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Apology and Organizations: Exploring an Example from Medical Practice

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APOLOGY AND ORGANIZATIONS: EXPLORING AN EXAMPLE FROM MEDICAL PRACTICE

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INTRODUCTION

In previous work, I examined the potential of apology in civil lawsuits. There I argued that to better serve their clients, under existing laws, lawyers should consider discussing the possibility of apology with them more often. For example, many lawyers fail to consider that offering an apology can greatly facilitate settlements and that "safe" apologies, which cannot be used as proof in court, can often be made within mediation. I also argued that in order to encourage apologies after injury, we ought to consider reforming our laws to exclude apologies from admissibility as evidence.[1] In this Article, I focus on injuries committed by members of organizations, such as corporations, and examine distinct issues raised by apology in the organizational setting. In particular, I consider: (i) the process of learning to prevent future errors; (ii) the divergent interests stemming from principal-agent tensions in employment, risk preferences and sources of insurance; (iii) the non-pecuniary benefits to corporate morale, productivity and reputation; (iv) the standing and scope of apologies; and (v) the articulation of policies toward injuries to others.

I begin my analysis with an article published in the *Philadelphia Inquirer* (the "Gerlin article"). The article reports about an atypical, and in some ways revolutionary, approach to instances of medical error that the Veterans Affairs Medical Center in Lexington, Kentucky (the "Lexington VA") initiated in 1987 and has followed since. This hospital's approach and its effects have been docu-

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1. *See* Jonathan R. Cohen, *Advising Clients to Apologize*, 72 S. CAL. L. REV. 1004, 1009 (1999). *See also* Aviva Orenstein, *Apology Expected: Incorporating A Feminist Analysis Into Evidence Policy Where You Would Least Expect It*, 28 SW. U. L. REV. 221 (1999) (arguing for an independent evidentiary exclusion for apologies).

mented subsequently by recent academic publications.[2] I reprint the newspaper account below, because it simultaneously offers an overview of the hospital's approach and addresses many of the central issues of apology and organizations.[3] After the Gerlin article, I supplement the framework established by her report with further specific information obtained from academic publications and from telephone interviews.[4]

A. Newspaper Account

Accepting Responsibility, by Policy[5]

by Andrea Gerlin

The Veterans Affairs Medical Center in Lexington, Ky., handles medical errors differently from most hospitals.

The 400-bed hospital does not simply encourage its staff to tell patients and their families the truth about errors. It has a tough policy that requires giving the information as soon as possible by aggressively seeking out patients and families, even after discharge if necessary. Beyond that, hospital employees persuade the occasional reluctant victim to accept financial compensation.

"Almost every risk manager and attorney says, 'We always tell the truth,'" said Steven Kraman, the hospital's chief of staff and chairman of its risk-management committee. "But I don't know of any other hospital that goes out and calls the family when there's been an error."

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2. *See* Steven S. Kraman & Ginny Hamm, *Risk Management: Extreme Honesty May Be the Best Policy*, 131 ANNALS OF INTERNAL MED. 963 (Dec. 1999); Albert W. Wu, *Handling Hospital Errors: Is Disclosure the Best Defense?*, 131 ANNALS OF INTERNAL MED. 970 (Dec. 1999).

3. Descriptions of fully-litigated cases are commonly given in judicial opinions and provide the "data" for much legal research. For cases that are settled through negotiation or other non-adjudicatory processes, records are far rarer. Hence, to study non-adjudicatory settlement, descriptions must be found elsewhere. Here we are fortunate that the Lexington VA's experience is well and concisely described by Gerlin's newspaper account and that Gerlin's account is confirmed by subsequent academic publication.

4. I conducted telephone interviews with Dr. Steven Kraman, the hospital's chief of staff and chair of its risk management committee; Attorney Ginny Hamm, the hospital's counsel and a member of its risk management committee; and Nurse Connie Johnson, a quality assurance nurse and a member of its risk management committee, on December 6, 1999. I conducted further telephone interviews with Dr. Kraman and Attorney Hamm on January 14, 2000 [hereinafter Telephone Interviews with Kraman, Hamm & Johnson].

5. Andrea Gerlin, *Accepting Responsibility, by Policy*, PHILADELPHIA INQUIRER, Sept. 14, 1999, at A18. Reprinted with permission from *The Philadelphia Inquirer*, September 14, 1999.

Is the VA Medical Center inviting its patients to sue it into oblivion? Not really, hospital officials say. Rather, they say, they are just accepting responsibility when they are at fault.

"Telling the truth is the right thing to do," said Connie Johnson, a clinical analyst and quality assurance nurse at the hospital.

"The attorneys around here in Lexington used to think we were crazy," said Ginny Hamm, the hospital lawyer. "But we have an ultimate responsibility to the veterans and their families."

The VA hospital in Kentucky has learned that doing the right thing can also mean saving money. By going out of its way to be open and honest with patients and their families, the hospital has found that it is minimizing its legal exposure because families are not as angry when they learn of a medical error.

Leonard J. Marcus, director of the Program for Health Care Negotiation and Conflict Resolution at the Harvard School of Public Health, has analyzed malpractice mediation sessions in an effort to determine what plaintiffs really want.

Marcus concluded that most patients who are harmed by medical errors want three things: an explanation of what happened; an apology from whoever was responsible; and an assurance that changes have been made to prevent harm from being done to someone else. Money seems to be a distant concern.

Lexington VA officials may have found a way out of the litigation thicket using this approach. The hospital's average total payout for settlements has been about $180,000 a year over the last decade, on eight to 10 cases in a typical year. The hospital has reduced its claims payments from among the highest in the 178-hospital VA system to one of the lowest.

Hospital officials admit that they arrived at that point painfully. In 1986, the hospital lost two malpractice lawsuits at trial, costing it a total of $1.5 million in awards. For a government facility that primarily treats older patients, whose claims usually result in lower damages, that was an eye-opening sum. Kraman was a defendant in one of the cases and said the outcomes forever changed the hospital's approach.

Hospital officials now begin assembling dossiers and taking testimony soon after incidents. Hamm said that as soon as they determine that a mistake has occurred, they notify the patient or

family members. If they believe harm has been done, rather than evade the truth in an attempt to avoid liability, they advise the family to hire a lawyer and they seek to quickly resolve the problem with a fair settlement.

That is what they are doing with Lloyd Brown, a 77-year-old veteran from Stanford, Ky. Last year, he temporarily lost sight in his right eye. Brown had previously lost most of the vision in his other eye to a cataract. His wife, Martha, said she called the VA's triage hotline and left a message with a receptionist describing the episode. No one ever called the Browns back because some messages were not being relayed by the triage hotline.

Two more episodes and six weeks later, they went to the medical center. A doctor there told them that an artery in the right side of Lloyd Brown's neck had closed due to a stroke and that he would be permanently blind in the affected eye. Worse, none of that had to happen.

"They said that if we'd gotten it within four hours they could have saved the eye," Martha Brown said. "We didn't think about seeing a lawyer."

Three months later they received a letter from the hospital advising them to get a lawyer so they could begin discussing a settlement, which is pending. Kraman said the couple, touched by having been dealt with honestly, became teary-eyed at the meeting during which the hospital acknowledged its mistake.

VA officials have also been helping Lloyd Brown obtain full disability benefits. The Browns are impressed: Lloyd Brown even returned to the medical center this spring for treatment of a heart problem.

"We think a lot of them," Martha Brown said. "They're taking responsibility. I never had experience with it, but I've never heard of a hospital admitting a mistake."

Kraman said the hospital drills its policy into its staff, especially the residents who train there, seeking to create a culture in which mistakes are acknowledged and lead to changes that prevent recurrences. Some of the ethics seminars it has held for employees have featured patients who were injured by treatment at the hospital, explaining how honesty reinforced rather than undermined their trust.

As obvious as this approach seems, there are reasons that a VA hospital can use it and that other hospitals will be slower to follow. As government facilities, the VA's liability is limited under the federal Tort Claims Act. Its hospitals are self-insured and its physicians are employees, and do not pay higher malpractice insurance premiums after a costly settlement.

Still, Kraman and his colleagues argue that their approach should be a model for other institutions.

"If everybody did this nationwide, every patient who was injured would get fair compensation, the lawyers would get nothing, and you wouldn't see $12 million verdicts," Kraman said.

B. Further Information

Before 1987, the Lexington VA's response toward instances of medical error was an adversarial combination of little disclosure and much opposition.[6] In 1987, following failed defenses of two malpractice claims that resulted in verdicts totaling $1.5 million,[7] the Lexington VA implemented a policy of proactively assuming responsibility for medical mistakes.[8] The essence of the policy was to maintain a care-giving relationship toward the patient following medical error rather than adopting an adversarial one.[9]

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6. Telephone Interviews with Kraman, Hamm & Johnson, *supra* note 4.

7. *See* Kraman & Hamm, *supra* note 2, at 964.

8. Telephone Interviews with Kraman, Hamm & Johnson, *supra* note 4.

9. In 1999, the Lexington VA formally adopted a policy on "Patient Safety (Integrated Risk Management Program)", VAMC Memorandum No. 00-1, VA Medical Center, Lexington, Kentucky, Nov. 4, 1999. Telephone Interviews with Kraman, Hamm & Johnson, *supra* note 4. Posted on easels at the hospital's entrances are excerpts including:

> 2. *PHILOSOPHY*: Human error is inevitable, even among the most conscientious professionals practicing the highest standard of care. Identification and reporting of adverse events, including those that result from practitioner error, are critical to our efforts to continuously improve patient safety. Likewise, medical managers have a duty to recognize the inevitability of human error and attempt to design systems that make such error less likely; and to avoid punitive reactions to honest errors.
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> 3. *POLICY*: Key components of the patient safety/risk management policy and approach are:
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> a. All employees and practitioners are responsible for fully cooperating in efforts to improve patient safety and eradicate potential risks. This includes the reporting of events which result in actual or potential injury to a patient.
>
> b. Patients and their families will be informed about injuries resulting from adverse events and the options available to them.
>
> c. The Risk Management Committee is [the] hub of responsibility for patient safety activity. This includes overseeing the investigation, reporting

The policy involved multiple steps. The hospital encouraged workers to report mistakes to its risk management committee, which included Dr. Steven Kraman, the hospital's chief of staff and chair of the risk management committee, and Ginny Hamm, the hospital's in-house counsel. Once a mistake was reported,[10] a typical case proceeded as follows. The committee rapidly investigated the mistake and attempted to determine its root cause. If the root cause was deemed "systemic," efforts at systemic reform were undertaken.[11] If the mistake resulted in harm to the patient, irrespective of whether the patient was aware of it, the patient was informed of the error. In some cases, the patient was not aware nor likely would have become aware of the mistake absent the hospital volunteering the information.[12] The risk management committee then brainstormed about ways to aid the patient through further medical treatment, disability benefits and compensation.[13]

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and analysis of patient safety and adverse event data as well as orchestrating family notifications and interventions when warranted.

While the approach of assuming responsibility for errors was implemented in practice in 1987, the Lexington VA did not formally articulate this policy until November, 1999. *See* Telephone Interviews with Kraman, Hamm, & Johnson, *supra* note 4. For a discussion of the delay, see *infra* text accompanying notes 114-119.

10. As the policy became established, the prevalence of reporting increased so that often an error was reported by multiple sources. Telephone Interviews with Kraman, Hamm & Johnson, *supra* note 4. Such multiple-source reporting no doubt provides an incentive for the person who has committed the error to report it directly and promptly.

11. A mistake was deemed "systemic" if another individual in the same circumstances would have been likely to have committed the same error. Telephone Interviews with Kraman, Hamm & Johnson, *supra* note 4. For example, on one occasion, after a patient received the wrong dilution of the medication herapin, it was discovered that dilutions of different strengths (1:1000 and 1:10000) were stored in the pharmacy on the same shelf next to one in highly similar bottles. Changes to prevent future confusion (e.g., using differently colored bottles and putting bottles of different dosages on different shelves) were then made. Since the adoption of their new policy, the hospital has "fixed" several systems based upon such analysis. *Id. See infra* text accompanying note 79 (discussing a similar instance of poor medication labeling at Kaiser Permanente in Denver); *see infra* text accompanying notes 69 - 80 (on the need for systemic approaches to the prevention of such medical errors).

12. *See* Kraman & Hamm, *supra* note 2, at 964 ("Since this policy has been in place .... [f]ive settlements involved incidents that caused permanent injury or death but would probably never have resulted in a claim without voluntary disclosure to the patients or families.").

13. While the hospital fully discloses all errors that cause harm to the patient, after much careful deliberation, the hospital decided that, where the mistake does *not* result in harm to the patient (i.e., "harmless error"), the hospital would not inform the patient of the mistake. Telephone Interviews with Kraman, Hamm & Johnson, *supra* note 4. (The description by Kraman & Hamm of error reporting does not address the harmless error scenario. Kraman & Hamm, *supra* note 2, at 964). Dr. Albert Wu critiques this position suggesting that, "Even if the mistake did not result in an ad-

The committee arranged a meeting between itself, the patient and anyone the patient wished to bring, usually family members and an attorney.[14] If the risk management committee believed that the hospital or its employees had been at fault, Dr. Kraman apologized to the patient at that meeting, including admitting fault verbally and, if the patient desired, subsequently in writing.[15] Members of the committee then discussed further steps the hospital could take to aid the patient medically and any disability benefits to which the patient might be entitled.[16] In cases where the risk management committee believed the hospital or its employees had been at fault, the committee made what it believed to be a fair settlement offer.[17] Typically, settlement ensued rapidly.[18]

From the financial viewpoint, the new approach of assuming responsibility, including apology, passed the Hippocratic test: it appears to have done the hospital no financial harm and may have done some financial good. Recall that in 1985 and 1986 the hospital paid two malpractice verdicts that together totaled $1.5 million.[19] 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.[20] This placed the Lexington VA in the lowest quartile of thirty-six comparable VA hospitals for malpractice payments and in the bottom sixth in terms of average liability payment per claim.[21] As Kraman and Hamm modestly put

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verse outcome, I still recommend that the near miss be disclosed." Wu, *supra* note 2, at 971; *see infra* text accompanying notes 108-113.

14. Dr. Kraman, Attorney Hamm and Nurse Johnson represented the hospital at a typical meeting. The employee who committed the error (e.g., the negligent physician) did not usually appear. For a discussion, *see infra* text accompanying notes 108-113.

15. *See* Telephone Interviews with Kraman, Hamm & Johnson, *supra* note 4.

16. *See id.*

17. *See id.*

18. Kraman estimated that, following the apology and the settlement offer, "nine out of ten cases settled very rapidly." *Id.*

19. Though I have not seen other pre-1987 data, these two verdicts totaling $1.5 million may be "outliers," greatly exceeding the average payment in pre-1987 years. Hence, some caution is warranted in comparing the 1990 to 1996 results with those two verdicts.

20. *See* Kraman & Hamm, *supra* note 2, at 964. In their published study, Kraman & Hamm report on the years 1990 through 1996 because data for comparable VA hospitals was only available for those years. However, the data for the Lexington VA for other years since the adoption of the new policy (i.e., 1987 through 1989 and 1997 through 1999) are similar. Telephone Interviews with Kraman, Hamm & Johnson, *supra* note 4.

21. *See* Kraman & Hamm, *supra* note 2, at 965 (the latter statistic is derived from a comparison of the tables).

it, "[Under the policy of assuming responsibility], the Lexington facility's liability payments have been moderate and are comparable to those of similar facilities."[22]

This may understate the overall financial benefits of the new policy for it overlooks savings in litigation costs. Under the new policy, most cases settled rapidly, and rapid settlement undoubtedly reduced expenses generated by litigation (e.g., legal fees, employee time, expert witness fees). Based upon an accounting of an earlier case,[23] Kraman and Hamm estimated that apart from the ultimate award the hospital incurred roughly $250,000 in other expenses for a single case litigated through the appellate level.[24] By fostering rapid settlement, the new policy helped avoid such litigation costs. During the period of their study (1990-1996), "[s]even claims proceeded to federal court and were dismissed before trial. One claim proceeded to trial and was won by the government [VA]."[25] If Kraman and Hamm's estimate that a single case litigated through the appellate level entailed $250,000 in legal expenses is even roughly accurate, then the decreased expenses through rapid settlement were likely significant sources of savings due to the new policy. In short, it appears that the approach of "assuming responsibility" helped rather than harmed the financial "bottom line" of the Lexington VA.

Other parts of the VA system have begun to take notice. In 1995, the Department of Veterans Affairs adopted a risk management policy toward medical errors resulting in injury. The policy required that, "the medical center will inform the patient and/or the family, . . . [offer appropriate medical treatment] . . . [and further] "inform[ ] the patient and/or family of their right to . . . Application for Compensation and Pension . . . or to file an administrative tort claim."[26] Within the past few years, two other VA hospitals have adopted the Lexington model.[27]

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22. *Id.* at 965-66.

23. *See* Telephone Interviews with Kraman, Hamm & Johnson, *supra* note 4.

24. *See* Kraman & Hamm, *supra* note 2, at 966; *see also* Henry S. Farber & Michelle J. White, *A Comparison of Formal and Informal Dispute Resolution in Medical Malpractice*, 23 J. LEGAL STUD. 777, 778 (1994) (indicating markedly lower legal expenses for medical complaints settled early within informal processes).

25. Kraman & Hamm, *supra* note 2, at 964.

26. *Id.* (quoting *Patient Safety Improvement*, Department of Veteran Affairs, VHA Manual 1051/1 (1998)).

27. *See* Telephone Interviews with Kraman, Hamm & Johnson, *supra* note 4.

C. Preliminary Observations

Before further discussing the Lexington VA's experience, several observations are in order. First, the rules governing liability for VA hospitals and their employees differ from those of their private sector counterparts. As Gerlin's article mentions, VA hospitals are government organizations, and malpractice actions against VA hospitals must be brought under the Federal Tort Claims Act ("FTCA"). There are procedural and substantive differences between such claims and ordinary malpractice actions.[28] Procedurally, claims brought under the FTCA are heard by a federal bench trial, which has no jury, and only after administrative remedies have been exhausted.[29] Substantively, while state law governs the claim, there is no possibility of punitive damages under the FTCA.[30] This substantive bar on punitive damages, along with the distinct procedural rules, certainly reduces the liability exposure of VA hospitals compared to private hospitals.[31] Note, however, that the presence of punitive damages in the private sector may actually help promote the use of apology in that sector. A private sector injurer may apologize in an effort to avert punitive damages.

A physician employed by the VA is also in a very different position from his private sector counterpart. As a VA employee, she has virtually no personal exposure for malpractice.[32] Unlike her private sector counterpart, the VA physician will also experience no increase in her medical malpractice premiums following a successful malpractice suit, because she need not carry any. Her error, however, can be reported for certain licensing purposes and, in repeat or egregious cases, can result in dismissal or the loss of medical license.[33] In short, the VA physician faces far less personal

28. *See* Thomas K. Kruppstadt, *Determining Whether a Physician is an Independent Contractor in a Medical Malpractice Action Under the Federal Tort Claims Act*, 47 BAYLOR L. REV. 223, 226 (1995).

29. *See* 28 U.S.C. § 2402 (1994).

30. *See* 28 U.S.C. § 2674 (1994).

31. Though admitting the comparison's imprecision, Kraman and Hamm suggest that VA hospitals face roughly half the liability exposure of their private sector counterparts on a given claim. "It is difficult to accurately compare the Veterans Affairs experience with that of the private sector, but [comparisons of U.S. Bureau of Justice Statics reports] indicate[ ] that [in the early 1990's] the average medical malpractice judgment in the private sector ($1,484,000) is considerably greater than that in the Veterans Affairs system ($720,000)." Kraman & Hamm, *supra* note 2, at 966.

32. *See* Kruppstadt, *supra* note 28, at 226.

33. *See* Kraman & Hamm, *supra* note 2, at 966.

exposure than her private sector counterpart.[34] Note, however, that while the Lexington VA and its employees enjoy certain protections under the FTCA that their private counterparts do not, the Lexington VA is on a level "legal playing field" vis à vis the other VA hospitals in the Kraman and Hamm study.

Second, while apology is an aspect of the Lexington VA's approach to medical mistakes, it is but one piece of an overall system of response. The overall system might be called "assuming responsibility for errors." Defense attorneys commonly assist defendants in denying responsibility for their mistakes.[35] By contrast, the Lexington VA embraced responsibility. Beyond the single act of apology, the broader orientation of accepting responsibility was reflected in acts such as offering fair compensation for injuries, attempting to prevent similar mistakes in the future, and developing channels for open, direct communication.[36] This general posture fits with VA's historical mission and organizational philosophy of caring for veterans.[37]

Third is the matter of equity in patient compensation. Putting aside for the moment the issue of the overall level of liability payments to patients, the Lexington VA's approach of assuming responsibility may also have produced more equitable results than the "lottery" of litigation that could ensue more often from a combative approach. A critique of our current malpractice liability system is that, as a means for compensating patients for medical errors, litigation is highly sporadic.[38] Most cases of medical malpractice go undetected,[39] and even once detected, jury awards fre-

34. For an overview of legal and financial incentives in private health care, focusing particularly on limited liability faced by managed care organizations because of ERISA provisions and how such provisions influence patient care, see Bryan A. Liang, *Patient Injury Incentives in Law*, 17 YALE L. & POL'Y REV. 1 (1998)[hereinafter Liang, *Patient Injury Incentives in Law*].

35. *See* Cohen, *supra* note 1, at 1009-10, 1042-46.

36. For an apology to "work," the injured party generally must perceive it as sincere. *See id.* at 1017-18. By coupling the apology with what it believed was a fair offer of compensation, the Lexington VA "put its money where its mouth was." Such action no doubt promoted the belief by the injured party that the apology was sincere.

37. *See* 38 U.S.C. § 7301 (1994).

38. *See generally* PAUL C. WEILER ET AL., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION (1993). For references to more recent works, see David M. Studdert et al., *Can the United States Afford A "No-Fault" System of Compensation for Medical Injury*, 60 LAW & CONTEMP. PROBS. 2 (1997).

39. *See, e.g.*, A. Russell Localio et al., *Relationship Between Malpractice Claims and Adverse Events Due to Negligence: Results of the Harvard Medical Malpractice Study III*, 325 NEW ENG. J. MED. 245, 249 (1991) (analyzing a study of 31,429 patient

quently fail to reflect the underlying merits of the case.[40] By contrast, I suspect that the new policy helped produce more equitable results across patient awards and fairer results in terms of tying compensation to the actual merits of the individual case. Not only were patients more likely to learn of medical errors under the new policy,[41] but there was also a high probability of a moderate level of settlement then ensuing. Out of the thirty-six comparable VA hospitals, the Lexington VA was the among the fifth highest in terms of the number of claims against it but among the lowest sixth in terms of liability payment per claim.[42] Compare these results with a litigious model, where the polar outcomes of either a large award or no award commonly ensues. Under the new policy, most cases settled quickly, in Kraman and Hamm's assessment, at moderate levels of compensation based upon "reasonable calculations of actual loss."[43] While one cannot draw definitive conclusions about either the distribution of payments or the merits of individual payments from such aggregate statistics and such a subjective assessment,[44] it is probable that the new approach promoted greater equity between cases and greater fairness in an individual case. If so, then these too are laudable achievements.

A question arises as to whether the Lexington VA's possible cost savings are fairly attributable to their adoption of the assuming responsibility approach. For example, could the statistics placing the Lexington VA in the lowest quartile for total claims payments and the lowest sixth for average payment per claim have resulted from factors other than its approach of assuming responsibility, includ-

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records finding malpractice claims were filled in less than two percent of cases in which medical negligence caused injury to a patient).

40. *See, e.g.*, Troyen A. Brennan et al., *Relation Between Negligent Adverse Events and Outcomes of Medical Malpractice Litigation*, 335 NEW ENG. J. MED. 1963, 1966 (1996) (analyzing a study of 51 malpractice suits finding that malpractice awards were correlated only with the severity of plaintiff's disability and not with the provider's negligence). *See generally* Bryan A. Liang, *Error in Medicine: Legal Impediments to U.S. Reform*, 24 J. HEALTH POL., POL'Y & L. 1, 28-38 (1999) [hereinafter Liang, *Error in Medicine*] (surveying shortcomings of the American malpractice liability and suggesting alternatives); Bryan A. Liang, *Promoting Patient Safety Through Reducing Medical Error: A Paradigm of Cooperation Between Patient, Physician, and Attorney*, S. ILL. U. L.J. (forthcoming).

41. *See* Kraman & Hamm, *supra* note 2, at 964.

42. *See id.* at 965.

43. *Id.* at 964.

44. The statistics reported in Kraman & Hamm are aggregate statistics (e.g., showing means and frequencies). While some inferences about the distribution's shape may be drawn from them, as they do not give precise information on the shape of the underlying distribution of data, these are probable inferences, but by no means certainties. *See id.* at 965.

ing apology, for medical errors?[45] Might it simply be that the Lexington VA committed fewer, less serious errors during this period than the other hospitals? These are certainly valid questions. The Lexington VA's experience may have resulted from many possible causes, and, as a single case study, its results are subject to multiple interpretations.[46] Yet, while such concerns should be recognized, they should not be overemphasized. The data appear to show that the Lexington VA's new policy of assuming responsibility, including apology, did not harm and may have helped the hospital financially. One cannot say for certain that this is so, but this seems to be a reasonable conclusion.

Many lawyers see only the obvious economic risks to apology but overlook the possible economic benefits.[47] Stepping back for a moment from the example of the Lexington VA, two reasons apology can be economically beneficial to the apologizer are as follows.[48] First, in some cases injured parties may refrain from suing if they receive an apology. Often a "vicious cycle" exists where following an error, an injurer (e.g., physician) wants to apologize but refrains from doing so out of fear of legal liability, and it is precisely this absence of an apology that triggers the lawsuit.[49] For example, one study found that twenty-four percent of the families who sued their physicians following prenatal injuries filed medical malpractice claims when "they realized that physicians had failed to be completely honest with them about what happened, allowed them to believe things that were not true, or intentionally misled them."[50] While there are some patients who say that they would

45. *Id.* at 964-66.

46. The Kraman and Hamm study is at root a descriptive study using comparative data, rather than a casual study testing hypothesis through methods such as experimentation. *See* Kraman & Hamm, *supra* note 2.

47. *See* Cohen, *supra* note 1, at 1042-46.

48. Some other reasons that apologizing following injury can be economically beneficial to the injurer, such as facilitating error prevention, are discussed below. Note that apologies also can offer non-economic benefits to the apologizer such as helping to repair a damaged relationship or alleviate guilt.

49. *See* Cohen, *supra* note 1, at 1011-12.

50. Gerald B. Hickson et al., *Factors That Prompted Families to File Medical Malpractice Claims Following Prenatal Injuries*, 267 JAMA 1359, 1361 (1992). In addition, 19% said they filed suit because of the "desire to deter subsequent malpractice by the physician and/or seek revenge," concerns that may also have been met by apology. *Id. See also* Charles Vincent et al., *Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action*, 343 LANCET 1609, 1612 (1994) (finding that 377 British patients and their families might not have brought malpractice suits had there been a full explanation and apology — and arguing that these are more significant factors than monetary compensation in determining whether to file a suit). For other related references, see Cohen, *supra* note 1, at 1011 n.7.

not have sued if they had received an apology but in fact would have, surely there are some patients who can be taken at their word.[51] Second, an apology can greatly facilitate the settlement process and thereby reduce settlement costs.[52] An apology often cannot substitute for compensation for the injury but can be a way of avoiding compounding insult upon the injury–insult that can prevent settlement.

I am not reducing apologies to mere matters of economics or suggesting that parties make insincere apologies solely for strategic advantage. Apology should be rooted in responsibility and remorse rather than in economics and strategy. It is the ethical response to injuring another, irrespective of the economic consequences. However, I think that parties often fail to make apologies out of their fear of adverse economic consequences and thereby fail to seriously consider both the potential risks and benefits of apology.[53] As VA hospital lawyer Ginny Hamm described, "The attorneys around here in Lexington used to think we were crazy [when we initiated our new policy]."[54] As one who studies the possible benefits and risks of apology, I can attest that many attorneys and legal academics greet the idea that apology can financially benefit the apologizer with much skepticism. The Lexington VA's experience helps refute the skeptic's view that apology necessarily entails financial suicide. Rather, it indicates the opposite: apology can be to the apologizer's financial benefit.

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51. The experience of one of my colleagues illustrates this poignantly. His first-born son, who recently died, was born with a rare metabolic disease. When he was fourteen months old, the child suffered a stroke and developed persistent seizures, the prevention of which required very high doses of powerful anti-convulsant medications. Several weeks into the child's hospitalization for the stroke and seizures, my colleague, who was then a law professor, received a telephone call at work from the doctor in charge of his son's care. The doctor instructed my colleague to come to the hospital as soon as possible. When my colleague arrived, the doctor informed him that the child had slipped into a coma and that it probably happened as a result of an accidental overdose of the anti-convulsant medication. He then apologized for the incident. Fortunately, the child survived the mishap. Upon hearing these events, I asked my colleague whether the physician's apology made any difference. His response was simple:

> Because the doctor apologized, we would never have sued. Everyone is human. In fact, the fact that he was honest gave us greater confidence in his future evaluations and recommendations concerning my son's care. But if he hadn't been honest — if he had denied the mistake and I had somehow found out later — I would have considered suing him because it would have raised doubt about my son's entire course of care.

52. *See* Cohen, *supra* note 1, at 1019-23.

53. *See id.* at 1022-23.

54. Gerlin, *supra* note 5.

One may ask whether other organizations, particularly private organizations, can achieve cost savings by adopting this approach of assuming responsibility, including apology and fair offers of compensation. At this point, I think the best one can say is that this is an open question, which is itself a significant statement. As noted above, under the FTCA , the Lexington VA faces reduced liability exposure when apologizing as compared to a private hospital or other private organization, which may in part help explain the willingness of the Lexington VA to apologize. However, even in the private sector, an approach of assuming responsibility by an organizational defendant can yield surprising results.

Consider the experience of the Toro Company ("Toro"), a major manufacturer of lawn care products including power mowers, blowers and trimmers. Toro is subject to many personal injury claims, roughly one hundred and twenty five annually.[55] For years, "Toro handled all lawsuits filed against it by immediately referring them to outside counsel to be aggressively defended. [The strategy, said] Toro's assistant general counsel James Seifert, could be summed up as 'litigate everything'."[56] In 1991, Toro decided instead to respond to claims in a non-confrontational manner by offering to mediate them.[57] In mediation, after exchanging essential information about the claim, Toro's counsel would typically express sympathy for the claimant's injury and then make what Toro saw as a fair offer of settlement. Note, however, that while Toro commonly expressed sympathetic words, it appears that Toro typically did not apologize in the sense of admitting its own fault.[58]

Despite much initial skepticism from the defense bar,[59] the net result was that under this new approach Toro settled claims far more rapidly and at far less cost. Pre-1991, the average lifespan of a claim from filing until settlement or verdict was twenty-four months, whereas from 1992 to 1996, the average lifespan was four

55. J. Stratton Shartel, *Toro's Mediation Program Challenges Wisdom of Traditional Litigation Model*, 9 INSIDE LITIGATION 10 (June 1995).

56. *Id.*

57. John J. Upchurch, *Pre-Litigation Resolution of Claims through Early Intervention/Mediation*, THE REVOLUTIONIZING LITIGATION MANAGEMENT REPORT, June, 1995, at 9; *see also* John D. McKinnon, *Cutting Legal Fees*, FLORIDA TREND, May 1996, at 27 (describing Toro's adoption of mediation "as a way of trimming its fast-growing litigation cost"); Miguel A. Olivella, Jr., *The Toro Company's Early Intervention ADR Program* at 3 (Sept. 1999) (unpublished paper on file with *Fordham Urban Law Journal*) (describing the adoption of a "pre-litigation intervention program that featured mediation as the cornerstone of claims disposition").

58. *See infra* notes 59-64 and accompanying text.

59. *See* Olivella, *supra* note 57, at 4.

months. Pre-1991, the average payout per claim on both verdicts and settlements was $68,368. From 1992 to 1996, it was only $18,594. Pre-1991, the average costs and fees per claim were $47,252. From 1992 to 1996, they were only $12,023. In sum, Toro's average total cost per claim fell from $115,620 to $30,617, saving Toro $54,329,840 during that period. In addition, Toro saved on insurance costs.[60] Based upon the documented liability savings following the adoption of the new program, Toro's liability insurance premiums were reduced by $1.8 million per year for three years, after which Toro opted to self-insure.[61] The savings have continued beyond 1996. Toro's counsel Miguel Olivella, Jr. estimates that by 1999, the Toro company saved over $75 million from the new approach to settlement that it had adopted in 1991.

Several comparisons between Toro's program and that of the Lexington VA should be made. First, Toro attempts to settle their cases within mediation. This setting frequently provides statutory confidentiality protection. Further, Toro insists upon written confidentiality agreements designed to exclude statements made within the mediation from admission in court. As with the Lexington VA, here too is a case where special legal provisions, though of a different sort, help to promote settlement. Second, the cost savings in legal fees per claim were considerable, falling by seventy-four percent from $47,252 to $12,023. In the Lexington VA case, the data on decreased litigation costs were far less precise; however, Toro's experience is suggestive of how significant rapid settlement can be in reducing litigation costs. Third, unlike the Lexington VA, Toro does not usually apologize in the sense of admitting fault during the mediation. Consider the words of Mr. Olivella,

> Apology to an injured claimant has been something I do from the beginning [of the mediation]. It lets the claimant know that despite the accident's fault, no one takes any pleasure in knowing that a human being has been injured, seemingly putting the claimant more at ease when he discovers that the company is not the cold, cruel evil empire he may have thought we were. In the context of a mediation, it is possible to act in such a fashion without it being a sign of weakness.[62]

60. *See id.* at 12-13. Based on such remarkable results, Toro's program received in 1994 the Center for Public Resource's Institute for Dispute Resolution Significant Practical Achievement Award. *See* Shartel, *supra* note 55, at 10.

61. Olivella, *supra* note 57, at 9.

62. Electronic correspondence from Miguel A. Olivella, Jr. to Jonathan R. Cohen (Dec. 3, 1999).

Some may describe this statement as crafty. By strongly expressing sympathy, the statement gives the claimant the feeling of having been apologized to without an actual admission of Toro's fault. I, however, do not see it as fundamentally duplicitous. Unlike the Lexington VA, Toro typically has limited information about the cause(s) of the accident. Whereas the Lexington VA has access to most of the relevant factual information concerning its role in a malpractice claim, Toro often does not. Hence, even if Toro sought to admit its fault fully at the commencement of the mediation, it would be difficult to know exactly what Toro should admit. Rather, I would suggest that Mr. Olivella's statement, though loose in its use of the word "apology," is suggestive of a richer sense of humanity[63] and perhaps a more complex understanding of responsibility[64] than is seen in most litigation.

Professor Owen Fiss has argued that justice is what takes place in a courtroom and that the settlement process is an inferior substitute, "a highly problematic technique for streamlining dockets . . . [and] a capitulation to the conditions of mass society [that] should be neither encouraged nor praised."[65] Yet our current system of litigation is largely based upon parties denying responsibility, and thus forcing the opposing party to prove one's fault rather than directly accepting responsibility and admitting those acts that one understands to be one's fault. By apologizing, parties assume responsibility for their mistakes rather than denying it. If the injurer is willing to apologize, surely this is the preferable path. Further, our legal system usually leads to dichotomized understandings of rights, bifurcating responsibility when it can be more just to apportion the responsibility.[66] Settlement discussions, by contrast, frequently produce understandings of shared and partial responsibility. Perhaps Mr. Olivella's statement, "despite the accident's fault," reflects a more complex understanding of responsibility, and hence of justice, than is found in most litigation.

It is easy to be "hard-nosed" and reflexively conclude without evaluation that approaches of assuming responsibility for injuries,

63. *Id.* ("[N]o one takes any pleasure in knowing that a human being has been injured, seemingly putting the claimant more at ease when he discovers that the company is not the cold, cruel evil empire he may have thought we were.").

64. *Id.* (observing that, through mediation, Toro acknowledges "despite the accident's fault").

65. Owen M. Fiss, *Against Settlement*, 93 YALE L.J. 1073, 1075 (1984).

66. *See* John E. Coons, *Approaches to Court Imposed Compromise — The Uses of Doubt and Reason*, 58 Nw. U. L. REV. 750 (1964); John E. Coons, *Compromise as Precise Justice*, 68 CAL. L. REV. 250 (1980).

including apology, increase legal expenses. The Lexington VA's experience is one striking example where accepting, rather than denying, responsibility for errors, including making a fault-admitting apology, was financially viable, if not beneficial.[67] While Toro does not typically make fault-admitting apologies, its response of accepting financial responsibility in mediation rather that denying it through litigation has produced tremendous economic savings for Toro. Such experiences should make even the most "hard-nosed" skeptic take a second look at the potential economic benefits to the injurer of accepting responsibility for injuries, including apology. While the best motives for responsible approaches, including apology, are not financial, for those driven solely by financial considerations, the question is not whether such approaches can save money, but where and when they can.[68]

67. Some may question whether the aforementioned reports on the experiences of the Lexington VA and the Toro Corporation could be biased due to the sources of the reports. The main report of the Lexington VA's experience was written by Kraman and Hamm, who were also central in creating and implementing the hospital's new policy. Similarly, some of the reports on Toro come from Miguel Olivella, Jr., who was central in creating and implementing Toro's program. That said, independent sources help confirm both accounts: Kraman and Hamm's article was subject to peer review; both the Lexington VA and Toro were reported in journalistic accounts; and Toro received a national award for its program.

Perhaps the concern about possible bias should be applied to this paper as well. Below, I use the Lexington VA's experience as a springboard for speculating about the possible effects — and generally positive effects — of apology in the organizational setting. In so doing, I have tried to be objective. However, as one who believes in the potential of apology, perhaps what I "see" in the data, especially when some of that data is anecdotal rather than statistical, may too be biased. For example, while Kraman and Hamm believe, based upon their experience, that the hospital's new approach of apology helped reduce future mistakes, they have no "hard data" to confirm this. Rather, they simply mention instances in which systemic reforms were made following investigations of errors. They cannot say for certain that such reforms would not have been made absent the approach of assuming responsibility. *See* Telephone Interviews with Kraman, Hamm & Johnson, *supra* note 4. Hence, I stress that below I offer *conjectures* about some organizational dimensions of apology. Evaluating the validity of such conjectures awaits further research.

68. Elsewhere, I have argued that we ought to consider reforming our laws to exclude apologies from admissibility as evidence and thus encourage, rather than discourage, apologies after injury. *See* Cohen, *supra* note 1. *See also* Orenstein, *supra* note 1. The experiences of the Lexington VA and Toro help to support this argument. The Lexington VA's fault-admitting apologies and the Toro company's apologetic expressions of sympathy both arose in contexts where the liability exposure engendered when making such statements was limited as compared to typical litigation by particular legal rules, viz., the FTCA and mediation confidentiality provisions respectively. This is not to discount the significance of the actions of the Lexington VA or Toro. Rather it is to say that creating more "safe" havens whereby an apology could not be used as evidence in court against the apologizer (e.g., creating an independent eviden-

I. LEARNING TO PREVENT FUTURE ERRORS

There can be little doubt that organizations are more likely than individuals to commit multiple, serious injuries over time. This is not a statement about the morality or intentions of organizations but simply a reflection of their size. Consider car accidents. Individuals involved in more than twenty accidents over their lifetime are rare. By contrast, a large organization with a fleet of vehicles, such as the U.S. postal service, may be involved in thousands of accidents each year. A doctor may be considered unfortunate if he is sued even once for malpractice in a given year, but the hospital at which he works may expect to receive dozens of such suits annually.

This basic difference raises a possible collateral benefit of apology in the organizational setting: learning to prevent future errors.[69] Both individuals and organizations can learn from their errors, but with organizations, the possibility of preventing future errors and lawsuits is much greater. Errors frequently stem from internal deficiencies and can afford particularly valuable learning experiences.[70] For example, in the nuclear power and aviation industries, extensive investigations of accidents and "near misses" are undertaken with the central aim being to undercover systemic

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tiary exclusion for apologies) would likely help foster apology and thus promote settlement.

How exactly the use of such mechanisms bears upon the sincerity of the apology is a more complex question. *See* Cohen, *supra* note 1, at 1067-68 (arguing that apologies made within "safe havens" can be both sincere and ethically acceptable, provided that both sides understand that the apology is offered within such a mechanism). *Cf.* Lee Taft, *Apology Subverted: The Commodification of Apology*, 109 YALE L.J. 1135 (2000). While there is merit in the concern that apologizing within a "safe" mechanism may "cheapen" the moral act of apology, it should be noted that, where an apology is offered within a "safe" mechanism, (a) the injured party can and should take note of the context in which the apology is offered, and (b) the apologizer always has the option of making an offer of financial compensation along with the apology. Thus, "safe" mechanisms increase the modes of communication available to the parties. Absent such "safe" mechanisms, we are more likely to witness the vicious cycle discussed above whereby the injurer fails to apologize out of fear of liability and it is precisely the absence of the apology that triggers the lawsuit.

69. The cost of medical errors is tremendous and has recently received much attention. *See* TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 1 (Linda T. Kohn et al., eds., 1999)(reporting studies estimating that between 44,000 and 98,000 Americans die each year from medical errors, which is more than from motor vehicle accidents, breast cancer or AIDS).

70. On evaluating the sources of medical error, *see id.* at 42-48 (distinguishing between "active" errors and "latent" or systemic errors stressing the need to reduce the latter); *see also* Liang, *Error in Medicine*, *supra* note 40.

problems and thereby prevent future errors.[71] As part of its approach of "assuming responsibility," the Lexington VA undertook a "root cause" analysis once an error was reported and, on multiple occasions, implemented systemic changes to prevent such future errors.[72]

What exactly is the link between apology and preventing future errors? Could an organization fully investigate errors and undertake systemic reforms without embracing an external apology? While such investigation and reform are possible without apology, I believe that they are facilitated by apology. As an act of external honesty, openness and humility, apology can facilitate the same internally and thus promote change. When an organization adopts the stance of assuming responsibility for its errors, its members are likely to be more prompt in reporting errors,[73] more honest in investigating them, and more willing to embrace reform. Common wisdom suggests that "you can't fix a problem until you admit you have one." I believe this applies both to individuals and to organizations. The converse may also be true. Organizations that deny or "cover up" problems may face difficulties not only in correcting those errors but in maintaining internally honest communication. Further, they risk damaging corporate morale.

Often members of organizations fail to report the errors they commit internally to their superiors and externally to those they harm. For example, one study found that "[h]ouse officers reported discussing the mistake with the supervising attending physician in only 54% of cases . . . [and] discussed the mistake with the patient or patient's family in only 24% of cases."[74] No doubt, part of this failure is motivated by liability concerns. A doctor may correctly think, "If I tell either the patient or my boss about the mistake I made, that admission will just come back to be used against me in court, but if I keep it to myself, I may well get away with it." Such concerns have led to the arguments that we should consider

71. *See* Liang, *Error in Medicine*, *supra* note 40, at 28-31. As with nuclear power and aviation, medical errors arise within complex systems and can result in grave consequences.

72. Telephone Interviews with Kraman, Hamm & Johnson, *supra* note 4.

73. For errors to be properly investigated, prompt reporting is best so that the investigation can begin when people's memories are fresh and the equipment is still in place.

74. Albert Wu et al., *Do House Officers Learn from Their Mistakes?*, 265 JAMA 2089, 2092 (1991).

excluding both internal reports of medical errors and external apologies from admissibility in court.[75]

Putting aside the question of whether the legal rules about the admissibility of such internal reports and external apologies should be changed, my suspicion is that when an organization expresses its willingness to accept the responsibility for errors, its employees become more willing to report their own errors and those of their coworkers. Just as external denial may breed internal denial, external responsibility may breed internal responsibility. By accepting responsibility for its errors, including apology, the Lexington VA implicitly gave its employees a message that, "It's okay for you to be open when you err, for we will be open with that information. We aren't going to hide it, so you need not either." The hospital's experience reflected this. Since the hospital initiated its new approach in 1987, there has not been, in the risk management committee's assessment, a single non-frivolous malpractice claim against the hospital where the hospital did not first learn of the medical mistake through internal reporting.[76]

Apology may also help enlist the injured party's involvement in the error reduction process. Sometimes injured parties will have information relevant to or ideas about error prevention that they are unwilling to share absent an apology. Suppose that an organization is trying to correct an internal pattern of sexual harassment. While the organization could attempt to correct the problem without input of those who have been harassed, such input would be highly valuable, and absent an apology, that input may be much more difficult to obtain. Just as organizations have an incentive to prevent future injuries, so do those who are injured. Apology can be critical to building a "team" approach to error prevention between the injurer and the injured.

To some, the possibility that openly admitting mistakes and accepting responsibility for them, including apology, could decrease legal costs, or the possibility that the evidentiary immunization of reports of medical error could decrease the level of medical error seems counterintuitive. The key is the difference between short-

75. On internal reports of medical errors, see Liang, *Error in Medicine*, *supra* note 40, at 39-43 (indicating that such internally reported information will often be discoverable in subsequent litigation despite the peer review privilege and arguing for legal reforms to ensure the confidentiality of such information); *see also* TO ERR IS HUMAN, *supra* note 69, at 94-113; Cohen, *supra* note 1 (arguing for consideration of evidentiary reforms to exclude apologies from admissibility to prove fault in court); Orenstein, *supra* note 1.

76. Telephone Interviews with Kraman, Hamm & Johnson, *supra* note 4.

run effects and long-run dynamics, dynamics that include the possibility of learning. For example, suppose that society wishes to decrease the incidence of an undesirable event like medical malpractice. How can this best be achieved? Generally speaking, the "legal" approach is to sanction instances of that undesirable event: when a doctor commits an error, punish him. By doing so, the law gives doctors a strong incentive to avoid committing errors. In essence, such reasoning is rooted in a static microeconomic perspective: if one raises the price (i.e., expected cost, including the chance of detection and the level of punishment) of malpractice, doctors will commit less of it.

The world, however, is dynamic. While sanctioning doctors for medical errors gives doctors an incentive to avoid committing errors,[77] it may have other side effects. For example, if doctors become unwilling to share information with one another about their medical errors for fear that such revelations will be used against them in malpractice suits, then medical education, in the broadest sense, and error prevention may become less effective.[78]

In short, external apology can prompt the disclosure and the investigation of errors that is needed for preventive measures. A recent report in the *New York Times* illustrates the relationship between disclosure and error prevention within a private medical practice:

> Dr. Michael Leonard, an anesthesiologist and chief of surgery for Kaiser Permanente in Denver, was operating on a cancer patient a few months ago when he reached into a drawer for medicine. Inside were two vials, side by side. Both had yellow labels. Both had yellow caps. One was a paralyzing agent, which Dr. Leonard had correctly administered to keep the patient still during the operation. The other was the reversal agent, which he

77. Other factors, such as medical ethics and reputation, also give doctors strong incentives to avoid committing errors.

78. A parallel argument has been advanced concerning genetic patenting. In the short run, granting what is in essence a monopoly right for scientific discoveries is a powerful incentive driving such discoveries. However, if the monopoly rightholder is stingy in allowing others to license that discovery (and, if the rightholder is a corporation and its central motive is profits, why shouldn't it be?) or if the transactions costs (e.g., legal fees) involved in obtaining licenses are prohibitive, the long run effects of such a legal regime could be socially suboptimal. *See* Michael A. Heller & Rebecca S. Eisenberg, *Can Patents Deter Innovation? The Anticommons in Biomedical Research*, 280 SCIENCE 698 (May 1, 1998)(suggesting that excessive patenting can produce an "anticommons" inhibiting overall scientific discovery). *See also* Michael A. Heller, *The Tragedy of the Anticommons: Property in the Transition from Marx to Markets*, 111 HARV. L. REV. 621 (1998).

> needed next. "I grabbed the wrong one," Dr. Leonard recalled. "I used the wrong drug."
>
> It would have been easy for the doctor to keep quiet; the drug wore off and the patient was not harmed. Instead, he talked — to the surgeon and scrub nurses, the patient's wife and the hospital pharmacist, who has since relabeled the paralyzing agents with red stickers and put them in a separate drawer. He also talked to his five partners, whose reaction unnerved him.
>
> "Four of the five of them said, 'You know, I've done the same thing,'" Dr. Leonard said. "One of them said, 'I did the same thing last week.' And I'm thinking, I've been chief of this department for five years. Now I'm chief of surgery. And nobody has ever said to me, 'We have this problem.' A lot of it comes back to this culture of silence."[79]

Until an organization is willing to admit its errors — and apologizing by definition involves admitting error — preventing future errors will be difficult.[80]

II. DIVERGENT INTERESTS

Divergent interests are a second source of complexity regarding apology in the organizational setting. Below I discuss three salient features: principal-agent tensions between organizations and their employees, differences in risk preferences between organizations and individuals and self-insurance versus third-party insurance by organizations.

A. Principal-Agent Tensions

An individual who injures another when working as an employee may ask whether revealing the mistake and apologizing for it will be in his best interest. However, for the organization, the relevant utilitarian question is whether apologizing will be in the organization's best interest.[81] Put differently, will the employee/agent do

79. Sheryl Gay Stolberg, *Do No Harm: Breaking Down Medicine's Culture of Silence*, N.Y. TIMES, Dec. 5, 1999, at D1.

80. *See* Cohen, *supra* note 1, at 1014-15 (discussing definitions of apology).

81. The best reason to apologize is not a simple utilitarian one. A person should apologize when she has harmed another because it is the right thing to do, rather than because it is in her own self-interest (e.g., leading the other party to drop the case). *See* Cohen, *supra* note 1, at 1065-67 (discussing ethical concerns regarding apologies made for strategic purposes). However, when analyzing the principal-agent tension, it is simplest to focus upon the utilitarian perspective. For characterizations of the utilitarian model of choice, see Amartya Sen, *Behavior and the Concept of Preference, in* CHOICE, WELFARE AND MEASUREMENT 54 (1982); Amartya Sen, *The Formulation of Rational Choice,* 84 AM. ECON. REV. 385-90 (May 1994). *See also* Jonathan R. Cohen,

what is in the organization's/principal's best interest? For example, throughout the Monica Lewinsky scandal, Bill Clinton may have refrained from apologizing fully, including fully admitting those acts, for fear that such admissions would have cost him the Presidency. However, from the viewpoint of the Office of the Presidency, it might have been best for him to apologize fully, because irrespective of whether he was replaced, the integrity of the Office would have been upheld.

While principal-agent tensions are prevalent throughout society,[82] they can be particularly acute in the dispute resolution setting.[83] Not only are the interests of agents and principals commonly at odds in dispute resolution, but the strategic possibilities for interacting with the opposing side can also complicate matters further.[84] Moreover, economic theory suggests that such tensions cannot be eliminated fully. We cannot make them disappear, rather the best we can do is address and manage such tensions.[85]

In many hospitals, a doctor will refrain from revealing his error to the patient out of fear of adverse consequences, such as an increase in his experience-rated medical malpractice premiums.[86] Undoubtedly, part of what induces physicians at the Lexington VA to reveal their errors, both to patients and to hospital administrators, is that they are largely shielded from personal financial exposure.[87] While other factors may still weigh against their reporting of a mistake, such as risking their reputation or having the mistake reported to state licensing agencies or the National Practitioner Data Bank,[88] compared to a private physician, a VA physician assumes little personal risk by reporting his own mistakes. At root the VA system, rather than the individual physician, bears the

Reasoning Along Different Lines: Some Varied Roles of Rationality in Negotiation and Conflict Resolution, 3 HARV. NEGO. L. REV. 111, 111-22 (1998) (arguing that the recognition of the plurality of roles that reasoning plays is central to understanding negotiation and dispute resolution).

82. *See* PRINCIPALS AND AGENTS: THE STRUCTURE OF BUSINESS (John W. Pratt & Richard J. Zeckhauser eds., 1985).

83. *See* NEGOTIATION ON BEHALF OF OTHERS (Robert H. Mnookin & Lawrence Susskind eds., 1999).

84. *See id.* at 6-8.

85. *See id.*

86. For a fine overview of incentives in medical care, see Liang, *Patient Injury Incentives in Law*, *supra* note 34.

87. *See* 28 U.S.C. § 2674 (1994).

88. *See* Kraman & Hamm, *supra* note 2, at 966. On the National Practitioner's Data Bank, see 42 U.S.C.A. §§ 11101-11152 (1999) (section 11132 discusses the reporting requirement of sanctions taken by Boards of Medical Examiners).

brunt of the cost of the individual physician's mistake. This provides an incentive for VA physicians to reveal their mistakes and apologize for them.

B. Risk Preferences

There are good reasons to suspect that individuals and organizations have different attitudes toward risk. First, organizations usually have far greater financial resources than individuals and are likely to be more risk neutral than individuals toward a given risk. Second, while a doctor may commit only one serious medical error a year, the hospital at which he works at may experience scores of such errors committed by different physicians per year. As a result, the hospital is able to spread the risks of a given legal strategy, such as apology, across multiple cases.[89] Both of these reasons suggest that, vis à vis a particular case, the organization is likely to be more risk neutral than the individual physician.

How does this apply to apology? The implication is not entirely clear. On the one hand, admitting a mistake and apologizing for it is a risky step. If the apology is not offered within a "safe" mechanism, such as certain mediations, then the opposing party can use the admission as proof in court. This suggests that organizations might be more willing to embrace apology than individuals. On the other hand, failing to apologize can also be a risky step, potentially destroying an already damaged relationship and resulting in a prolonged suit or punitive damages that might have been averted through an apology.[90] From an economic perspective, both apologizing and not apologizing can be seen as gambles. If organizations tend to be more risk neutral than individuals, one would expect organizations to embrace apology more often than individuals if apologizing is riskier than not apologizing.

C. Self-Insurance versus Third-Party Insurance

A distinctive feature of the Lexington VA is that it self-insures. In contrast to many private hospitals that carry third-party liability insurance, the VA system does not, but as a large organization directly bears its liability costs. This too has ramifications regarding apology, since organizations and their third-party insurers may have divergent interests concerning apology.

89. This reasoning also applies to claims, such as many private medical malpractice or automobile accident claims that are ultimately paid by insurance companies, as spreading risks across many cases lies at the heart of the insurance business.

90. *See* Cohen, *supra* note 1, at 1015-23.

Though at times an organization that has third-party insurance will be more willing to apologize than one that self-insures,[91] I suspect that self-insurance may actually promote apology overall. Third-party insurers may give little weight to some of the benefits of apology that an organization may value. For example, the Lexington VA's embrace of apology helped promote the well-being of its patients, its internal morale, and its reputation as a caring institution — all interests that a third-party insurer might very well disregard.[92]

Self-insurance also gives the Lexington VA greater control over its approach for handling errors, including apology, than would third-party insurance. Most insurance contracts impose upon the insured a general duty of cooperation with the insurance company in defense of the claim.[93] Some insurance contracts specifically prohibit the insured from voluntarily assuming liability, a restriction that some courts have taken as a condition precedent to the contract.[94] Hence, there is an issue of whether a hospital or doctor might void the insurance coverage by apologizing. The short answer to that question is "probably not,"[95] and I know of no case in which an organization's insurance coverage was voided by apologizing. However, this concern may still have a chilling effect on the use of apology by an injurer that carries third-party insurance.[96]

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91. An organization with third-party insurance may think, "It's the insurance company, and not we, who will have to pay for the cost of the mistake." Consider one example. Following a crash off of Nova Scotia in which 229 people were killed, Swissair was forthcoming in assuming responsibility and seeking a settlement in which it accepted responsibility for compensatory damages provided punitive damages were dropped. *See* Hope Yen, *Swiss Airline Offers To Pay the Families of 229 Crash Victims*, SUN-SENTINEL (Fort Lauderdale), Aug. 6, 1999. The fact that Swissair carried third-party insurance was likely a factor. As Swissair's Chairman Philippe Bruggisser commented, "We are well insured and able to face [compensation payments.]" AIRLINE FIN. NEWS (Mar. 1, 1999).

92. Similarly, in the case of the individual injurer, he may have interests in apologizing (e.g., protecting his reputation or alleviating his guilt that a third-party insurer may disregard).

93. *See* JOHN A. APPLEMAN & JEAN APPLEMAN, 8 INSURANCE LAW AND PRACTICE § 4771 (1981); JEFFREY W. STEMPEL, INTERPRETATION OF INSURANCE CONTRACTS § 31.9 (1994).

94. *See* APPLEMAN & APPLEMAN, *supra* note 93, § 4780; 14 COUCH ON INSURANCE 2D § 51: 22 (rev. ed. 1982).

95. *See* Cohen, *supra* note 1, at 1025-28.

96. *See, e.g.*, Naneen K. Baden, *The Japanese Initiative on the Warsaw Convention*, 61 J. AIR L. & COM. 437, 464 (1995) (indicating that concerns, ungrounded in Baden's view, over increased insurance costs are a factor inhibiting airline companies from assuming responsibility for injuries). The central concern of Baden's article–that Japanese airline companies have sought to have restrictions on their liability for international accidents imposed by the Warsaw Convention removed–is intriguing. While

With the control of the "purse strings," may come some control not only over the litigation but the dispute resolution processes that precede it. I find it noteworthy that in the Toro example, soon after switching to a policy readily accepting responsibility within mediation, Toro switched from third-party insurance to self-insurance.

Third, self-insurance gives an organization a strong incentive to prevent future errors: the organization itself will have to pay for them. Therefore, if adopting a policy of apology will help prevent future errors, a self-insuring organization will be inclined toward it. Now compare this to an organization that carries third-party insurance. While an organization that carries third-party insurance does have an incentive to keep its insurance premiums from rising by preventing errors, having the insurance does reduce the "sting" of such errors.[97] Consider also the interests of the third-party insurance company. After the insurance contract is signed and the premiums are set, reducing future errors is no doubt a good thing. Fewer errors mean fewer claims payments and hence greater profits for the insurance company. Let us call this "incentive one." However, before the contract is signed, the insurance company has no incentive to help reduce future errors. Indeed, if ways could be found to prevent all future errors, the insurance company would be out of business for there would be no need to buy insurance. More generally, if one supposes that an insurance company's profits are tied to the volume of their business and that this volume is tied to underlying levels of errors, then an insurance company has little incentive to promote error reduction.[98] Let us call this "incentive two."

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denial may be a central part of American culture, assuming responsibility for mistakes, including apology, is far more prevalent in Japan. For references to the use of apology internationally, see Cohen, *supra* note 1, at 1013 n.10. *See generally* NAOMI SUGIMOTO, JAPANESE APOLOGY ACROSS DISCIPLINES (1999).

97. *See, e.g.*, ROBERT H. FRANK, MICROECONOMICS AND BEHAVIOR 193-94 (1991).

98. A cynic might argue: "To err is human. To make money off of it is the business of lawyers and insurers. Thus, both lawyers and insurers benefit because errors occur." While it goes to far to say that lawyers or insurers actively seek to promote errors from such interests, perhaps it is right to view such passive beneficiaries and the systems within which they work with a critical eye. Recall Lincoln's advice, "Discourage litigation. Persuade your neighbors to compromise whenever you can. Point out to them how the nominal winner is often a real loser — in fees, expenses and waste of time. As a peacemaker the lawyer has a superior opportunity of being a good man. There will still be business enough." Abraham Lincoln, *Lecture Notes*, *in* 2 COLLECTED WORKS OF ABRAHAM LINCOLN 81 (Roy P. Basler ed., 1953). More recently, some scholars have suggested that legal disputes may have a prisoner's dilemma element in which each side is better off getting a lawyer than not, but both sides are

I do not suggest that incentive two outweighs incentive one. Rather, I wonder whether incentive two decreases the desire of insurance companies to pursue approaches to dispute settlement, including apology, that might help prevent future errors as vigorously as self-insuring organizations. In short, a self-insured organization has a clear and direct incentive to prevent future errors and thus has a strong incentive to use mechanisms like apology. In contrast, where an organization buys third-party insurance, the organization's immediate incentive to avoid errors decreases, and the insurer's incentives may be mixed. By spreading the responsibility for errors between the organization and its insurer, some of the responsibility may get lost in the cracks.

III. NON-PECUNIARY BENEFITS TO CORPORATE MORALE, PRODUCTIVITY AND REPUTATION

From both positive[99] and normative[100] perspectives, it is easy to conceive of organizations, like corporations, in largely economic terms. Yet corporations are more than just economic entities. They are centers of human activity, and as such, are and should be centers of moral activity too.

Though it is a mistake to envision perfect parallels between individual and organizational functioning, limited parallels do exist. An individual injurer who apologizes may relieve his internal sense of guilt and increase his self-esteem. Similarly, an organization that apologizes for errors may bolster its corporate morale. When Connie Johnson, a quality assurance nurse, states that, "Telling the truth is the right thing to do," or when Steven Kraman, the hospi-

made worse off when both sides get lawyers. For discussions and references, see Ronald J. Gilson & Robert H. Mnookin, *Disputing Through Agents: Cooperation and Conflict Between Lawyers in Litigation*, 94 COLUM. L. REV. 509, 510 n.7, 524 n.43 (1994) (suggesting lawyers may actually help solve this prisoner's dilemma).

99. *See generally* OLIVER WILLIAMSON, THE ECONOMIC INSTITUTIONS OF CAPITALISM (1985) (arguing that firms arise because contracting to cover all future contingencies in the production process is impractical). For references to both economic and sociological approaches to understanding organizations and their interaction with the law, see Marc C. Suchman & Lauren B. Edelman, *Legal Rational Myths: The New Institutionalism and the Law and Society Tradition*, 21 L. & SOC. INQUIRY 903 (1996); Lauren B. Edelman, *The Legal Environments of Organizations*, 23 ANN. REV. SOC. 479 (1997).

100. *See, e.g.*, Milton Friedman, *The Social Responsibility of A Business is to Increase Its Profits,* N.Y. TIMES, Sept. 13, 1970, § 6 (Magazine), at 32 (arguing that fidelity to shareholders requires corporate executives to seek profits and disregard broad conceptions of social responsibility). For a critique of narrow, role-based conceptions of ethical responsibility, see ARTHUR I. APPLBAUM, ETHICS FOR ADVERSARIES: THE MORALITY OF ROLES IN PUBLIC AND PROFESSIONAL LIFE (1999).

tal's chief of staff and chair of its risk management committee, states that, "Almost every risk manager and attorney says, 'We always tell the truth,' . . . But I don't know of any other hospital that goes out and calls the family when there's been an error[,]" the pride these people feel in the Lexington VA is apparent.[101] Such pride fosters organizational loyalty and productivity. Offering an apology after an injury is a matter of respect, and treating others with respect generates self-respect. In the medical setting, the ethical impetus to apologize for error is even stronger than in other organizational settings. Medical ethics require that physicians put the patient's best interests first, and it is hard to imagine many cases where, having been harmed by the doctor's errors, it is not in the patient's best interests for the doctor to apologize.

Some benefits associated with apologizing are external to an organization. For example, offering an apology can enhance an organization's reputation. Although some organizations would rather deny responsibility than admit error, other organizations benefit from embracing responsibility. For example, when the Lexington VA apologized to the Browns, the Browns gladly "came back" for more business.[102] Errors happen, and apologizing to customers following errors can promote greater customer loyalty and hence profitability. Goodwill can be a highly valuable corporate asset. Indeed, non-apology can have a price, and sometimes organizations may offer apologies because failing to do so would be too costly. For example, following reports of racism toward its own employees, Texaco repeatedly apologized publicly for that racism. While one may wonder whether such apologies were motivated primarily by sincere contrition or by the fear of losing customers who might otherwise have perceived Texaco as a racist organization and thus opt for non-Texaco products, the fear of losing customers was likely one motivating factor.[103]

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101. *See* Gerlin, *supra* note 5.

102. *See id.* (Of course, the Lexington VA may have remained the best financial choice for the Browns, but their attitude toward the hospital reflected more than finances.)

103. *See* Hanna Rosin, *Cultural Revolution at Texaco*, THE NEW REPUBLIC, Feb. 2, 1998, at 18:

> [O]nce the Times story appeared [documenting Texaco's racism], Texaco CEO Peter Bijur quickly adopted a strategy known in public- relations circles as "total contrition." With [a] p.r. maven . . . at his side, Bijur issued a series of tortured apologies. "We care about each and every employee," he said on a satellite broadcast. "I care deeply. . . . I am sorry for our employees and both ashamed and angry that such a thing happened in the Texaco family."

The internal and external benefits to organizations of assuming responsibility often go hand in hand. Although apology was not involved, consider the effects of Johnson & Johnson's responsible response in the Tylenol poisoning episode.[104] Johnson & Johnson reacted to reports of poisoning by rapidly pulling Tylenol from retail shelves at a cost to Johnson & Johnson of over $50 million.[105] Once it was confident the Tylenol supply was safe, Johnson & Johnson reintroduced the product with added safety features under the same brand name, rather than under a new brand name as many had suggested. John H. Bryan, Jr., chairman and chief executive officer of Sara Lee Corporation, commented,

> [C]ommunity responsibility is an important measure of corporate excellence. By enhancing a company's reputation, it makes it easier to hire better people, easier to sell products, and easier to cope with difficult problems. For example, Johnson & Johnson well-deserved reputation as a good corporate citizen undoubtedly helped the Tylenol brands survive in the marketplace, despite the potentially devastating impact of the poisoning scares.[106]

Johnson & Johnson's responsible handling of the Tylenol episode seems to have also enhanced its external reputation. Note too that Johnson & Johnson's response did not occur in an organizational "vacuum." Instead, its response was consonant with its famed corporate credo of making responsibility to those who use its products, rather than its own profits, the corporation's first priority.[107]

Id. Within two weeks, he turned the nightmare into an opportunity for enlightenment. He met with Jesse Jackson and Al Sharpton and asked for their help in making Texaco a "model of diversity." He bravely shouldered the historical burden. "The moment is now, and the responsibility is ours to demonstrate to the nation that discrimination can be eradicated. That true inclusion can exist. And that equal opportunity can be provided to every man and woman," he said, sounding totally contrite at a November 15, 1996, press conference. "We will work ceaselessly and tirelessly, day after day, to build a company of undisputed opportunity for all individuals." *Id.*

104. For descriptions, see *Tylenol's "Miracle" Comeback*, TIME, Oct. 17 1983, at 67 (observing that a year after the poisoning, public confidence was restored); Mark L. Mitchell, *The Impact of External Parieties on Brand-Name Capital: The 1982 Tylenol Poisonings and Subsequent Cases*, ECONOMIC INQUIRY, Oct. 1, 1989, at 601; John B. Cullen et al., *An Ethical Weather Report: Assessing the Organization's Ethical Climate*, ORGANIZATIONAL DYNAMICS, Sept. 22, 1989, at 50.

105. *See Tylenol's "Miracle" Comeback*, *supra* note 104.

106. John H. Bryan, Jr., *The Corporation and the Executive in the Community*, 1987 COLUM. BUS. L. REV. 695, 697-98 . For a list of recent awards Johnson & Johnson has received for good corporate citizenship, see Johnson & Johnson, *Awards and Recognition* (visited Mar. 30, 2000) <http://www.johnsonandjohnson.com/who_is_jnj/awards.html>.

107. The first paragraph of Johnson & Johnson's credo provides:

Legal expenses paid in compensation of injuries will typically appear on most organizations' balance sheets. However, many of the non-pecuniary benefits of apology (e.g., to organizational morale, loyalty, communication, productivity, reputation, and customer loyalty) will not typically appear on an organization's balance sheet. Hence, organizations that overly focus on short-term profits as reflected in balance sheets may tend to neglect apology. In some ways, a policy of apologizing for errors is like an investment: though the immediate price may be clear, the long run economic benefits, though real, are less defined. If the current CEO cares primarily about short-run profits, he may "underinvest" in an approach of apology that may financially benefit a future CEO.

IV. STANDING AND SCOPE

Two issues arising with apology in the organizational setting, but far less in the individual setting, are standing and scope.[108] By standing, I mean who has the moral authority to apologize. By scope, I mean what the apology will cover. When an individual acting on his own commits an injury, generally speaking, both standing and scope are clear: that individual should apologize to the extent that he believes himself to be at fault.[109] In the organi-

> We believe our first responsibility is to the doctors, nurses and patients, to mothers and fathers and all others who use our products and services. In meeting their needs everything we do must be of high quality. We must constantly strive to reduce our costs in order to maintain reasonable prices. Customers' orders must be serviced promptly and accurately. Our suppliers and distributors must have an opportunity to make a fair profit.

Johnson & Johnson, *Our Credo* (visited Mar. 30, 2000) <http://www.johnsonandjohnson.com/who_is_jnj/cr_usa.html>. The last paragraph of that credo provides, *inter alia*, "Our final responsibility is to our stockholders. Business must make a sound profit." *Id.* For a history of that credo, its significance within the organization, and mention of its influence of the organization's handling of the Tylenol episode, see Johnson & Johnson, *The History of the Johnson & Johnson Credo* (visited Mar. 30, 2000) <http://www.johnsonandjohnson.com/who_is_jnj/cr_index.html>. Discussion of this credo forms an important component of ongoing employee training, especially among executives, and influenced how the Tylenol episode was handled. *See* Speech of David E. Collins, Formerly Member of Executive Committee and Vice Chairman, Board of Directors, Johnson & Johnson and the employee principally responsible for the management of the Tylenol crisis (Sept. 23, 1999, Notre Dame Center for Ethics and Religious Values in Business, South Bend, IN). Perhaps it is not surprising that Johnson & Johnson, a corporation that had both clearly articulated and regularly addressed its policy of corporate responsibility, acted so responsibly to the Tylenol poisoning episode.

108. For factors to consider when making an apology, including standing and scope, see Cohen, *supra* note 1, at 1047-52.

109. In some cases, a lawyer or other agent might offer an apology on the individual's behalf.

zational setting, standing and scope are less clear. If an employee's error injures a customer, who should apologize, the employee, the head of the organization, or an ombudsperson? What should that person say? In the case of the Lexington VA, Dr. Kraman, the hospital's chief of staff and chair of the risk management committee, offered an apology to the injured patient. Is he the right person? Could one argue that the person who committed the error (e.g., the treating physician) should be the one to apologize? After all, if Dr. Kraman did not make a mistake, what does he have to apologize for?

No doubt much will depend upon the particular facts of a situation, and it is beyond my aim here to fully explore the issues of standing and scope. Rather, let me suggest two levels at which these issues ought to be considered: the theoretical and the practical.

A. Theoretical Level

At the theoretical level, one would think that standing and scope when making an apology should be tied to an agent's moral culpability. In the individual case, this means that a person who commits an error should apologize for that error to the extent that he believes himself at fault, and that, concomitantly, he has no moral capacity to apologize beyond the extent to which he believes himself to be at fault. The organizational context is more complex. In the organizational context, the injurer's fault can be both multidimensional and overlapping. The individual injurer may place the fault upon himself, "If only I had paid more attention the mistake would not have occurred." The organization may also see itself at fault and think, "We shouldn't have workers on twelve-hour shifts," or "We should have been more careful in screening those we hire," or, most generally, "We are responsible for what happens at our hospital."[110] *Respondeat superior* is not just a legal concept but a moral one: if the individual committed the injury while acting in his scope as an employee, then the organization bears some responsibility. As mentioned above, at the Lexington VA, apologies are typically offered by Dr. Kraman rather than by the individual

110. The first two statements ("we shouldn't have workers on twelve-hour shifts" and "we should have been more careful in screening who we hired") point to systematic errors. The latter statement ("we are responsible for what happens at our hospital") does not point to a systemic error but simply represents a broad understanding of organizational responsibility.

who made the error. While this practice might be critiqued,[111] perhaps this policy stems in part from a broad understanding of organizational responsibility.

B. Practical Level

Practical considerations also bear upon who should make an apology. Consider the case where the error is caused by an individual physician's mistake. At the Lexington VA, Dr. Kraman and Attorney Hamm suggest that the main reason to have Dr. Kraman rather than the erring physician apologize is practical: If the individual physician attends the face-to-face meeting with the patient, emotions tend to run very high, both on the part of the patient and on the part of the physician, and easily obstruct settlement.[112] In contrast, if the physician is absent, emotions tend to be much "cooler," thus settlement is facilitated.[113] Consider also the common case where following the injury, the organization discharges the injuring employee. That employee may be unwilling to apologize to the injured party, and if the organization wants to apologize to that party, it must select someone else to offer the apology. The scope and content of that apology will be quite different than had the injurer apologized directly, but the apology may still be of much value.

V. Policy Articulation

While many individuals are highly reflective about how they should respond when they have injured another, few ever formally articulate a policy about it.[114] Generally speaking, there is no need. Even if the individual consciously decides on a particular approach,

111. Albert Wu has critiqued the Lexington VA's practice, suggesting that the individual who made the error should offer the apology. *See* Wu, *supra* note 2, at 971.

112. Some may say that allowing strong emotions such as shame and anger to be released is ultimately helpful and hence that it is good when high emotions accompany apology rather than being buried or avoided. Yet such intense emotions may sometimes interfere with reaching a settlement, and, if reaching settlement is the goal, using agents can be helpful. For barriers to conflict resolution generally, see Barriers to Conflict Resolution (Kenneth Arrow et al. eds., 1995). For a discussion of the use of agents to at times overcome such barriers, see Negotiating on Behalf of Others, *supra* note 84; Jeffrey Z. Rubin & Frank E.A. Sander, *When Should We Use Agents? Direct vs. Representative Negotiation*, 4 Negotiation J. 4, 395, 395-401 (1988).

113. Telephone Interviews with Kraman, Hamm & Johnson, *supra* note 4.

114. Some individuals look for advice, such as psychological or religious prescriptions, about how to act when they have injured another, but that is quite different from articulating their own policies.

he can simply follow it without formally expressing it. Yet the situation is different with organizations. Organizations regularly articulate a variety of policies, for unlike individuals, organizations often need to formally articulate policies to implement them. Further, organizations are also more likely than individuals to commit multiple injuries over time, and the policies that they adopt may receive multiple applications.

From the viewpoint of a scholar studying dispute resolution, the ideal scenario would be if an organization formally articulated a policy, implemented that policy, collected data on the effects of that policy, and then formally revised that policy in light of the data. In such an ideal world, policies toward dispute resolution would undergo iterative design and development. Our world, however, is far muddier than that. Consider the experience of the Lexington VA. Following two large, adverse verdicts in 1985 and 1986, and also shortly after hiring Dr. Kraman and Attorney Hamm,[115] the Lexington VA implemented a new approach of assuming responsibility, including apology and a fair offer of settlement. Yet, in part due to bureaucratic complexities of working within the VA, a large government system,[116] this approach was not formally articulated as a hospital policy until 1999. In other words, the reality preceded the writing by more than a decade.

This suggests two questions: (i) to what extent is an organization's actual approach consistent with its articulated policy, and (ii) to what extent does policy articulation influence actual organizational behavior? It is beyond the scope of this paper to try to resolve such questions here. Let me simply suggest several considerations. Regarding the first question, organizations frequently articulate policies that members do not follow. For example, many hospitals have ethical guidelines calling for the reporting of medical errors, but medical errors often go unreported.[117] Second, the fact that policies are not always followed does not mean that the articulation of a policy has no influence. Articulating a policy may help an organization to follow it. For example, part of what influenced Johnson & Johnson to handle the Tylenol poisoning episode so responsibly was its credo.[118] Similarly, the Lexing-

115. *See* Telephone Interviews with Kraman, Hamm & Johnson, *supra* note 4.

116. *See id.* Note, too, that the formal policy articulation in November 1999 slightly preceded the publication of Kraman & Hamm's study. *See* Kraman & Hamm, *supra* note 2.

117. *See, e.g.*, Wu, *supra* note 74; TO ERR IS HUMAN, *supra* note 69, at 74-93 (discussing existing error-reporting systems and recommending reforms).

118. *See supra* note 107 and accompanying text.

ton VA may now feel more bound to follow the approach of assuming responsibility now that it has formally articulated that policy. Articulating a policy can be a form of self-constraint at the institutional level.[119] Though it may not work perfectly, it may still have some bite.

CONCLUSION

The approach of the Lexington VA to medical errors over the past decade provides a glimpse of the potential of apology in the setting. In this paper, I have discussed the following issues concerning organizational apology: (i) the process of learning to prevent future errors; (ii) the divergent interests related to principal/agent tensions between organizations and their employees, risk preferences and sources of insurance; (iii) the non-pecuniary benefits to corporate morale, productivity and reputation; (iv) the standing and scope when apologizing; and (v) the effects of policy articulation.

Before ending, let me underscore several points. First, I do not suggest that under the current legal and economic arrangements, all organizations can adopt the approach of assuming responsibility for injuries, including apology, with financial consequences similar to the Lexington VA's. The legal and economic arguments governing VA hospitals and their employees, as well as the VA's historical relationship with its members, differ from those typical in the private sector.[120] Further, the medical setting has features,

119. *See* THOMAS C. SCHELLING, *The Intimate Contest for Self-Command*, 60 PUB. INTEREST 94-118 (Summer 1980); JON ELSTER, ULYSSES AND THE SIRENS: STUDIES IN RATIONALITY AND IRRATIONALITY (1979).

120. Unlike the Lexington VA example, the private sector often presents the complexity of multiple defendants with multiple sources of insurance. Such multifaceted, structural differences between legal and economic incentives within the VA system as compared to private medical practice may help support arguments for multifaceted, structural reform of the latter. For example, if legal and economic incentives discourage private physicians from apologizing when they make errors, a question arises of whether structural reforms should be undertaken to change those incentives. *See* TO ERR IS HUMAN, *supra* note 69, at 3 ("A comprehensive approach to improving patient safety is needed. This approach cannot focus on a single solution since there is no 'magic bullet' that will solve this problem, and indeed, no single recommendation in this report should be considered *the* answer. Rather, large, complex problems require thoughtful, multifaceted responses."). Consider, too, the prevalence of apology under Britain's system of nationalized health coverage. *See* Frances H. Miller, *Medical Malpractice Litigation: Do the British Have a Better Remedy?* 11 AM. J. L. & MED. 433, 434-35 (1986) (describing how nationalized health care has fostered the markedly lower incidence of malpractice suits and much greater role of apology in cases of medical error in Great Britain); *see also* Charles Vincent et al., *supra* note 50.

such as pre-existing relationships between doctors and patients and an ethic of care, not found in many other contexts. Rather, experiences of organizations like the Lexington VA, the Toro Company and Johnson & Johnson suggest that, if only from a financial viewpoint, the approach of assuming responsibility for mishaps — at times even including apology — is worthy of much broader organizational consideration. Many lawyers fear that apology will inevitably produce financial ruin. The experience of the Lexington VA helps disprove that claim and thus shifts the discourse. From the financial viewpoint, the question is no longer whether the approach of assuming responsibility including apology can be economically viable, if not profitable, rather the question is where and when.

Second, this Article has considered the economic ramifications of apology, because much of the skepticism toward apology is rooted in economic concerns. I do not suggest, however, that adopting the approach of assuming responsibility, including apology, to injuries should be evaluated solely, or even largely, on economic terms. There is more to life than profits and more to apology than the economics of it. An apology is meant to show regret, and an insincere apology that is motivated by economic factors alone, rather than by internal remorse, is little apology indeed. Whether or not it is profitable to do so, individuals and organizations have moral obligations to apologize when they have injured another. Assuming responsibility is not just a matter of economics but of ethics.

Third, the above discussion of special issues concerning apology in the organizational context is a theoretical exploration. For example, I make no claim that by adopting an approach of assuming responsibility, including apology, an organization will necessarily decrease future errors, bolster corporate morale or ultimately benefit financially. The experience of the Lexington VA is but one "data point." Rather than drawing deductive conclusions, my goal has been to inspect that "data point" closely and to use it as a lens for offering conjectures about some central dimensions of organizational apology. Evaluating such conjectures awaits future research.

When social systems are awry, it is easy to lose sight of the way things should be. In some respects, our current medical system, so driven by economics and the fear of malpractice liability that doctors are afraid to apologize to patients when they have made er-

rors, is a system gone awry.[121] The Lexington VA took a courageous step in adopting the approach of assuming responsibility, including apology, for errors. There was no doubt that this policy would better serve its patients. How good it is to see that it was also financially sound. Perhaps their experience can serve as an impetus for other organizations to consider embarking on similar paths.

121. The same can be said of how injuries are handled generally within our society, with injurers frequently focused on avoiding, rather than accepting, responsibility.