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Dissembling and Disclosing: Physician Responsibility on the Frontiers of Tort Law

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DISSEMBLING AND DISCLOSING: PHYSICIAN RESPONSIBILITY ON THE FRONTIERS OF TORT LAW

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INTRODUCTION

This Commentary addresses an issue that emerges as a common theme in the three papers in this Symposium Issue dealing with legal considerations in advising physicians: are there circumstances in which telling "less than the whole truth" is warranted?[1] In a bygone era, physicians would have had no difficulty providing an affirmative answer to this question. Well into the twentieth century, it was common practice to withhold from patients the dire news that they suffered from a terminal illness. In a different context, the consensus view until the latter part of the century was the so-called "physician's standard" in informed consent cases; that is, the practice of informing a patient of only those risks associated with an anticipated medical procedure that the physician deemed advisable to disclose to the patient.[2] When physician autonomy clashed with patient autonomy, the former held sway.

These scenarios, however, largely describe the hallmarks of a time past. Today, physicians routinely exercise candor with terminally ill patients and their families about the diminished prospects for long-term survival. In the sphere of responsibility in tort, most state courts now adhere to what has been labeled the "patient standard" on informed consent, which dictates—in the name of patient autonomy—the revelation of all material risks associated with a given medical procedure, whatever the physician's instincts on the risks and benefits of disclosure to the patient might be.[3]

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1. Mary Simmerling, Peter Angelos, Joel Frader, John Franklin, Joe Leventhal & Michael Abecassis, Primum Non Nocere*: Beneficent Deception*, 57 DEPAUL L. REV. 243 (2008); Aaron Lazare, *The Healing Forces of Apology in Medical Practice and Beyond*, 57 DEPAUL L. REV. 251 (2008); David A. Hyman, *When and Why Lawyers Are The Problem*, 57 DEPAUL L. REV. 267 (2008). This theme is only addressed briefly in the Hyman Article. *See* Hyman, *supra*, at 275–77. The other aspects of lawyering in physician-attorney relations that he discusses are outside the scope of this paper.

2. *See* DAN B. DOBBS, THE LAW OF TORTS 655 (2000).

3. *See id.* at 655–56.

But, if legal and medical disclosure norms have shifted dramatically over the course of a century, more subtle aspects of the truth-telling obligation remain highly contentious. In this Commentary, I discuss two categorical instances in which a physician's responsibility to be entirely forthcoming in dealing with medical matters, as well as the correlative legal consequences of abandoning candor, have proven to be especially vexing. Initially, Part II discusses what Mary Simmerling and her coauthors refer to as the "blameless medical excuse" in organ transplant cases; more specifically, the common practice of providing prospective organ transplant donors a medical excuse as a cover for their unwillingness to donate an organ to a family member or close friend.[4]

I then turn from questions of dissembling the truth to compunctions about revealing it. The latter survive as a lively, ongoing dialogue in both the medical and legal arenas in the context of the role of apology for medical negligence, a topic addressed by both Aaron Lazare and David Hyman.[5] I conclude with some summary observations about physician disclosure and its fit within a regime of medical malpractice law.

II. THE UNEASY CASE FOR DISSEMBLING: THE MEDICAL EXCUSE

Simmerling and her coauthors provide a straightforward description of the blameless medical excuse.[6] A potential organ donor candidate, say for a liver or kidney transplant, informs a member of the organ transplant team that he is under great pressure to serve as a donor for a needy potential recipient—often a close family member—but in fact has serious reservations about assenting, perhaps based on anxiety over physical or psychological consequences or, in some instances, grounded in interpersonal reservations. The prospective candidate, however, feels trapped into moving forward in the absence of a covering explanation. In these circumstances, physicians have provided the cover: a spurious medical excuse or explanation that absolves the candidate of any obligation to donate. This is, as it turns out, a standard practice.[7]

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4. Simmerling et al., *supra* note 1, at 243–44.

5. *See* Lazare, *supra* note 1; Hyman, *supra* note 1. Apology is only one of a number of aspects of attorney-medical profession relations discussed by Hyman, but it is the sole issue that closely corresponds to the theme of professional obligations of truthfulness that is central to the other articles.

6. Simmerling, *supra* note 1.

7. *See, e.g.*, Authors for the Live Organ Donor Consensus Group, *Consensus Statement on the Live Organ Donor*, 284 JAMA 2919, 2921 (2000); Joint Commission on Accreditation of Health-

While not flatly opposed to the practice, Simmerling and her coauthors are deeply skeptical about it apart from the strongest cases of family coercion. In other than these limited circumstances, they voice both ethical and practical concerns. Dissembling seems inconsistent with the professional role of the physician, and it may lead to a string of related deceptions or long-term feelings of guilt that undermine the psychological and interfamilial well-being of the donor himself. Then there are troublesome variants on the paradigm case of donor reluctance in which the physician decides on her own—at times counter to the donor's own inclinations—that it would be better for the prospective donor, all things considered, to opt out under the cover of a medical excuse.[8]

Simmerling's interesting discussion focuses almost exclusively on the ethical dilemmas posed for the physician by the medical excuse scenarios, with virtually no consideration of legal responsibility. In this Commentary, I add some thoughts from a tort perspective that may sharpen the image of whether the prospect of legal responsibility is likely to play a significant role in these situations.

Two important dimensions of tort provide some context for this perspective. The first is mentioned above: the substantial movement in recent years on the informed consent front toward respecting patient autonomy, rather than deferring to a paternalistic version of the physician-patient relationship.[9] Simmerling, in her somewhat equivocal expression of support for the medical excuse in limited instances of strong family coercion, suggests that, under those narrow circumstances, the physician may be buttressing patient autonomy. This strikes me as a debatable proposition. At crisis points in life, everyone faces situations where the pressure to conform to the will of others is exceedingly strong. Whether we accede to this pressure is beside the point. The crux of the matter is that these are situations where the strength of our convictions is tested; relying on others for a way out—that is, a way to do what we would "really prefer"—is not an instance of buttressing our personal autonomy. To the contrary, conspiratorial deception by the physician harks back to the days when patients were kept in the dark about the tragic risks that they faced on the grounds that they were too emotionally fragile to live with the truth. Present day tort duties of disclosure rest on a more robust set

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care Organizations, Preparing to Be a Living Organ Donor, *available at* http://www.nicelungs.com/donor_brochure.pdf (last visited Jan. 5, 2008).

8. *See* Simmerling, *supra* note 1.

9. *See supra* notes 1–3 and accompanying text.

of assumptions about taking responsibility as a critical feature of individual autonomy.

The second aspect of tort responsibility that provides relevant context in the medical excuse scenario is the developing law of negligent infliction of emotional distress (NIED) and its boundaries. Until well into the twentieth century, NIED did not stand as an independent claim in tort. While distress-related harm was routinely recognized in physical injury cases as "pain and suffering," a stand-alone claim for emotional harm caused by another's negligent conduct was not recoverable absent some physical contact.[10] The standard explanations for this position were judicial fear of fraud and concomitant anxiety over opening the floodgates of litigation.[11] In the latter part of the century, NIED emerged as a generally recognized claim in tort for both "bystander claims," such as a mother eye-witnessing her child's demise from negligent driving,[12] and "direct" claims, such as personally experiencing a near miss from negligent driving.[13]

However, the newly emerging tort was hedged with limitations that reflected the remaining vestiges of concerns about fraud and floodgates.[14] Thus, bystander NIED, even in more plaintiff-friendly jurisdictions, has threshold requirements: close familial relationship to the physical injury victim and direct observation of the accident.[15] Direct claims for NIED, absent some physical contact, generally require that the claimant be in the zone of danger for physical injury.[16]

How do these considerations play out in the various medical excuse scenarios, or, to put it another way, are there background risks of tort liability for the organ transplant team in supplying the customary medical excuse? First, consider the case discussed by Simmerling in which there was a threat of legal action (Case 3).[17] The prospective donor's wife, rather than the donor himself, requests the medical excuse—and nondisclosure to the husband as well—because of the hus-

10. DOBBS, *supra* note 2, at 835–36.

11. *See id.*

12. *See* Dillon v. Legg, 441 P.2d 912, 920 (Cal. 1968).

13. *See* Falzone v. Busch, 214 A.2d 12, 17 (N.J. 1965).

14. In addition to fraud and floodgate concerns, the limitations reflected a *de minimis*-based conviction that a certain amount of emotional strength is a prerequisite to encountering everyday risks of communal living.

15. *See Dillon*, 441 P.2d at 920. In many jurisdictions, the claim requires an additional prerequisite: that the bystander is in the zone of danger. *See also* Bovsun v. Sanperi, 461 N.E.2d 843, 847 (N.Y. 1984).

16. *See Falzone*, 214 A.2d at 17. There is also a well-recognized tort of intentional infliction of emotional distress, but it is premised on "outrageous misconduct," so it has no bearing on the cases discussed here. *See* RESTATEMENT (SECOND) OF TORTS § 46 (1965).

17. Simmerling, *supra* note 1, at 247–48.

band's fragile emotional make-up. Her threat seems not to pose any substantial risk of legal liability in this case of double-duplicity—that is, duplicity on the part of the organ transplant team (OTT) toward the prospective recipient, as well as the husband himself. Because the zone of danger requirement is not satisfied, refusal to supply the medical excuse could not conceivably lead to a breach of duty claim against the OTT for any mental distress that the wife might suffer. Moreover, on independent grounds, courts have been reluctant to recognize duties of physicians to third parties outside the physician-patient relationship in claims of medical malpractice.[18]

But suppose the OTT were to accede to the wife's wishes and provide a surreptitious medical excuse. Might the husband have a claim in tort for the intercession contrary to his desires? Once again, in the absence of physical injury, or perhaps economic loss, this arguably gross departure from the physician's professional responsibility to his patient does not seem to meet the requisites of the NIED tort. Similarly, in Simmerling's Case 1[19]—where the team takes it upon itself to suggest reliance on a medical excuse to a prospective donor who wants to be candid with his father about his lack of any sense of familial obligation—if the donor reluctantly defers to the OTT's proactive advice and later suffers serious remorse, it seems highly unlikely that the later emotional distress could serve as the grounds for any liability claim.[20]

Indeed, in each of these cases, as well as the paradigm case in which the medical excuse is provided at the behest of a grateful donor candidate who is thereby relieved of substantial family pressure, the most interesting tort question arises from a singular aspect of the medical excuse scenario: namely, the implicit conflict of interest in the OTT's professional obligation not only to the organ transplant donor, but also to the prospective organ transplant recipient. This added dimension of professional responsibility removes the barrier of the NIED tort in cases where a prospective recipient dies because there is no viable alternative but the prospective donor, who has availed himself of the medical excuse to refuse participation. To put the scenario in tort terms, is there a colorable wrongful death claim against the OTT for providing a fictitious medical excuse that arguably denied an organ to the prospective recipient when that organ would have saved his life?

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18. But the picture is mixed. *See generally* MARC A. FRANKLIN, ROBERT L. RABIN & MICHAEL D. GREEN, TORT LAW AND ALTERNATIVES 163–65 (8th ed. 2006).

19. Simmerling, *supra* note 1, at 245–46.

20. Once again, the zone of danger limitation would stand as a bar in this scenario.

There are substantial cause-in-fact problems that might subvert the duty issue. Would the prospective recipient in fact have gone through with the transplant if no medical excuse were provided? Would the transplanted organ in fact have saved the recipient's life? These are counterfactual inquiries that are never easy to resolve and which might not survive the "more probable than not" civil burden of proof threshold.

But, assuming a colorable claim of causation, the scope of physician duty in this singular situation is borderline at best. Does the OTT's duty extend to liability for having assisted a highly stressed third party, the prospective candidate, who after all is also in a professional relationship with the team, to exercise his right to protect his own physical and emotional security?[21] Does a physician's duty under these distinct circumstances extend beyond the ordinary obligation to exercise due care in implementing the anticipated medical procedure and include a broader obligation to take no steps that might interfere with the identification of a suitable candidate? On the latter score, what of the traditional medical malpractice standard that would link due care to the customary conduct of physicians under the circumstances? Is this scenario more like the informed consent requirement that would regard the patient's individual autonomy as the paramount consideration?

In the end, a proactive stance that would impose affirmative obligations on the OTT far beyond the traditional scope of due care in implementing medical procedures seems unlikely to appeal to courts. But, as Simmerling suggests, from an ethical perspective, medical deception, like deception generally, portends so many bad consequences that it should probably be regarded with great caution, irrespective of the attenuated prospect of tort liability. Even in the strongest case for the medical excuse—that is, countering potentially severe emotional distress and coerced donation—the ethical base for dissembling and deception remains dubious despite the likely impunity from legal liability.

III. THE ATTENUATED CASE FOR DISCLOSURE: PHYSICIAN APOLOGY

Aaron Lazare addresses an issue of recent prominence in medical literature and practice: tendering an apology for medical negligence.[22]

21. There are, of course, the physical risks to the organ donor, as well as the prospect of emotional distress.

22. Lazare, *supra* note 1, at 251. *See also* David A. Hyman & Charles Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solu-*

In his view, there are substantial benefits from a physician offering a fulsome, candid apology to a patient who suffers harm as a consequence of negligent treatment, benefits not only to the patient but to the physician as well. From the patient's perspective, an apology provides needed information about what happened and restores personal dignity that is compromised by being kept in the dark about treatment-related physical harm.[23] From the physician's perspective, an apology has a cleansing effect that similarly restores lost dignity, as well as intrinsically binding the professional relationship.[24]

Both the psychological and humanitarian rewards derived from a physician's apology to a patient for negligence seem unexceptionable, and Lazare buttresses his central theme by pointing out the imperatives of implementing the apology in a direct and uncompromising fashion.[25] Where the going gets difficult is when one turns to the legal dimensions of apology.

For Lazare, an uncompromising apology—and one that is fully healing—requires that the physician accepts risks in making amends.[26] In particular, for Lazare, this means that the physician should face the possible legal consequences of openly apologizing, such as potential medical malpractice liability.[27] On that score, one aspect of his argument is that a medical malpractice claim becomes less likely if the patient is offered a genuine and heartfelt apology.[28] But he does not let the matter rest on this somewhat instrumental ground; indeed, he admits that the impact of apology on tort claims is an essentially empirical question that remains open.[29] Lazare's main case for apology is unqualified by possible risks of litigation.[30] Consistent with this view, as discussed below, Lazare appears to be opposed to statutes that would shield apologies from being presented as evidence of negligence at trial.[31]

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tion?, 90 CORNELL L. REV. 893 (2005); Jennifer K. Robbennolt, *What We Know and Don't Know About the Role of Apologies in Resolving Health Care Disputes*, 21 GA. ST. U. L. REV. 1009 (2005); David M. Studdert et al., *Disclosure of Medical Injury to Patients: An Improbable Risk Management Strategy*, 26 HEALTH AFF. 215 (2007); Marlynn Wei, *Doctors, Apologies, and the Law: An Analysis and Critique of Apology Laws*, J. HEALTH L., Winter 2007, at 107.

23. Lazare, *supra* note 1, at 256.
24. *Id.*
25. *Id.* at 257.
26. *Id.* at 260.
27. *Id.*
28. *Id.* at 252.
29. Lazare, *supra* note 1, at 265.
30. *Id.*
31. Specifically, Lazare argues as follows:

> Several concerns arise regarding the efficacy and ethics of the "inadmissibility" legislation. First, how might patients feel when their physicians apologize to them and then

It does seem plausible that, if meaningful apologies for negligence were tendered, some medical malpractice claims would be dropped, mediated, or more readily settled. In this regard, from the prospective plaintiff's vantage point, one must keep in mind that a great deal of what counts for negligence in the medical context is unintended failure to meet customary, professional treatment standards. This is hardly tantamount to injury from careless driving or a dangerously defective product, even if one puts aside the similarly cogent fact that the careless driver or errant product manufacturer is virtually always a stranger rather than the other party in an ongoing relationship of trust.

Moreover, out-of-pocket loss associated with additional medical treatment and lost income may not be in dispute, leaving only intangible loss, characterized as "pain and suffering," as a potential obstacle to early settlement. Here, however, the matter is somewhat more complicated than Lazare's physician versus patient-centered approach indicates. Pain and suffering has many components: past, present, and future pain itself; loss of enjoyment of life; humiliation and shame; loss of dignity; and a sense of unjust treatment.[32] When the latter looms large, as Lazare would cabin the consequences of medical negligence, apology may play a critical role in defusing anger and bitterness. However, to the extent that the other components of the complicated mix of psychological aftershocks from negligent treatment are prominent, the impact of an apology may be diminished.

In addition, to some extent, Lazare's progressive take on the shared values in healing a wounded relationship reflect a somewhat anachronistic perspective on the contemporary world of physician-patient relationships. Increasingly, in a world of highly specialized treatment facilities and physicians, there is only the most attenuated relationship between the physician and patient in the course of treatment, let alone the relationship with the hospital staff when the negligence occurred during an inpatient procedure. This is no argument for being less attentive to the patient's individual autonomy claims for information

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acknowledge that the apologies are inadmissible in court? If one of the healing forces in an apology is the risk the offender takes, and the risk is then negated through inadmissibility legislation, the apology may be negated. In addition, if the patient's lawyer hears an inadmissible apology, she may simply ask the right questions in court to prove medical culpability. Finally, if the patients believe that their physicians are being manipulative by using inadmissible aplogies, they may take more aggressive stands toward the physician or hospital rather than feeling healed.

Id. at 253.

32. *See, e.g.*, Robert L. Rabin, *Pain and Suffering and Beyond: Some Thoughts on Recovery for Intangible Loss*, 55 DEPAUL L. REV. 359 (2006).

and respectful treatment. But these constrained relationships do suggest that apology, in and of itself, may do little to diminish the impulse to seek legal recourse.

These speculative reservations, as well as the similarly speculative case for apology's positive role in diluting the impulse to sue in tort, are empirical questions that deserve study.[33] While intuition may suggest that apology could play some affirmative role in diminishing medical malpractice claims, the critical question in light of existing uncertainty is how to convince physicians that complete honesty is the best policy. Surely Lazare's assertion that the negligent physician's suffering and risk-acceptance are an integral part of the injured patient's healing process is going to ring hollow with many physicians.[34]

It follows that, contrary to Lazare's reservations in principle, a more pragmatic approach would view the critical issue as whether legal rules can be designed so as to encourage, or at least not discourage, disclosure. Correlatively, then, the principal question is whether a physician's apology can be afforded protection in litigation aimed at establishing fault in a medical malpractice case. One might begin by looking for related scenarios: are there analogies outside the medical malpractice area where admissions are shielded from use as evidence against the defendant?

One area that might supply a rough analogy would be the treatment of subsequent remedial measures in product defect cases. In recent years, a number of courts have afforded protection to subsequent remedial measures—a rough surrogate for apology—from being introduced at trial as an implied admission of preremedial defect.[35] A

33. In 1987, the Veterans Affairs (VA) hospital in Lexington, Kentucky began following a mandatory disclosure policy in the event of medical error. The procedure included notifying patients of negligence, setting up in-person meetings between hospital administrators and the patient or family, and helping patients file claims. As a result, the Lexington VA settled most claims and had few malpractice payouts. However, as Marlynn Wei cautions, it is difficult to generalize from the Lexington experience for three reasons. First, since the VA system is government-based, it has options available to provide additional recourse to sources of compensation that are not available to nongovernmental hospitals. Second, under the Federal Tort Claims Act, prelitigation procedural requirements create additional incentives to settle in the VA context. Third, with a predominantly male patient population, VA hospitals rarely have obstetrics departments, which generate frequent medical malpractice claims. *See* Wei, *supra* note 22, at 143–44.

34. On this count, Hyman's assertion that the physician's attorney—in counseling against full disclosure—is central to the problem of securing disclosure seems problematic. Indeed, he ends with a substantial qualification: "Thus, it is possible the 'advice of counsel' defense may have simply given physicians license to do something they would have done anyway." Hyman, *supra* note 1, at 276.

35. *See, e.g.*, *In re* Joint E. Dist. & S. Dist. Asbestos Litig., 995 F.2d 343, 346 (2d Cir. 1993).

statutory codification of this doctrinal development is found in the Federal Rules of Evidence:

> When, after an injury or harm allegedly caused by an event, measures are taken that, if taken previously, would have made the injury or harm less likely to occur, evidence of the subsequent measures is not admissible to prove negligence, culpable conduct, a defect in a product, a defect in a product's design, or a need for a warning or instruction . . . .[36]

On initial appearance, the rationale for a shield in the product defect context appears to be different; it is meant to encourage improvements in the safety of products by not letting those improvements be utilized to sanction a defendant for its earlier product design. But, from a broader perspective, the rationale bears some similarity to a shield from allowing apologies as evidence of negligence in a medical malpractice case. The premise of the apology shield is that there will be public health benefits from encouraging physicians to be open and above-board about their mistakes, putting their errors behind them.[37]

More generally, tort law does not, in most circumstances, shield confessions of error from evidence. Consider the driver who, after an auto accident, admits speeding or the store employee who, after a slip-and-fall injury, admits that messy vegetables were on the floor for a long time prior to the accident. This evidence would be routinely offered and admitted at trial to bolster the case for the defendant's negligence.

With these cross-cutting considerations in mind, what is the state of the law shielding apologies from evidence in a lawsuit? A majority of the states have, in fact, enacted what might be termed "weak" versions of apology; weak in that they only shield benevolent gestures, not admissions of fault, from admission at trial.[38] In this regard, consider the California Evidence Code on "benevolent gestures," defined as "actions which convey a sense of compassion or commiseration emanating from humane impulses":[39]

> The portion of statements, writings, or benevolent gestures expressing sympathy or a general sense of benevolence relating to the

36. FED. R. EVID. 407.

37. This, of course, involves a major assumption about the indifference of physicians to a reputational concern as an end in itself—an assumption that seems counter to long-standing observations by members of the medical profession. This continuing disincentive to apologize would have far less bearing on a product manufacturer's assessment of residual costs in adopting a litigation-shielded superior design.

38. *See, e.g.*, FLA. STAT. ANN. § 90.4026 (West 2007); MD. CODE ANN., CTS. & JUD. PROC. § 10-920 (LexisNexis 2006); OKLA. STAT. ANN. tit. 63, § 1–1708.1H (West 2008); TEX. CIV. PRAC. & REM. CODE ANN. § 18.061 (Vernon 2006); VA. CODE ANN. § 8.01-52.1 (West 2007).

39. CAL. EVID. CODE § 1160(b)(2) (West 2007).

> pain, suffering, or death of a person involved in an accident and made to that person or to the family of that person shall be inadmissible as evidence of an admission of liability in a civil action. *A statement of fault, however, which is part of, or in addition to, any of the above shall not be inadmissible pursuant to this section.*[40]

By contrast, consider the "strong" version of an apology law, found only in Colorado at this point, which would shield admissions of negligence as well:

> In any civil action brought by an alleged victim of an unanticipated outcome of medical care, or in any arbitration proceeding related to such civil action, any and all statements, affirmations, gestures, or conduct expressing apology, fault, sympathy, commiseration, condolence, compassion, or a general sense of benevolence which are made by a health care provider or an employee of a health care provider to the alleged victim, a relative of the alleged victim, or a representative of the alleged victim and which relate to the discomfort, pain, suffering, injury, or death of the alleged victim as the result of the unanticipated outcome of medical care shall be inadmissible as evidence of an admission of liability or as evidence of an admission against interest.[41]

Note that the strong version undercuts some of the positive benefits that claimants derive from apologies, as Lazare sees it. In particular, the shield is inconsistent with assuring that negligent doctors suffer as a consequence of the apology, take risks, and avoid manipulative conduct. But, in my view, one cannot have it both ways: as suggested, if the shield is not provided, then there will be substantial disincentives to apologize in the first place.

Pragmatic considerations of this sort do not exhaust the reservations that one might have about the prospects for broad-based apologies. The strong version of apology law, promoting an obligation to candidly respond to negligent acts, as well as express sympathy for unavoidable mishaps, implicitly assumes two categories of iatrogenic injury—medical error and unavoidable error—and advocates promoting openness regarding the former, as well as the latter. But, in many cases, one would suppose that a physician will consider the resultant injury unavoidable, whereas the patient will seek apology for fault; in other words, there will be genuine disagreement about whether there was any fault on the part of the physician.[42] In these cases, one can predict that no apology will be forthcoming, as distinguished from an

40. § 1160(a) (emphasis added).

41. COLO. REV. STAT. ANN. § 13-25-135(1) (West 2005). It should be noted that the statute only shields admissions of negligence involving unanticipated outcomes of medical treatment, not apologies in cases of willful or intentional harm.

42. I disavow any claim to medical expertise, but examples might include the following: (1) an incision during high-precision surgery that leads to a punctured organ; (2) pneumonia that spi-

expression of sympathy at most, even if there is an evidentiary shield. Indeed, it is conceivable that excessive pressure to confess wrongdoing in these borderline situations could create resistance on the part of physicians to be forthcoming under any circumstances.

Perhaps the most intractable reservations about apology gaining wide acceptance, however, are those elaborated by Marlynn Wei.[43] She discusses at length deeply rooted internal professional norms, grounded in the dynamics of medical practice, status considerations, and an ethos of self-regulation that cut against revelations to "outsiders"—anyone outside the medical profession if not the immediate practice group—of professional conduct that might be damaging to reputation.

Having offered these reservations, I nonetheless wholly subscribe to the efforts of Lazare and others to steer medical practice along a more humane and respectful path by encouraging physicians to be forthcoming about the consequences of their healthcare services. In the end, the social and public health benefits of doing so are certain to be substantial. I would venture to say that tort law will only stand as an obstacle to achieving these salutary ends as long as public policy—that is, the absence of protective legislation—as well as norms of medical practice, and the reputational concerns of physicians all conspire to suppress disclosure.

IV. Closing Thoughts

Is there an obligation for medical professionals to be forthcoming under all circumstances? As a professor of law, I am far more comfortable answering this question from the perspective of what the law requires, rather than proclaiming the ethical obligations of physicians. As far as the law is concerned, with special reference to tort obligations, I have suggested that very little is in fact mandated in the two areas discussed: the provision of medical excuses to prospective organ transplant donors and the offering of apologies for medical negligence.

Is this an indictment of the law for failing to create a match between legal norms and social norms? Ironically, perhaps, whatever progressive critics might propose, in both instances the law reflects the dominant practices within the medical profession. Is there, then, a failure of enlightened law reform and legal advocacy? Some would say so.

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rals out of control; (3) infections under some circumstances; and (4) dislocation after joint replacement, again under some circumstances.

43. *See* Wei, *supra* note 22, at 132–34, 146.

But the most striking characteristic of legal advocacy, in these two instances at least, is how deeply in the shadows law resides. The law is simply not a salient feature of the medical excuse landscape, nor are there calls for affirmative legal obligations sanctioning physicians who refuse to tender apologies. It follows that a deferential posture in fashioning tort duties is the wisest course of action until the medical profession itself demonstrates far greater resistance to dissembling and nondisclosure than is presently the case.