to your kidney function . . . and I agree that you should be compensated,” there is no disagreement about the apology being an admission of the claim but there might be a dispute as to the amount, thereby bringing into question how much protection *FRE 408* affords that specific portion of the apology.

FRE 408 poses the issue of “consideration.” Can an apology be considered consideration? *FRE 408* states that “Evidence of furnishing . . . valuable consideration in a claim . . . is not admissible to prove liability . . . of the claim or its amount.” Here, although the courts have been inclined to interpret “consideration” broadly, there may be a question as to whether or not the definition can be stretched to encompass apologies.

Under *FRE 408*, the apology as an admission of fault must occur during the course of settlement negotiations. But, as is well known, most apologies from physicians usually are given in conversations held shortly after the patient’s injury has been detected, not after learning that an attorney has been retained and a suit filed. That fact alone could mean that the apology, offered prior to beginning actual settlement negotiations, could fall outside the penumbra of *FRE 408* protection and thereby become admissible as evidence.

Admissibility should not be confused with discovery. Even when *FRE 408* bars an apology from admissibility at trial, it does not preclude getting the same information at discovery.

Although an apology might qualify and be protected under *FRE 408*, there are numerous circumstances in which

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it could still find its way into evidence, such as being offered for some other purpose such as proving bias or prejudice, combating a charge of undue delay, or impeaching a witness by inconsistent statements, itself an enormous loophole.

Also, FRE 408 also does not bar the statement's being revealed to third parties. As pointed out by Jonathan Cohen, if, during settlement negotiations, President Clinton apologized to Paula Jones, FRE 408 might prevent Jones from introducing it at trial but it would not stop her from revealing it to the world. It also does not bar from admissibility evidence of facts just because they were first disclosed during compromise negotiations.

FRE 409 (Payment of Medical Expenses) provides that "Evidence of furnishing or offering or promising to pay medical, hospital, or similar expenses occasioned by an injury is not admissible to prove liability for the injury."

FRE 501 defers to applicable state law, in considering apology as admissible admission. For instance, California Evidence Code 1160 reads "(a) The 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 that person or to the family of that person shall be inadmissible as evidence of an admission of liability in a civil action. A statement of fault, however, which is part of, or in addition to, any of the above shall not be inadmissible pursuant to this section. "For example, "I'm so sorry for this terrible drug reaction you suffered. Unfortunately, our notes didn't include any information about prior sensitivity to medicines." Although this statement contains an expression of sympathy and as such might be considered safeguarded by 1160, the portion containing the admission of fault, juxtaposed to that sympathetic expression but separate from it, could be argued to be "in addition to" and therefore not protected under the heading of a benevolent gesture or statement of sympathy

CONCLUSIONS

When patients suffer injury as a result of their treatment, an apology from their attending physician can have definite benefits for both doctor and patient. This human, compassionate response to another's misfortune is widely acknowledged to be healing, is becoming more widely codified in law, and within reasonable limits ought to be supported. But, under present law, although the physician is given some protections through mediation, confidentiality agreements, judicial exclusion, and rules of evidence, the threat of an apology being introduced as evidence of wrongdoing remains potentially dangerous.

The essence of this uneasy contest between the law and, as opposed to, our moral code can be found in our continuing struggle to find a balancing point between these two

strong, competing impulses, the compelling urge to say "I'm sorry" on one hand pitted against the perpetual peril of legal liability on the other.

Endnotes

1. Extracts from the official White House text of President Clinton's address to religious leaders at White House prayer breakfast, by Associated Press, Internet.
2. Jay S. Cohen, MD, *Ways to Minimize Adverse Drug Reactions*, Hospital Practice (15 July 1999) 69-79 131(12).
3. Steve Kraman, MD, and Ginny Hamm, JD, *Risk Management: Extreme Honesty May Be the Best Policy*, Ann. Intern. Med. 963-967 (1999) (VAMC Memorandum No. 00-1, VA Medical Center, Lexington, Ky., Nov. 4, 1999). Whereas almost all articles dealing with physician apology cite only personal impressions or anecdotal experiences, the Lexington Medical Center report examined their hospital experience under their full disclosure program and concluded that, in spite of the anticipated risk inherent in full disclosure, their liability payments were moderate and comparable to those of similar facilities. However, they were careful to avoid claims of financial savings, and whether or not the total number of lawsuits diminished is not clear. This material has spawned numerous opinions claiming that saying "I'm sorry" produces malpractice savings, a possible but unwarranted assertion.
4. <http://www.med.umich.edu/patientsafetytoolkit/disclosure/chapter.pdf>.
5. Daniel Shuman, *The Role of Apology in Tort Law*, 83(4) Judicature 183 (2000).
6. Check on Informed Consent
7. *The Institute of Medicine Report on Medical Errors*, Medscape Internet (June 8, 2005).
8. Jonathan R. Cohen, *Advising Clients to Apologize*, S. Cal. Law Rev. 1009-1069 (1999).
9. Arizona, Connecticut, Georgia, Louisiana, Idaho, Missouri, Massachusetts, Montana, New Hampshire, South Dakota, Vermont, Texas, California, Illinois, Iowa, Rhode Island, Tennessee, West Virginia.
10. Cal. Evid. §1160 (portions of the Code have been selectively lifted from original text for emphasis).
11. For a discussion of this issue, see Cohen, *supra* note 8.
12. Article on communication
13. P. Rehm & D. Beatty, *Legal Consequences of Apologizing*, J. Dispute Resolution 115 (1996).
14. *Phinney v. Vinson*, 605 A. 2d 849.
15. *Sutton v. Calhoun* (1979, CA10 Okla.) 593 F 2d 127.
16. *Senesac v. Associates in Obstetrics & Gynecology* (1982) 141 Vt. 310, 449 A. 2d 900.
17. *Greenwood v. Harris* (1961, Okla.) 362 P. 2d 85.
18. Arthur Best, *Evidence*, 5th ed., (2004).
19. Federal Rules of Evidence (2004).
20. These rules have been abbreviated in the interest of limited space. They are easily available in their entirety in standard texts or on the Internet under the heading of Federal Rules of Evidence.