Conflict Resolution in Healthcare

Kathy Clark & Ruth Rickard

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by

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Introduction[1]

Our primary focus in this chapter is conflict resolution in healthcare. In particular, we look closely at non-adversarial responses to adverse medical events (AME)[2] in both a legal and medical context.[3] Examination of both contexts will assist in promoting and sustaining the valuable, growing synergy between law and healthcare,[4] which provides the opportunity to expand and enhance communication with patients/clients. Although we look at these practices in the narrow context of AME, the concepts we discuss apply across the board in most areas of healthcare conflict resolution.

In Part I, Kathleen Clark calls on both lawyers and doctors to think differently about how each group attempts to resolve conflicts after an adverse medical events. In sum, she advocates preventing conflicts from arising by building trust through sensitive early communications after such events. She also describes the detrimental effect of non-communication on the patient, the family, and the healthcare practitioners. She describes how one hospital CEO, through communication and authenticity, was able to turn a tragic litigation case into a situation where healing began for all parties.

Part II, Ruth Rickard continues the theme of healing, describing two successful systems that use collaborative processes after an adverse medical event (AME). Both succeed in providing open communication about what happened, apology and compensation if warranted, faster resolution, and lower costs. She also describes her lone-wolf attempt at using collaborative methods in a case of hers; though unsuccessful in persuading the healthcare side to collaborate, she shares lessons learned, and thoughts on how we might overcome barriers and move forward in adopting methods that get the parties more of what they want.

Our discussion is intended to assist the reader in rethinking and expanding our traditional practices as lawyers to include non-adversarial approaches; at the very least, we hope to create an awareness of possibilities in both law and healthcare using new thinking, new language, and new ideas.

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[1] In this chapter, the two authors each speak from personal experiences and conversations they have had. Thus, the chapter is divided into two parts, to clarify for the reader who is speaking when the authors use the first person "I."

[2] "Medical error" is the terminology that has been generally used to describe an adverse medical event situation. Because it sounds legalistic and may imply blame, use of the word "error" without any investigation/discussion has been set aside in most literature and conversation in favor of an "adverse medical event".

[3] The "medical context" refers to physicians' roles and responses to AME, as well as attorneys' roles of listening, discussing, assisting, and advising medical practitioners in rethinking their practices associated with prevention of and responses to AME.

[4] In particular, synergy is continually enhanced through practices such as medical-legal partnership; see *infra* note 16.

Part I

Disclosure, Apology, and Compensation

Expeditious, open exchanges between healthcare practitioners, with the advice and counsel of their attorneys, and their patients/families after the occurrence of an AME are traditionally referred to as "disclosure."[5] Disclosure, and when appropriate, apology and compensation, are integral parts of a collaborative process.[6] The disclosure process helps to increase understanding, trust, learning, compassion, and healing. Additionally, it promotes patient safety by creating a cultural shift from an adversarial to a collaborative process, even if only temporarily.[7] Stakeholders, which include patients, physicians, insurers, and attorneys, work together to resolve the situation expeditiously, while finding new ways to improve healthcare.

If a collaborative process (disclosure, apology, and compensation) brings the matter to a close, litigation is unnecessary. When resolution does not occur after an open, respectful, and compassionate exchange, a very real possibility exists that a far less painful, less time-consuming, and less destructive adversarial process will follow, because some trust has been established.

By their very nature, conversations based on openness and transparency after AME are not adversarial, and can be quite healing. Such a collaborative process creates the possibility of creating,

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[5] *See infra* discussion of the use of language, including "disclosure", herein.

[6] David Mayer, MD & Timothy McDonald, MD, JD, *Medical Error Calls For Honest Disclosure*, amednews.com (Sept. 12, 2011), http://amednews.com/article/20110912/profession/309129949/5/; Full disclosure of a medical error is defined as a communication between a healthcare professional and a patient, family members, or the patient's proxy that acknowledges the occurrence of an error, discusses what happened, and describes the link between the error and outcomes in a manner that is meaningful to the patient.

[7] Disclosure and other collaborative practices are not always successful and litigation is always a possibility.

or maintaining, trust and respect between the parties. If, on the other hand, attempts to resolve an AME situation *begin* with litigation, any opportunity to develop trust or maintain a physician-patient relationship is lost.

For example, James Woods, the brother of a patient that died due to an AME, heard nothing from the hospital or physician after his brother's death. He said, "Tragedy and sadness can turn to rage that you can't imagine."[8]

Lawyers have the opportunity to take the lead in facilitating and supporting non-adversarial, collaborative practices in AME situations by starting from a place of conversation and open exchange. This sets a tone that can prevent the anger and rage that James Woods talks about.

Additionally, the tone we take, and the language we use, help build community among healthcare providers, attorneys, and other stakeholders to improve future responses to AMEs. This occurs while caring for patients, families, physicians, communities, and ourselves. Creating new thinking and collaboration in AME situations helps build bridges across law, medicine, and community.

What do/could those bridges look like? How can all the stakeholders prevent a similar AME in the future with openness, respect, and transparency so that they promote and participate in a patient-centric, fair, economically viable, and healing process?[9]

What if *lawyers* saw law and legal processes differently, "as an opportunity for forgiveness, for healing and for coming into touch with a true sense of community?"[10] The ABA Model Rules of Professional Conduct, Preamble: A Lawyer's Responsibilities, states: "A lawyer, as a member of the legal profession, is a representative of clients, an officer of the legal system and *a public citizen having special responsibility for the quality of justice*"[11] and the public good. Chief Justice Warren Burger said, "[t]he *healing function* ought to be the primary role of the lawyer in the highest conception of our profession."[12]

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[8] James Woods, Healing at the Intersection of Law and Medicine Presentation at the ABA Dispute Resolution Section Annual Conference, San Francisco, CA (April 10, 2010).

[9] A healing process for all, not just the patients, but the healthcare practitioners as well, is one of the primary goals of this process. In addition, this process can, literally, be a large step in healing healthcare itself.

[10] Alan Reid, *Seeing Law Differently: Views From a Spiritual Path* (Ontario ed. 1992).

[11] *Model Rules of Professional Responsibility Preamble*, American Bar Association, http://www.abanet.org/cpr/mrpc/preamble.html/> (last visited January 31, 2009).

[12] Chief Justice Warren E. Burger, *The Role of the Lawyer Today*, 59 Notre Dame L. Rev. 1, 1 –8 (1983) (emphasis added).

What if *physicians* saw law and legal processes differently? Physicians have similar responsibilities and values as lawyers: "The doctor-patient relationship, unlike an arms-length transaction, is a fiduciary relationship. A fiduciary is 'one who owes to another the duties of good faith, trust, confidence and candor.' As a fiduciary relationship, it must rely on principles of autonomy, non-malfeasance, beneficence, justice and fidelity at all times."[13]

The foundation of both doctor-patient and attorney-client relationships are good faith and trust; the core values of justice and healing are woven through the fabric of both. Couldn't these values, particularly the value of healing, be the basis of a new conversation using new language?[14]

Lawyers Shifting the Culture in Healthcare and Law

How can lawyers assist in shifting the culture of thinking and language in healthcare and law, so that healthcare practitioners and lawyers understand which responses could be most helpful to all involved after an AME occurs? As lawyers, how can we shift the culture away from battle and toward healing?

A patient's attorney expressed an example of a hopeful shift in thinking and language, after a collaborative meeting with the patient's physician and the hospital following an AME situation:

> "Instead of adversarial, it was conversational. Instead of trying to figure out what the claims and defenses needed to be, *I found myself trying to figure out some higher calling, what's the right thing to do here? What is the best thing to do here?* My role changed from advocate to warrior to counselor is the best way I can describe it. *We are attorneys and counselors and the counselor part became emphasized, in fact, became the dominant, the ascendant part* just as soon as it became clear that University Hospital was going to take a different approach to this case."[15]

Another attorney's experience with a collaborative process occurred three years into litigation. Mark Decof, the attorney representing James Woods in a wrongful death medical malpractice suit against Kent Hospital on behalf of the patient Michael J. Woods said:

> "It is never too early to start the conversation. It is never too early to acknowledge error and

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[13] A.K. Edwin, *Non-Disclosure of Medical Errors: An Egregious Violation of Ethical Principles*, 43(1) Ghana Med. Journal 34, 34 –39 (Mar. 2009).

[14] *See infra* note 34.

[15] Richard C. Boothman, Amy C. Blackwell, Darrell A. Campbell, Jr., Elaine Commiskey, & Susan Anderson, *A Better Approach to Medical Malpractice Claims? The University of Michigan Experience*, 2 J. Health & Life Sciences 125, 158 (2009) (emphasis added).

apologize. Nothing should stand in the way of speedy resolution, due to the expense and emotional difficulty in the litigation process. **Cases become more and more difficult to settle as they move through the litigation process.** *It takes participants getting involved with a genuine desire to make this type of [collaborative] process happen. It opens up a whole new way of communicating*. The ice has been broken."[16]

In 2006, Michael J. Woods died of a heart attack at Kent Hospital while lying on a gurney in the emergency room. The attending physician called James Woods within minutes and told him that his brother had died. From the time that James Woods was told his brother had died, to the time the case was settled in November 2009, no one from Kent Hospital spoke to the Woods family. The devastated family waited for an explanation and/or an apology from the hospital. When it became apparent that an apology was not going to happen, Woods decided to sue on behalf of his brother's children. The case continued in litigation (and in the press) for three years before going to trial, a painful process for all involved.

Much of the harm done to the Woods family in connection with Michael's death appears to have been preventable. For example, not sharing information openly and honestly after adverse medical event is disrespect, itself a preventable harm. Failure to communicate with the Woods family immediately, express regret and concern, answer questions, keep the family informed as the investigation unfolds, and more suggest disrespect from which the family may never recover.

When an explanation is necessary, every day that passes without one cements mistaken beliefs. When an apology is owed, every day that passes without one results in a new injury, more mistrust, more disrespect, and more misunderstanding.

Disrespectful responses to adverse medical events, such as being secretive, obstructionist, withholding, or worse, not responding at all, creates more emotional harm at least as damaging, if not more so, than the initial injury. It is, though, difficult to imagine anything more damaging than the loss of Michael Woods for his family. However, refusing to be forthcoming about his care and death created and continues preventable harm that can last for years, and may be completely avoidable.

So many opportunities to resolve the Woods case were lost, in large part because hospital counsel moved forward as litigators are trained—into battle, arguing, secreting information, and refusing to give an inch. Sandy Coletta, the President and CEO of Kent Hospital, stated that if the hospital did not do what they were supposed to do, litigation and trial should not be the option chosen. The

[16] Kathleen Clark, *A New Legal Approach to Health Care*, San Francisco Daily Journal, May 10, 2010, at 5 (emphasis added).

decision to proceed to trial was based on the assessment of the hospital's attorney that causation between the hospital's error and Woods' death was not clear.[17] Looking back on the events that transpired, Coletta, the non-lawyer in the equation, noted that how the hospital did something wrong should be the main concern, not causation.

Think about that: The attorneys for the hospital may only have seen a small piece of the situation that they were trained to see—the legal case. In their view, it was very unlikely that the Woods family would be awarded damages because causation could not be established.[18]

However, non-lawyer Coletta saw a much more extensive picture:

- The hospital did something wrong;
- The pain for the family was unbearable;
- The adverse publicity was devastating; and
- The impact on the community was polarizing.

After settlement, Coletta described the culture of the hospital (and many other health care organizations) once litigation begins: *the closing of ranks, the failure to listen, the lack of understanding and empathy, and the villainizing of the patient/family*. The entire litigation process can be destructive for all parties involved.

The Woods case brings me to other questions:

- Could attorneys, rather than confining themselves to the conventional wisdom of litigators, take the lead in facilitating non-adversarial practices in healthcare?

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[17] Kent Hospital argued that failure to put a heart monitor on Michael J. Woods, as ordered by the ER physician, did not cause Woods' heart attack and death.

[18] While [Oliver Wendall] Holmes, his colleagues, and their progeny may have produced a system unexcelled in its ability to train the mind to produce airtight, unassailable legal arguments, *they also managed to marginalize most of human experience*. In the law today, first in law school, then in practice, you run the risk of overlooking the central fact of human life that makes laws necessary in the first place: that we are formed by and exist in a web of relationships. Our laws are about our relationships, they affirm them by clarifying and enforcing the rights and responsibilities that we, as a society, believe they should entail; and they help us deal with them when they founder or fall apart. However, it is only in relationship to the relational nature of human beings that the law makes any sense. Yet we sometimes make the law about relationships more important than the relationships themselves, allowing doctrine to eclipse humanity." Steven Keeva, Transforming Practices Finding Joy and Satisfaction in the Legal Life 7 (Tenth Anniversary ed., Am. Bar Ass'n 2009).

- Could non-adversarial practices allow us to practice law in a healing, hopeful way, and allow future patients and our communities to be parties to the process?
- Could we support healthcare practitioners to build, rebuild, and mend their relationships with patients and their communities?
- Could we assist healthcare practitioners early on after a possible AME to heal their relationships with patients and families, rather than only stepping in to defend them in litigation after they have been sued?[19]

The Woods case suggests that the answer is 'Yes' to all these questions. As attorneys, we do not always have to be warriors—we can truly be servant lawyers when the situation calls for us to counsel and support. We can take our battle gear off.

This mind frame would be particularly fitting in healthcare, where the focus is healing, not conflict escalation. *We, the lawyers, can assist and support healthcare practitioners in healing their patients and communities, as well as themselves, no matter what, no matter when.*

Once litigation begins, deny-and-defend thinking, language, and action propel the adversarial process forward and keep anger, obfuscation, and misunderstanding flowing. At the same time, the culture of healthcare defendants (hospitals, physicians, other healthcare practitioners) often shifts, perhaps only temporarily,[20] from healing to winning, from openness to defensiveness, and from

[19] In some situations, insurers will not deal with plaintiff's counsel without a complaint having been filed and served. To begin conversations with patients/families expeditiously, without waiting for the complaint, insurers would need protocols in place to support this approach. Like the cultures of law and medicine/healthcare, the culture of professional liability insurance would have to change.

[20] I say this hopefully. The culture of at least some of healthcare is anger and blame, directed at lawyers and the law. Perhaps, developing a common language would help. In the arena of medical-legal partnership, "public interest law organizations learned to describe the impact of legal problems on health, such as why living in substandard housing conditions triggers asthma or how lacking enough money to buy healthy foods makes diabetes harder to manage. They also learned to articulate how legal services help improve health outcomes, and started to reframe legal services as a way to increase health care workforce productivity and reduce health care costs. *Adapting their language to the values of health care providers and administrators neither changed the work of public interest lawyers nor led to mission creep. It did, however, make health care partners listen and engage in collaboration.*" Kate Marple, *Fostering Collaboration Through Common Language*, Stan. Soc. Innovation Rev. (September 23, 2014), http://ssir.org/articles/entry/fostering_collaboration_through_common_language.

collaboration to Us v. Them.[21] Litigation infuses the healthcare systems with negativity, fear, and mistrust. Instead of focusing on litigation, lawyers can use more thoughtful language to assist healthcare practitioners to have different conversations at work following an AME.

What if attempts had been made immediately after the death of Michael J. Woods to sit down and talk to the family, and offer them emotional support and respect for what they have been through? Even if an apology and/or acceptance of responsibility were not part of the process at that point,[22] think of the possible savings in human terms, to say nothing of financial terms.

The Kent Hospital Example

Without a policy/process/protocol in place to immediately respond to the family, Kent Hospital was left with only one option—call in the lawyers and begin to deny and defend.[23] Kent Hospital now has a disclosure process in place that trains healthcare practitioners to respond expeditiously and compassionately to an AME. Now, when CEO Coletta is preparing for a conversation with patients/families, she thinks: *what would give the patient/family comfort?* Coletta said, "If outside counsel won't talk openly, the hospital doesn't hire them. Nothing will be swept under the rug."[24]

Mark Decof, Woods' attorney, said that focusing on collaborative efforts is important to improving situations, so that parties can work through AME cases. Coletta spoke of removing roadblocks that the legal system and lawyers put in the way of resolution. Although intended to protect the hospital, legalities can get in the way, or prevent the hospital from doing the right thing.

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[21] One aspect of the us vs. them thinking in the shadow of litigation is the great care taken in the healthcare system with what is written and spoken in fear that it might be "discoverable".

[22] "Despite the fact that all law school graduates who practice law will have to write statements of facts for briefs, memos, and client letters, law schools don't teach them how to marshal facts and law into coherent stories. Instead, lawyers are taught to communicate with other lawyers or judges rather than simply learning how to communicate with people". Perhaps many of us could learn new ways of communicating. Once we do, we begin communicating more openly and effectively, while helping others in healthcare do the same. Jonathon Shapiro, Lawyers, Liars and The Art of Storytelling (2014).

[23] This is not to question the humanity of Kent Hospital healthcare practitioners or Kent's attorneys. Rather, it is to point out that, without even the possibility of any type of collaborative process in place, without openness and transparency, the results can be considerably more painful, disastrous, and expensive for all concerned.

[24] At present, clinicians present adverse medical event cases to the Kent Hospital board, explaining systems failures and interactions with patients/families. According to Coletta, quality and safety issues are more in evidence in board discussions since the Woods case. Perhaps patients presenting to the Board are in Kent's future.

Roadblocks in the Woods case included the apparent unwillingness of hospital counsel to discuss settlement. Decof tried to warn both the hospital, as well as the hospital's counsel, that a trial in the Woods case would not be ordinary. His prediction that the hospital would look like a disaster, and that publicity would be devastating for the hospital, both proved to be true.

Decof said that the Woods case caused him to be encouraged that lengthy, harsh, and adversarial litigation is preventable. He stated, "[t]his case can be looked at as a model for how claims can be addressed in the future. It is an example of how management at hospitals can take the bull by the horns, irrespective of advice management was getting from litigation counsel." Decof also discussed the meeting he, Woods, Woods' mother, and Coletta had in the middle of trial, "*nothing but good could come from it*.…This remarkable action of accountability has turned a bitter event into a landmark opportunity for hope."[25] Further, he noted, "It's best to resolve differences without invoking the court system."[26]

Decof told us that had it not been for Coletta, resolution in the middle of trial could never have happened. Today, Decof said that he and Coletta speak regularly on pending cases and that there is an open dialogue between them. Decof now reaches out to Coletta or her representative at the earliest possible time, but not prematurely, asking if he or she is interested in addressing a particular case. If the response is affirmative, he provides facts and a list of experts. However, if the case is complex Decof files suit followed by a call to Coletta. By all accounts, Decof considers his and Colleta's relationship "wonderful."

Decof said quite simply that: "The climate between [he and Colleta] has changed." Decof said even more important is that "*Sandy [Coletta] is trustworthy.*" There it is, the centerpiece of the entire process—trust—which was established in Decof and Colleta's collaboration during the Woods case. Decof said, "Sandy is able to personalize an evil institution." As a result of the Woods case, Decof has different conversations with his clients about the possibilities of resolving cases early and collaboratively. Coletta has become a champion for this type of collaborative process. Further Colleta's input will be even more valuable in terms of collaboration in AME situations now that she is both CEO of Kent Hospital and COO of Care New England.

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[25] Clark, *supra* note 15, at 5.

[26] Bringing Healing to Law and Medicine, American Bar Association Dispute Resolution Conference (April 10, 2010).

James Woods spoke with several attorneys about the case,[27] and stated that lawyers lost sight of the relevant issues because they had tunnel vision. Woods reminded attorneys that the concept of collaborative practices had real potential to help people who have lost a loved one and are "bleeding to death emotionally" in the face of "unimaginable tragedy."[28]

Decof told us that other hospitals are following the lead of Kent Hospital. For example, Rhode Island Hospital, on its own initiative, is attempting to resolve cases expeditiously and informally. Decof can now reach out to hospitals' risk management departments and insurers, which results in a claims process that is less bogged down. Much of the traditional, embedded conflict that could not be eradicated in the past is now starting to disappear, as a result of open exchange between parties and their attorneys.[29] According to Decof, though, it is still difficult to convince insurers to participate in the process.

The Woods case is tremendously hopeful and healing on so many levels. My hope is that attorneys use it as a model to move forward, so that they can be an active part of this non-adversarial process that gives a voice to patients and their families. At the same time, the non-adversarial environment can help them strengthen their connection with their health care providers. Shifts in thinking need to take place all the way around with hospital management, insurers, and attorneys, not just with the healthcare practitioner, Everyone can participate in re-designing the health care system's relationship with the legal field by working as a team. This is a rare opportunity in which attorneys can bring their skills, expertise, and humanity to truly assist in healing healthcare.

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[27] Woods, *supra* note 7.

[28] *Id.*

[29] Early resolution of cases, with or without litigation, can be considerably less lucrative for attorneys, particularly defense attorneys, than lengthy litigation. Could we, as attorneys, begin to think about resolution of disputed adverse medical events as *potentially* non-adversarial, approaching these cases with different skills and language, promoting healing and envisioning each case taking much less time (and energy)? Could we replace the attorneys' fees that traditionally arise from a small number of lengthy, adversarial cases with attorneys' fees from a greater number of smaller, non-adversarial cases? Could we help a greater number of injured individuals/families for smaller per case fees, involving less time? Could we make up for the small volume of large, complicated, adversarial cases (w/the probability of large contingency fees) with a larger volume of smaller, less adversarial cases (and smaller fees)? One well-respected Florida plaintiff's attorney in med mal cases told me that he winds up only taking the large, complicated cases. As trial approaches in one of those cases, he becomes completely focused on that case alone, forcing him to turn away many other worthy smaller cases. Resolving big cases quickly through non-adversarial practices also, when appropriate, frees up our courts, presently burdened by overwhelming calendars and courtroom closures (due to economics). These are subjects for another time, although we are more than happy to discuss ideas with our readers.

Disclosure Following an AME

A collaborative process that is healing and non-adversarial begins with language that shifts the conversation from one of obfuscation to one of open communication. That shift in language could begin with the word "disclosure" in the context of AME.

Although the term "disclosure" is used universally, it seems inappropriate in the context of AME. This is because disclosure is traditionally defined as uncovering or displaying something that was previously hidden. It seems that this type of harsh, adversarial, and litigation-like term is inconsistent with openness, and therefore out of place in the healthcare context.

The Massachusetts Coalition for the Prevention of Medical Errors' Study states: "[b]ecause the term [disclosure] suggests revealing of privileged information and *implies an element of choice*, in this document we use instead the term communication, by which we wish to convey a sense of openness and reciprocity."[30]

The disclosure process surrounding AME should be viewed as only one aspect of the ongoing dialogue between the healthcare practitioner and the patient. The process can also be viewed from the perspective of informed consent, which is a process of ongoing disclosure and communication that results in informed patient choice.[31]

Attorneys can begin to be aware of and, when appropriate, change their communications to non-deficit and non-adversarial language of shared goals and common ground, such as:

- collaboration,
- listening,
- learning,
- continuing conversation,

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[30] Although we wholeheartedly agree with the Massachusetts Coalition's clear and cogent statement, such that we would like to use "continuing communication" or "communication after adverse medical event", we use "disclosure" here because it is a term that is ingrained in the culture of both medicine and the law. In addition, it is considered a legal term, triggering anger and resentment against lawyers and the law. Therefore, we may want to put it aside in healthcare. It seems fitting that attorneys be the ones who recommend this shift in language. We would love to promote conversations with our readers about this possibility and/or how it is already occurring.

[31] Informed patient choice, rather than informed consent, suggests patients are active participants in decision-making about their healthcare, rather than passive participants, giving only "consent". When we use the language of choice, we empower patients.

- informed patient choice,
- openness and transparency,
- improvement,
- counseling,
- healing,
- teamwork,
- cooperation,
- participation,
- participatory medicine,
- patient-centered communication, and
- open communication.

Thinking in non-adversarial terms, by its very nature, takes attorneys away from the adversarial, sometimes threatening and distancing language, that separates them. That adversarial language is often present in

- lawsuit,
- order,
- mandatory,
- gag order,
- silence,
- demand,
- discoverable,
- in/admissible,

- breach,
- failure,
- sanction,
- non/disclosure,
- privileged,
- negligent,
- intentional,
- reckless,
- without due care,
- defensive medicine,[32]
- non-compliant,[33]

and the like.[34]

This is not to suggest that adversarial language doesn't have its place, just that non-adversarial language is a more fitting place to start to address shared goals.[35]

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[32] Defensive medicine is often described as physicians seemingly practicing in a fashion that is intended to protect them from litigation, often without apparent evaluation of other reasons for practicing in this manner, i.e., nondisclosure, leading to litigation, resulting in defensive medicine in preparation for the next litigation case.

[33] Refers to patients who don't take a prescribed medication or follow a prescribed course of treatment. The term is thought of as disparaging by many in medicine as it doesn't take into consideration that patients have their own reasons for not following their physicians' directions (lack of money, cultural differences, transportation problems, misunderstanding, and the like).

[34] A physician friend of mine was sued once. The case was quickly dismissed for failure to state a claim. The physician's attorney told the physician not to be concerned about the language of the complaint, i.e. negligently, recklessly, intentionally, telling the physician that that was standard language in a complaint. The physician said, that might be, but, here, they are saying this about *me*. Anger, hurt, and distance, if not already in play, can arise for the physician, just reading the complaint.

[35] Marple, *supra* note 19. "Why, not what, unlocks common ground and shared goals." *Why* do we, the attorneys, want to support expeditious, open communication after adverse medical events? To relieve the pain and suffering of all involved, to bring speedy resolution, and to witness the humanity of others. *Why* promote collaborative practices in adverse medical event situations? In order to ensure, as much as possible, that the patient/family both doesn't have to suffer further indignity and disrespect, and doesn't have to wait for years to get answers. To relieve the pain and suffering of all involved, to save considerable time and money, and to permit healthcare to accept responsibility (not blame, not fault) and learn from mistakes.

Stakeholders work together to resolve the situation at hand quickly and find new ways to collaborate on the promotion of patient safety. Taking AME out of the realm of secrecy and obfuscation and into an open, transparent process will create tremendous time, financial, and emotional savings. The more transparency there is in our healthcare system after AME, the more potential there is for improvements and increased patient safety. The patients who have been informed and compensated have the opportunity to move on with their lives, whether that involves further medical care, a new beginning, or both.

Physicians Shifting the Culture in Healthcare and Law

We have discussed the impressions and experiences of attorneys, hospitals, and patients/families. Where are the physicians in mediation, settlement discussions, disclosure, or litigation? What are their experiences? When open disclosure is absent, physicians often worry and wait to be sued, which is often followed by lengthy, angry, and expensive litigation.

How could this be different, so that physicians have the opportunity to talk to patients/families, offer explanation, listen to patient's experience, and learn from those conversations? How could open disclosure become the standard? Wouldn't such open disclosure conversations assist physicians in forgiving themselves?[36] How could physicians play an active role in the entire process, rather than something akin to a bystander in the immediate aftermath of an AME?

Several judges that we have spoken to told us that physicians never attend mediations and or settlement conferences. Even when ALL parties are ordered to be present, defense attorneys often push

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The reader might lead the conversation with the motivation behind her/his work. Two of the missions of the law are to assist in resolving disputes, and to ensure fair compensation. The primary mission of medicine/healthcare is to heal the sick. The missions and goals of both law and medicine can be supported through collaborative practices. As to insurers, we can reframe collaborative practice in terms insurers can support: saving money for the insurance company, as well as supporting and, potentially, saving the careers of physicians. In addition, collaboration creates the possibility of learning and improvement for physicians and hospitals, which is generally either not available in the litigation process or only available after extensive delay.

[36] "For many physicians, the most difficult challenge is forgiving themselves for the error.". Thomas H. Gallagher, MD, Amy D. Waterman, PhD, Alison G. Ebers, Victoria J. Fraser, MD, Wendt Levinson, MD, *Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors*, 289 JAMA 1001, 1001 –07 (2003).

back and tell the court that it is not necessary for the physicians to be there, since the mediation is only about money and the insurance carrier is present.[37]

Even if the physician is present, he or she is generally silent throughout the process, at the insistence of the physician's attorney and/or insurer. The physicians are literally sidelined throughout the litigation/mediation process. Physicians' insurers and/or attorneys do all the talking and make the decisions on settlement, with or without the physician's consent.

In *Perceptions in Litigation and Mediation*, Tamara Relis discusses the silence of the physicians in medical malpractice litigation. She states that attorneys for both sides in medical malpractice focus almost entirely on money, *perhaps not hearing that their clients wanted more*. Lawyers spoke of the tactical assistance they hoped to receive from mediators, while the parties spoke of human attributes. Further, Relis found that disputants' needs are not being met in either litigation or mediation. Patients and their families want an opportunity to speak directly with healthcare practitioners about their situation and what may have gone wrong, as well as an opportunity to tell their experience, in the hope of prompting improvements in healthcare delivery to protect future patients.

Overwhelmingly, injured patients wanted mediation to be a forum where they could sit across from their physician, have an open exchange, and get their questions answered. Physicians often wanted that face-to-face opportunity as well. Attorneys wanted to get to the bottom line, often telling their physician clients to not bother attending mediation because it was only about money. Unfortunately, both patients and physicians are denied the opportunity to speak and learn from each other; their voices are not heard, either because they are not present (physicians) or because they are present but silent (often at the insistence of their attorneys).

Meanwhile, patients want much more from the process, and mandatory or discretionary mediation[38] is an opportunity for them to get what they want and need, with money often being secondary. James Woods is a recent example of just that. He wanted acknowledgement and apology by the hospital, and settlement for his brother Michael's minor child. Mark Decof told me that he advised Woods many times that litigation would bring him and his family only money. When Coletta did reach out to

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[37] Albert Wu, M.D. referred to the "golden moment" as one arising quickly after a possible AME, the moment when patient/family and physician sit down for to communicate and connect about AME. I think of it in a broader framework, as the moment when a connection is made and true exchange of information, as well as listening to each other, begins. This can be the moment of disclosure, if that takes place, or, even much later, the moment of mediation.

[38] Mediation traditionally, although not always, takes place within the litigation context, whether mandatory or discretionary.

Woods, Decof told Woods that this might bring everything he wanted—acknowledgment, apology, and compensation.

We suggest that it is of the utmost importance that physicians and other healthcare providers[39] attend mediations and settlement discussions. The process can involve:

- open communication between the parties,
- reconnection and/or strengthening of patient-physician relationships,
- opportunity to enhance/update/improve patient safety through patient/family participation,
- enhancement of the health care community, and
- the very real possibility of substantial financial savings.

We see the mandatory mediation process as a leverage point to bring both patients and physicians what they often want and need. Although mandatory mediation takes place late in the litigation process, this will likely change once the insurers, physicians, and defense counsel take part in the process, and see its possibilities and financial advantages.

The Impact of AME on Physicians

Many studies have assessed the burden of AME on patients. But little attention has been given to the impact of AMEs on physicians. That impact can occur in the mediation/litigation process, or as the physicians' immediate response to an AME.

Specifically, physicians who had a medical malpractice claim filed against them showed an elevated risk of incurring a second insurance loss during the year following the first claim. In the six months after the filing of the first claim, the odds ratio is as high as 3:1.

The loss experience declines to normal levels after 18 to 24 months. That suggests, though does not prove, that the effect is attributable to the pendency of the first claim, rather than to an unusual

[39] Physicians are the insureds. As a result, they have the opportunity, the responsibility, to demand, with the support of their attorneys, that their insurer provide attorneys to counsel and support the physician in her/his work of disclosure and open communication with patients/families in a non-adversarial process in lieu of or before litigation.

propensity toward error.[40] In addition, many studies indicate that physicians are more likely to have other difficulties in their lives while living in the shadow of a malpractice action.

I say this not to neglect the tragedy of patients and their families, but to focus on the financial AND emotional costs beyond the cost of any one case for physicians and their insurers. Litigation is expensive, but so too are the collateral costs of another physician error while the physician is distracted. Also, another error can occur because the healthcare system has not made the necessary changes after the first error, at least partly because the physicians and the system they work in may not know about it. This, too, leads to more errors.

In addition to the physical and emotional stresses associated with involvement in AME, "[i]t has been suspected for some years that the stress physicians experience while being subject to malpractice claims may result in a degradation of their performance."[41] Other serious health effects, including emotional distress, and performance and work-related consequences in staff members, are common.[42]

[40] Edward Dauer, *Ethical Misfits: Mediation and Medical Malpractice Litigation*, in Accountability: Patient Safety and Policy Reform 185, 188 (Virginia A. Sharpe ed., 2004).

[41] Dauer, *supra* note 39, at 188.

[42] David L. B. Schwappach & Till A. Boluarteb, The Emotional Impact of Medical Error Involvement on Physicians: A Call for Leadership and Organizational Accountability, 139 Swiss Med. Weekly 9 (2008), available at http://www.ncbi.nlm.nih.gov/pubmed/18951201.

Other contributors to altered mental states include:

- partial isolation from peers and patients (self-imposed or otherwise),
- excessive rumination,
- self-doubt,
- anger, and
- hostility.

These contributors also affect physician judgment and performance. For example, one major liability insurer that examined its own claims records found evidence strongly suggestive of these effects on physicians after involvement in medical error.[43]

Waterman et al. examined the effects of a medical error experience on five work and life domains in a large survey of 3,171 physicians in internal medicine, pediatrics, family medicine, and surgery in the US and Canada. Surveyed doctors reported that due to involvement in an AME, they experienced:[44]

Experience	Percentage affected
increased anxiety about future errors	61%
loss of confidence	44%
sleeping difficulties	42%
reduced job satisfaction	42%
harm to reputation	13%

These results suggest that personal distress and self-reported error involvement are related in a reciprocal cycle. Feeling responsible for a serious medical error enters a vicious cycle by provoking

[43] *Id.*

[44] Amy D. Waterman et al, *The Emotional Impact of Medical Error on Practicing Physicians in the United States and Canada*, 33 Joint Commission J. on Patient Quality and Safety 467, 467 (2007).

burn-out, depression, and reduced empathy. In turn, these feelings often result in suboptimal patient care and higher odds for future errors.

Wu et al. reported that nearly one-third of surveyed house officers indicated that "the hospital atmosphere inhibited them from talking about the mistakes." Twenty percent reported that the "administration was judgmental about the mistakes."[45]

Sexton et al. describes in an international comparative survey study among physicians, nurses, and cockpit crewmembers that a quarter of medical staff indicated they would not be encouraged to report safety concerns in their hospitals. Only one-third responded that errors are handled appropriately.[46] "Personal reputation" (76%) and "the threat of malpractice claims" (71%) were commonly reported as barriers to acknowledging or discussing errors by staff in intensive care.[47]

As Schwappach and Boluarteb noted:

> In the study by Waterman et al., 90% of surveyed physicians disagreed that health care organizations lend adequate support in coping with stress associated with medical errors (37% disagreed strongly). Physicians who perceived their institutions as unsupportive were four times more likely to report increased stress after being involved in serious errors. The experience of error can also cause considerable changes in medical practice. In the study by Wu et al., many residents described constructive changes as response to an error, such as increased information seeking (seeking more advice (62%)) and increased vigilance (paying more attention to details (82%); confirming clinical data personally (72%)".[48] "The evidence suggests that communication and interaction with colleagues and supervisors are perceived as the most helpful resource by physicians.[49]

"Medical mistakes haunt the conscience of those involved…."[50] Many reported an overwhelming sense of responsibility. Some were still troubled by guilt, acknowledging that they still tried to minimize, qualify, or justify their mistake. "A physician expressed the opinion that to be forgiven too

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[45] AW Wu, S Folkman, S J McPhee & B Lo, *Do house officers learn from their mistakes?*, 12 Qual. Saf. Health Care 221, 225.

[46] David L. B. Schwappach & Till A. Boluarteb, *supra* note 41, at 4.

[47] *Id.*

[48] David L. B. Schwappach & Till A. Boluarteb, *supra* note 41, at 12.

[49] David L.B. Scwappach & Till A. Boluarte, *supra* note 41, at 13.

[50] Richard T. Penson, Sasha S. Svendsen, & Bruce A. Chabner, *Medical Mistakes: A Workshop on Personal Perspectives*, The Oncologist (February 2001), http://theoncologist.alphamedpress.org/content/6/1/92.full.

quickly was unhelpful. He felt that for the sake of personal integrity as much as for the present medical culture, problems should be clearly identified and a concrete plan for change should be set in place."[51]

The two most cited ways to reduce the impact of medical error are systems management, and improved communication.

Changing the current system may be dependent on influential physicians who will champion these issues and change the entire culture. They can accomplish this by opening a new understanding of accountability that moves beyond blaming individuals. "Although full disclosure may fracture or tarnish relationships, admitting mistakes may strengthen trust and a sense of community among doctors."[52]

The most effective way to prevent malpractice claims is through improved patient-physician relationships. "Acknowledging a mistake offers the opportunity to improve the quality of medical practice but is also the first step in minimizing the emotional damage to both the patient and the doctor."[53] Robert Wachter states:

> "Physicians worry more about the costs—both financial and psychic—of the [litigation] process than the costs of settlement… the expense and emotional costs, time lost to depositions, hand-wringing and demoralization, sleepless nights, and suppressed anger over the inherent unfairness of it all, is essentially the same for the physician whether the payout is $400,000 or 2 million dollars. As doctors, our decision-making is driven more by the potential for being sued than by the cost of losing a judgment."[54]

The phrase "second victim" is appropriate to describe physicians' considerable emotional reactions, and often long-lasting distress, in the aftermath of error. "The admission, reporting and disclosure of a serious medical error can be utterly traumatic to the involved professionals. Institutions should offer them profound support, not unlike what is offered to any employee in need of help with a trying life problem."[55] "Feeling responsible for a serious medical error enters a vicious cycle by provoking

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[51] *Id.*

[52] *Id.*

[53] *Id.*

[54] Robert Wachter, M.D., Understanding Patient Safety 205 (2nd ed. 2008).

[55] Dauer, *supra* note 39, at 186.

burn-out, depression and reduced empathy, which in turn often result in suboptimal patient care and higher odds for future errors."[56]

The sooner the parties come together, the more likely healing will take place.[57] When an explanation is necessary, every day that passes without one cements mistaken beliefs. When an apology is owed, every day that passes without one results in a new injury, more mistrust, and more misunderstanding. When a collaborative process is used expeditiously after an AME, there is a tremendous possibility for healing to occur. Otherwise, anger and resentment set in and grow, due to continuing perceived mistreatment and disrespect, i.e., the continuing refusal to speak, apologize, or explain. The possibility for healing arises through early communication between the healthcare system and the injured party/family. Mistrust and misunderstanding grow primarily in the deafening silence that so often occurs after an AME.

The Use of Collaborative Law Principles Following an AME

A process of healing and creating a partnership between healthcare practitioners, patients, and their families must occur one case at a time. The process should include:

- face-to-face conversations,
- confidentiality,
- tolling the statute of limitations,
- listening to each other,
- exchanging information,
- providing an apology, as appropriate,

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[56] *Id.* at 3; Amy D. Waterman et al, *supra* note 43, at 469.

[57] This expeditious response is often referred to as the "Golden Moment", a term first used by Albert Wu.

- seeking patient input/observations, and
- enhancing a continued relationship between the healthcare practitioner and patients.

These collaborative practices include non-adversarial approaches to AME that can begin quickly after an AME. They can offer parties a voice in the outcome, an opportunity to create their own outcome, and learning opportunities for health care providers and future patients.

Jim Conway speaks to the responsibilities of healthcare leadership. Much of what Conway has to say can also assist attorneys to see the big picture in AME situations, helping us support all the stakeholders in AME situations.

> "Given that the vast majority of errors are due to failures of bad systems and not bad people, providing support to clinicians and other staff at the sharp end of medical care is simply the respectful and compassionate thing to do. A growing list of leadership initiatives and expectations seek to mitigate the impact of medical errors on clinicians. At the top of this list is the expectation that leaders will establish and nurture a culture of quality and safety that is anchored in respect, trust, human rights, repentance and forgiveness. Those who practice within a fair and just culture will find that systems support safe practice and mitigate the chances of errors reaching patients and causing harm. Leaders must commit resources to this effort and establish peer support groups and other resources to help clinicians deal with the emotional burden of clinical care, including preventable adverse events. Leaders must respond promptly and proactively in the event of an error or accidental injury, ensuring that affected staff members are treated with respect, compassion and support from leaders and their colleagues. Leaders must establish an organizational expectation that anything less than a supportive response is unacceptable."[58]

[58] James B. Conway & Saul N. Weingart, *Leadership: Assuring Respect and Compassion To Clinicians Involved in Medical Error*, 139(1 –2) Swiss Med. Weekly 3, 3 (2009).

Part II

In the previous edition of this handbook, the author of this section on healthcare and the law said—in understated fashion—"Anger, the need for an apology, and an understanding of 'why?' are significant non-monetary concerns of plaintiffs in medical malpractice cases that sometimes cannot be satisfactorily addressed."[59]

The typical defendant-physician would rather eat nails than face a lawsuit. Less well publicized perhaps is the extent of the detrimental effects on healthcare providers who are sued. This includes the emotional toll on healthcare workers who are sued and the concomitant negative effect on their practices.[60]

The need for an alternative to typical litigation in this arena keeps getting more pressing. In 1999, the Institute of Medicine announced the unfortunate news that medical error was the eighth leading cause of death in this country, involving some 98,000 deaths.[61] In 2013, the Leapfrog Group (a non-profit group of hospitals advocating for improved patient safety) announced even worse news: Medical error is now the *third* leading cause of death in this country,[62] involving over 400,000 deaths per year.[63] As Leapfrog CEO Leah Binder points out, "We're burying the equivalent of Miami every year from medical errors that can be prevented."[64]

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[59] Maxine M. Harrington, *Health Care Dispute Resolution*, in Alternative Dispute Resolution Handbook (3d ed. 2003).

[60] A W Wu, *Medical Error: The Second Victim. The Doctor Who Makes Mistakes Needs Help Too*, 320 Brit. Med. J. 726, 726-27 (2000).

[61] Committee on Quality Healthcare in America, To Err is Human: Building a Safer Health System (Linda T. Kohn, Janet M. Corrigan & Molla S. Donaldson, eds., 1999).

[62] Mnnurses, Patient Safety Group: "*We're Burying a Population the Size of Miami*", Safe Patient Standard, (Oct. 23, 2013), http://safepatientstandard.com/patient-safety-group-were-burying-a-population-the-size-of-miami/ (last visited Apr. 10, 2015).

[63] John T. James, *A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care*, 9 J. Pat. Safety 122, 127 (2013).

[64] Mnnurses, *supra* note 61.

The good news is that there is new evidence showing that the significant, non-monetary needs of both healthcare plaintiffs and defendants (including institutions) can be met in groundbreaking ways, using alternative-resolution thinking.[65] Compensation to the plaintiff, when warranted, can be delivered in less time and with lower administrative costs. Many of the early adopters express support for broader implementation of such programs. [66]

While various types of mediation and other ADR techniques are well established in resolving AME, here I focus on the use of the collaborative and collaborative-like processes. Joint face-to-face meetings, a hallmark of the process, are especially suited to resolving these cases.

One of the root causes of patients and families seeking redress after an adverse medical event is the breakdown in communication between the patient and physician or other healthcare worker.[67] In the experience of those described here, re-establishing an avenue for direct communication (in a facilitated or "safe" setting) has high value to patients, families, and doctors or other healthcare providers.

Specifically, though not necessarily couched in terms of "collaborative law," components of the collaborative process have been successfully used to better satisfy non-monetary needs and to reduce the cost of resolving unexpected-outcome events. These collaborative techniques include:

- Early, open, low-cost disclosure of known facts;
- Joint meetings with relevant stakeholders present, encouraging direct dialogue between the involved parties, with them free to respectfully express their perceptions; and
- Transparent, constructive discussion of settlement options.

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[65] This section of the chapter is not meant to be an exhaustive review of all institutions and others implementing ADR processes in adverse-medical-event situations. Rather, this portion reviews the experience of a few to convey a flavor of situations where an ADR approach has worked, and one instance where it has not.

[66] *See* Michelle M. Mello, Richard C. Boothman, Timothy McDonald, Jeffrey Driver, Alan Lembitz, Darren Bouwmeeter, Benjamin Dunlap, & Thomas Gallagher, *Communication-And-Resolution Programs: The Challenges and Lessons Learned From Six Early Adopters*, 33 Health Affairs 20, 29 –30 (2014).

[67] Beth Huntington & Nettie Kuhn, *Communication gaffes: a root cause of malpractice claims*, 16 Baylor Univ. Medical Ctr. Proc. 157, 157 (2003); Archie A. Alexander, *Complaints, grievances, and claims against physicians: Does tort reform make a difference?*, 30 J. of Healthcare Risk Mgmt 32, 32 –42 (2010).

The University of Michigan Experience

One of the pioneers in applying collaborative-like practices to unanticipated medical outcomes is Chief Risk Officer Richard (Rick) Boothman at the University of Michigan Health System (UMHS). Boothman was a trial lawyer who defended doctors and hospitals for over two decades. This experience provided Boothman with a vantage point for his insights into the costs, both financially and personally, of the conventional deny-and-defend approach to malpractice claims. In late 2001, Boothman spearheaded an effort to develop an alternative to litigation, in concert with key players on the medical staff, including Lazar Greenfield, M.D., Chair of Surgery and later, Executive Vice President for Medical Affairs, and Darrell A. Campbell, Jr., M.D. In response to the Institute of Medicine's estimate of 98,000 deaths per year from medical error,[68] Dr. Campbell publicly announced the goal that UMHS would become "the safest hospital in the U.S."[69] Boothman recognized the common-sense (but not so common) central tenet that mistakes and an *absence of accountability for those mistakes* are fundamental drivers of malpractice claims and that the highest-order risk management strategy is to reduce mistakes. He also recognized that a categorical deny-and-defend response to adverse events was antithetical to accountability for mistakes and putting into place a methodical approach to implementing lessons learned. That, coupled with an underlying ethical commitment to do the right thing in the event of a medical error, led UMHS to create a new model for resolving adverse events.[70] They first looked at what drives patients to the court system; the answer, in large part, was deny-and-defend.

Historically, most physicians and hospitals who are confronted with an adverse event adopt the deny-and-defend approach. Often, they are following their attorney's advice, whether or not they or their attorneys believe there was medical error. The process is characterized by silence and stonewalling. As one commentator describes it, "the prudent insurer and its counsel urge secrecy, dispute fault, deflect responsibility, and make it as slow and expensive as possible for plaintiffs to continue the fight."[71] Ironically, this stance sets up a self-fulfilling prophecy: It can drive the patient/family to seek an attorney, often just to seek help in getting an explanation of what happened.

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[68] Committee on Quality Healthcare in America, *supra* note 60.

[69] Anstett, Patricia, *U-M Hospital's Goal: Safest in the Nation*, The Detroit Free Press, February 24, 2004;

Richard C. Boothman, Sarah J. Imhoff, & Darrell A. Campbell Jr., *Nurturing a Culture of Patient Safety and Achieving Lower Malpractice Risk Through Disclosure: Lessons Learned and Future Directions*, 28 Frontiers of Health Services Management 13, 16 (2012).

[70] *Id.* at 14.

[71] William M. Sage, *The Forgotten Third: Liability Insurance and the Medical Malpractice Crisis*, 23 Health Affairs, 10, 11 (2004).

The Big Three Interests of Patients and Families

Experienced plaintiffs' counsel know that when patients/families seek them out they are seeking:

(1) An honest explanation of what happened;

(2) Accountability from their healthcare giver, including an apology and compensation if warranted; and

(3) Assurance that action has been taken to prevent the same from happening to another patient.

The literature confirms this.[72] For example, one study found that when asking patients/families what could have been done to avert a lawsuit, 37% responded that an explanation and apology would have made a difference.[73]

Abandoning Deny and Defend

In addition, deny-and-defend is antithetical to an effective quality improvement and patient-safety culture. Among other things:

- It is not practically possible to openly apply lessons learned from an adverse outcome, while publicly maintaining a stance denying error.[74]
- Workers in the system are disincentivized from scrutinizing an event, for fear that it will turn up evidence of culpability.

Boothman bluntly states: "By systematically justifying substandard care, [deny and defend] is both an obstacle and threat to patient safety. It undermines accountability, actively ignores dangerous individuals and patterns in the health care system, and disregards the ongoing risks that they present to patients."[75]

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[72] Charles Vincent et al., *Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action*, 343 The Lancet 1609, 1609 – 13 (1994); Gerald B. Hickson, Ellen W. Clayton, Penny B. Githens & Frank A. Sloan, Factors That Prompted Families to File Medical Malpractice Claims Following Prenatal Injuries, 267 JAMA 1359, 1361 (1992).

[73] *Id.*

[74] Boothman et al., *supra* note 14, at 132.

[75] Richard C. Boothman & Margo M. Hoyler, *The University of Michigan's Early Disclosure and Offer Program*, Bulletin, (Mar. 2, 2013), http://bulletin.facs.org/2013/03/michigans-early-disclosure/.

The average length of litigation is five years.[76] Once a preventable injury occurs, submitting future patients and caregivers to the same risk of injury while an individual's claim is pending is "not just imprudent, it is unethical."[77] Time is of the essence to disseminate new knowledge of a safety risk and put measures into effect to prevent recurrences.

Accountability

UMHS decided not to rely on trial lawyers to drive the institution's response (and to deal, if at all, with the emotional fallout). Rather, they took control of their response to adverse outcomes. They recognized that the institution itself had the requisite expertise to determine when care rendered was unreasonable—an inherently medical, not legal, question. In short, *UMHS decided to own its mistakes*.

Importantly, at the heart of the shift at UMHS has been their determination to own their clinical mistakes and to work with them in a principled way. Boothman sees this ownership as a prerequisite to any improvement in safety. "That's what's missing when one sees medical errors and the ensuing medical malpractice claims as just a cost of doing business, an insurance issue, or a lawyer's problem."[78] Boothman points out that honesty and accountability are paramount to the success of the UMHS model:

> Honesty comes first–the first disclosure is the one we make to ourselves when we admit we could have and should have done better. Absent that honesty, we won't ever acknowledge that we even HAVE a problem. Transparency is the manifestation of that honesty–it's the commitment we make to act consistently with that first disclosure–absent THAT, all we've learned is that we can hurt people and dodge the bullet by lying about it. Both transparency and honesty are absolutely necessary if we are to create a culture of accountability, and it's only through accountability that we will hurt fewer people in avoidable ways. We will improve—and of course, reduce our claims, improve our care and help our staff rediscover the joy and meaning our health care providers find in their work.[79]

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[76] Sage, *supra* note 70, at 11.

[77] Boothman et al., *supra* note 74, at 22.

[78] Comments from Richard C. Boothman to Ruth Rickard (Oct. 24, 2015) (on file with author).

[79] *Id.*

The Three Core Principles

UMHS adopted the following three principles:

1. Compensate patients quickly and fairly when unreasonable medical care caused injury;

2. If the care was reasonable or did not adversely affect the clinical outcome, support caregivers and the organization vigorously; and

3. Reduce patient injuries, and therefore claims, by learning through its own and patients' experiences.

The Process

The process is now known variously as the "Michigan Model," "Disclosure, Apology, and Offer," (DA&O), "Disclosure and Offer" (D&O), and more broadly as Communication-and-Resolution programs. The values underlying the process are:

(1) accountability,

(2) honesty, and

(3) transparency [80]

Early communication and disclosure with patients and their families

UMHS has an early response team whose members have expertise in working with patients and families. In the acute phase of the event, *they listen first*. The risk management consultants are mostly medical personnel who are trained in things-legal (not the other way around), including mediation training encompassing empathetic listening. Early-response team members give patients/families answers and explanations to the extent that they are known.[81] They make it clear that the situation is being addressed, and establish expectations for follow-up with the patient/family as the investigation progresses.[82]

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[80] Boothman et al., *supra* note 74 at 13 –27.

[81] Boothman et al. point out the importance of sharing known facts only, not speculation: admissions can rarely be retracted; denials that turn out to be erroneous undermine credibility going forward. *See* Boothman et al., *supra* note 74, at 21.

[82] Boothman et al, *supra* note 14, at 140.

As a result, patients, families, and their lawyers understand what happened before misconceptions are firmly set. This approach enables further constructive conversations. Boothman states, "too often, stonewalling patients prevents anyone from understanding the totality of what happened—patients and families have critical information that we've intentionally avoided under deny and defend. Any defense litigator knows that cases very often seem different once they hear the patient. Historically, and tragically, that typically only happens in depositions and court testimony and by then much damage is done and the opportunity to fix clinical problems is long gone."[83] Communicating with involved caregivers requires skill as well. Studies confirm that most caregivers involved in an adverse event experience a complex mix of emotions, including betrayal, guilt, fear, and shame.[84] Because of this, most of UMHS's claims managers are experienced nurses, which enhances their credibility with the caregivers whose care is at issue.

Assessment

The risk management team begins the assessment of the event. Critically, this includes the institution's own assessment of these questions: "Was the care given reasonable in the circumstances?" and "Did the care cause the patient injury?" A medical committee reviews the team's investigation and gives its assessment. [85]

Continuing communication and disclosure

After the Committee evaluation, the patient, family, and the patient's attorney are invited to a meeting with the treating physician(s) and risk management personnel. Regardless of UMHS's opinion on the reasonable/unreasonable care question, the patient and family receive a thorough explanation. In Boothman's words, "Why not simply fast-forward the process to share conclusions early and less expensively?" Thus, the disclosure is far timelier than in litigation. Moreover, the spirit of the disclosure is *transparent* and *interest*-based.

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[83] Boothman, *supra* note 77.

[84] Amy D. Waterman et al, *supra* note 43, at 467.

[85] The Committee is composed of hospital medical personnel. They engage outside experts when advisable to guard against "protecting one's own." *See* Boothman et al., *supra* note 16, at 140.

At the meeting, expert opinions are exchanged. The patient and family receive acknowledgment of, and an apology for, true mistakes. According to Boothman, "Open, honest and robust discussions occur between patients and their doctors and between doctors *and the lawyers poised to sue them*.[86] Ultimately, agreements are reached to drop the claim, to settle the claim, or occasionally, to agree to disagree.

A UMHS case

One UMHS case applying this approach reveals a number of dynamics that can emerge in these cases:

(1) The liability facts need not be straightforward for the process to work well.

(2) Non-monetary interests can be extremely important to the patient and family.

(3) The plaintiff's attorney may be able to quickly make the "paradigm shift" to a constructive, transparent discussion when deny-and-defend is dropped.

(4) The process can yield better results for the healthcare worker and institution *even when external experts are available to testify on their behalf*.

Some detail is warranted to show the less-than-straightforward liability facts.[87] In August 2003, a 36-year old female schoolteacher with two young sons (six and eight years old) had a clear checkup with her primary care physician at UMHS. In November 2003, she presented with a lump in her breast that apparently only she could feel. After examination, the physician who was covering for her regular physician pronounced it not worrisome and said that she should self-examine, report any changes, and get regular mammograms starting at age 40.

Nine months later at her annual exam by her usual physician, she reported "no problems whatsoever," because the previous physician had normalized the lump she had felt. The clinical breast exam revealed no issues with the breast and no mention was made of the lump discussed the previous year. Nearly a year later, in July 2005, she returned with a tender lump in her breast. Metastasized cancer was diagnosed. After chemotherapy and a lumpectomy, she nonetheless required a mastectomy and radiation.

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[86] Boothman et al, *supra* note 43, at 142 (emphasis added). This departs from the Collaborative process, which includes the mutual agreement that the collaborative attorneys will withdraw if the case does not settle and the parties move to file suit.

[87] Boothman et al., *supra* note 14, at 151 –58.

In February 2006, her attorney submitted a claim asserting, among other things, that a delay in diagnosis caused unnecessary surgery, disfigurement, diminished opportunity for cure, lost life expectancy, lost earnings, and disability. Her primary-care physician described her as being depressed, suffering from chronic fatigue syndrome, chronic shoulder pain, and anxiety over fear of recurrence.

The UMHS evaluators (both internal and external) concluded that when she first presented with the lump in November 2003, the failure to order a mammogram or a short-term follow-up was below the standard of care. But two of five of the external UMHS physician-experts were willing to testify—albeit lukewarmly—that the substandard care was not the cause of the adverse outcomes. They relied on her report of "no problems whatsoever" some nine months after first presenting with a lump.

Despite the two favorable experts, UMHS decided that the substandard care did increase the chance of recurrence and more extensive surgery. The plaintiff's attorney was promptly invited to a meeting. At the meeting, the demand was $2 million; the parties discussed the patient's deep concern that she would not live to see her sons to college. After that, UMHS engaged an economic expert who responded to the patient's economic evaluation, criticizing certain assumptions and calculations as unreasonable and inflated. UMHS also engaged a financial planner. The patient's attorney responded with a revised demand of $1.2 million. UMHS replied with an offer of $400,000, which was the amount the financial planner deemed necessary for the boys' college fund.

In December 2006, a meeting was convened with the patient, her husband, her attorney, her physicians who treated her for the cancer, and risk management personnel. This meeting was the patient's chance to tell her story and allow the physicians a chance to tell their perceptions and experience.

At the outset, an apology with a commitment to settle was extended to the patient. Then two critical things opened up the process. When asked why she reported "no problems whatsoever" in the August 2004 meeting (the notes showed no evidence of cancer), she stated she thought the (covering) doctor in the previous year's visit, in November 2003, had given her "a clean bill of health." She felt assured it was not an abnormality. For UMHS, this was a critical piece of information that further

strained the opinion of one of their experts who had otherwise been willing to testify on lack of causation.

The meeting continued, with the patient expressing her fears about recurrence. In addition to her symptoms of anxiety, depression, and chronic fatigue, she was afraid to resume work. Her medical and surgical oncologists were able to counsel her, with evidence-based opinions, that her fears of recurrence were greatly exaggerated. They encouraged her to return to work.

The case ultimately settled for $400,000 (which included an annuity for the boy's college fund). Thereafter, the patient returned to teaching. She had a more optimistic view of life and no longer reported symptoms of depression. As part of the settlement, UMHS promised to videotape the patient and her attorney, for educational purposes. UMHS presented the case in numerous educational faculty meetings, including Grand Rounds. The patient's testimony reveals the healing power of the face-to-face meeting. In her video she states,

> After that night (of the meeting), I left there like I was on a mountaintop. I felt like I had finally been heard, they listened .... If that had been the end of the legal pursuit, that would have been fine with me. I was perfectly satisfied after that night. What that apology meant to me was that they had listened finally and I had been heard. I can't even describe how euphoric I felt ....

The effect on the patient's lawyer was profound as well:

> Instead of adversarial, it was conversational. It was instead of trying to figure out what claims and defenses needed to be, I found myself trying to figure out some higher calling, what's the right thing to do here? ... (My role) changed from warrior to counselor is the best way that I can describe it. (We) are attorneys and counselors and the counselor part got emphasized, in fact became the dominant, ascendant part just as soon as it became clear that the University Hospital was gonna take a different approach to this case.[88]

Results from the UMHS Program After the First Five Years

Before the UMHS program, a well-known study had given great weight to the fact that less than 2–3% of medical error claims reach a lawyer. The study predicted that implementing open, transparent dis-

[88] *Id.* at 158.

closure would stir up otherwise dormant events and would increase claims and malpractice litigation.[89] Notably, the Michigan data point dramatically in the opposite direction.

Since the inception of its DA&O program in late 2001—despite dealing with all incidents openly, and not just those reported by the patient or family—the Michigan data show

- the number of claims has fallen;
- the average monthly rate of lawsuits decreased;
- time between reporting a claim and resolution decreased; and
- the average monthly costs for liability, patient compensation, and non-compensation legal costs all decreased.[90]

Astonishingly, UMHS was able to cut its insurance reserves from $73 million to $13 million.[91]

While Boothman and company do not assert that the favorable drop in claims numbers and malpractice costs are all due to the transparency-and-communication process implemented in 2001, they state that "transparency at UMHS has not been the catastrophe predicted" but rather has yielded "unquestionable benefits that enable UMHS to deliver safer and better care."[92]

What Participants Say

Data from the participants indicate that both the physicians and the plaintiff's bar are satisfied with the UMHS system. In a survey answered by 400 physicians in the UMHS system:

- 98% of the physicians approved of the system,
- 55% stated the approach was a significant factor in their decision to stay at UMHS, and

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[89] David M. Studdert et al., *Disclosure of Medical Injury to Patients: An Improbable Risk Management Strategy*, 26 Health Affairs 215, 215 – 26 (2007).

[90] Allen Kachalia, et al., *Liability Claims and Costs Before and After Implementation of a Medical Error Disclosure Program*, 153 Annals of Internal Medicine 213 (2010).

[91] Emily Paulson, *To Lower Your Malpractice Risk, Be Firmly Committed to Reporting, Assessing and 'fessing Up*, Hospital Impact, (Feb. 11, 2010), http://www.hospitalimpact.org/index.php/2010/02/11/to_lower_your_malpractice_risk_be_firmly.

[92] Boothman et al., *supra* note 43, at 145.

- They consistently called for more attention from Risk Management to help them further reduce the threat of malpractice.

In a survey answered by 26 of the plaintiff's bar members in southeast Michigan, they indicated:

- 100% rated UMHS as "the best" and "among of the best" for transparency;
- 81% said their costs were lower;
- 86% agreed that transparency allowed them to make better decisions about what claims to pursue; and
- 57% stated they declined cases after 2001 that they believe they would otherwise have taken.

Boothman reports that nearly every plaintiff's attorney agrees to pre-suit sharing of information. It is not unusual for a lawyer to send email or make a phone call about a potential claim before the lawyer has investigated or decided to take the case.[93] Pre-suit sharing of information would indicate a level of trust that UMHS will act consistently with its announced principles of open, transparent disclosure with a commitment to compensate if it determines the care was unreasonable and caused harm.

Boothman notes that with open dialogue, a plaintiff's lawyer can make better choices about taking or rejecting cases, allowing meritorious claims to be sorted out early and efficiently. Coupled with UMHS's strict adherence to defending when it determines care was reasonable or did not cause injury, UMHS has largely been spared having to defend non-meritorious claims. Moreover, UMHS is able to resolve most meritorious claims without litigation.[94] Boothman notes that a number of plaintiff's attorneys, upon learning that a potential client has already engaged with UMHS, will refuse to take those cases on contingency, instead taking a modest hourly fee they feel it would be unethical to take one-third of the recovery if UMHS is at the table.[95]

Adopting the UMHS Approach Elsewhere

But UMHS is a self-insured institution, and the healthcare workers, including the physicians, are all employees of the system. As employees, they all are, at the very least, subject to persuasive efforts by UMHS to participate in the process. Accordingly, UMHS is able to bring all of the key people involved

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[93] Boothman et al., *supra* note 43, at 138.

[94] Boothman et al., *supra* note 74, at 23.

[95] E-mail from Richard C. Boothman to co-author Kathleen C. Clark (Jan. 2, 2010) (on file with author).

in an event into the process from the outset. The open question has been whether the process and its advantages can be replicated in other settings.

The IACT Program

Jessica Scott, a physician and lawyer in Raleigh, N.C., originated a program for resolution of medical error cases called the Integrated Accountability & Collaborative Transparency Program, or the IACT program. Working with Diann Seigle, J.D., the program is part of the larger Carolina Dispute Settlement Services (CDSS), a non-profit that encompasses ADR services for a variety of disputes. The program combines features of the UMHS disclosure-and-offer program with classic Collaborative Law practices.

Importantly, the IACT program is designed to optimize the advantages of the collaborative process that litigation is not designed to do:

(1) the focus of the process is not on a blame game, but on learning from the events leading up to the adverse event; and

(2) the focus is not on money alone.

To qualify, patients and families must be seeking closure or human interaction with those involved on the healthcare side. The IACT program screens out the few cases where money is the primary motivation for bringing the case.

The program includes the collaborative elements of:

- early, voluntary, transparent disclosure of information;
- collaboratively trained lawyers;
- neutral experts;
- joint meetings amongst the stakeholders; and
- a participation agreement that prohibits the collaborative lawyers from litigating the case.

The typical path of a case follows along these general lines:

1. Generally, the involved institution or plaintiff's counsel initiates cases. Often pastors and therapists initially suggest the program.

2. A case manager is assigned when a case is received.

3. A thorough review occurs to determine whether the case is appropriate for the IACT program.

4. Two neutral experts review the medical records thoroughly and produce a timeline (chronology) of events. The experts include a physician[96] in the relevant area of practice and an attorney experienced in dealing with grievances against healthcare workers.

5. The timeline includes notations where a so-called "learning event" occurred. Also, the timeline notes, if appropriate, where the care may have fallen below the standard of care.

Seigle reports that on at least one occasion, a surprised carrier has responded that the timeline "was indeed fair and balanced."

If the case is appropriate for IACT, the case manager sends the timeline to the involved parties, who are then invited to participate. A collaborative attorney is assigned to the patient/family and to the institution and/or healthcare professionals. All of the collaborative attorneys are trained in collaborative practice specific to this setting.

Initially, many of the attorneys were collaborative family attorneys who were paired with medical malpractice attorneys to gain subject matter expertise, although the med mal attorneys did not participate in the conduct of the joint meetings. Importantly, the roster of collaboratively trained attorneys includes at least one well-known medical malpractice defense attorney. According to Seigle, this inclusion has gone a long way to increase the program's credibility for the healthcare participants.

The collaborative lawyers meet with their clients to identify and clarify their goals and interests. A collaborative coach, a trained therapist, may be used as well. She or he can coach clients on how to effectively participate in the process, such as behavior in the joint face-to-face meetings.

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[96] The physicians are carefully screened to ascertain suitability to serve as neutral experts.

Before collaborative conferences, the lawyers meet to confer on ways to make the joint meeting as effective as possible. A series of joint meetings take place with the involved parties sitting around the table, where they have the opportunity to express themselves and speak directly with one another. Ideally, all involved parties attend, including the patients, their doctor(s), other healthcare professionals, and a representative of the involved institution(s). Usually two or three conferences are required, each about two to three hours long. If the parties reach a resolution, they sign a healthcare settlement agreement that incorporates the mutually agreed terms. These often include measures that the healthcare providers promise to institute to prevent a similar adverse event in the future.

The IACT Cost Structure

If a case qualifies for the IACT program and both sides agree to move forward, the healthcare side pays the fee. The patient/family pay nothing. The fee is comparatively modest and based on the complexity of the case. Ultimately, it is distributed amongst the professionals who participated in the case.

Notably, the program can attract cases that otherwise would not be economically feasible for a plaintiff's attorney to take on contingency.[97] Currently, the cost-structure of the IACT program (with its fee assessment based on a sliding scale) comfortably accommodates a case with a projected $30,000 in damages.

Results To Date

Seigle says that patients feel supported by "a village." Over the process, they develop trust in:

- CDSS personnel,
- the neutral experts,
- their coach if they have one, and
- their attorney.

So far, experts have willingly participated for a modest fee.[98] They value knowing they will never be called to testify. Although the lawyers are modestly paid, they enjoy the work; they don't have to do any depositions or other discovery. Rather, they spend their time communicating and working with

[97] In addition to the generally high cost of mounting a case, tort reform caps affect which cases get filed. Like Texas, North Carolina has adopted tort reform measures that cap noneconomic damages.

[98] Seigle reports that physicians who are already volunteers, for example those working with the Medical Board, often do this for free, or for a modest fee.

others in pursuit of the overall goals of closure and improved patient care. Seigle says that, in her experience, the doctors, though scared initially, want to participate; they want to be able to communicate with their patients and the family to explain their experience in the course of the event and, if warranted, apologize.

Doctors are not being shamed and blamed in the process. Instead, the focus is to find lessons learned and prevent repetition. Ultimately, this focus improves patient safety and healthcare.

Seigle further explains that, while they may be seeking forgiveness from others, physicians are often unable to forgive themselves.[99] This is a fundamental dynamic in adverse events. The communication amongst the participants can help to enable that self-forgiveness.

So far, the consistent obstacles to participation in the IACT program have come from insurance carriers. This can pose a problem when all necessary parties are at the table except the healthcare professional, because the insurance carrier has refused to authorize participation. The experience of IACT and UMHS shows that when compensation is paid, it is not extravagant. As discussed above, the longer-term experience of UMHS shows a far less costly process overall than litigation. The collaborative process generally comes with a much smaller price tag as well. Thus, the physician who is denied participation by the carrier loses the potential benefits of the quicker, less costly process as well as the chance for emotional closure.

A Case of Lost Opportunities

When this author tried to steer an AME case toward the collaborative process, the insurance carrier's deny-and-defend stance, along with the agreement or acquiescence of the doctor, proved impenetrable.

My client had lost her sight in one eye after cataract surgery. Though she had called the on-call physician the Saturday and Sunday after the surgery, he did not see her. By Monday, she had a full-blown infection. Ultimately, she lost all useful vision in that eye. I began to explore collaborative possibilities.

I made multiple efforts to persuade the carrier to authorize the collaborative process or participate in a joint meeting. In the pre-suit notice letter to the doctor, I briefly explained the process and enclosed a short article by Kathleen Clark in the newsletter of a physician-owned insurer.[100] The letter made it

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[99] "For many physicians, the most difficult challenge is forgiving themselves for the error." Thomas H. Gallagher, et al., *Patients' and Physicians'Attitudes Regarding the Disclosure of Medical Errors*, 289 JAMA 1001, 1001 –07.

[100] Kathleen Clark, Collaborative Law, Disclosure is Effective on Several Fronts, 12 PRF News 1, 1 –4 (July 2009), *available* at

clear that the client was interested in hearing the doctor's explanation of why he chose not to see her. The letter further said that if his explanation were satisfactory, "it may even persuade my client not to go forward with asserting a claim."

The initial response was from his lawyer. She had represented him in an earlier lawsuit, and thus the doctor had contacted her directly when he got the notice letter. I explained the collaborative process briefly, and she agreed to have lunch to discuss it. She knew the detrimental effects litigation has on her clients and was open to the idea of bringing her client to a joint meeting. She felt compelled to explain, however, that the defendant-doctor had contacted her personally rather than the insurance company, so she had not yet been hired on the case.

Trying to Persuade the Carrier: Monologues in the Presence of One Another

The next communication was made directly with the insurance company's claim representative. I tried to explain the advantages of the process from another perspective. I had recently received a newsletter from the Harvard Project on Negotiation (PON), which made relevant points. Summarizing ideas from Professor Mnookin (his ideas are in italics), I sent this:

> 1) *Find low-cost ways to exchange information. Negotiate an information trade.* As the article notes, although discovery can cost a fortune, only 10% of the discovery process yields 90% of the useful information. In the collaborative process, the parties agree not to hide the ball and agree to exchange the relevant information upfront.[101]
>
> 2) *Don't focus on the dollars only. Identity ways to satisfy all the interests that are seeking satisfaction.* In medical malpractice, the plaintiffs are most often seeking to know what really happened and what is being done to prevent it from happening again. As the attached article on Disclosure (by Eve Shapiro)[102] shows, often the physician just wants to say what happened but is prevented from this by the posturing engendered by the litigation process. The collaborative process allows open communication and disclosure in a confidential setting. Physicians

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http://www.servantlawyership.com/my_slideshow/PRF-July09_5.pdf.

[101] Kathy Bryan, former CEO of the CPR Institute states, "probably more than 80% of the relevant information is obvious in the first month of a case evaluation," and asks, "How much 'hiding the ball' actually benefits clients?" She further notes, "Document exchange shrinks significantly when information exchange is designed to identify business interests, rather than strengthen legal claims, and when it is focused on what is needed to evaluate settlement proposals."" Kathy A. Bryan, *Why Should Businesses Hire Settlement Counsel?*, 2008 J. Dispute Resolution 195, 200 (2008).

[102] Eve Shapiro, Disclosing Medical Errors: Best Practices from the "Leading Edge" (Mar. 2008) (unpublished manuscript) (produced for the Institute for Healthcare Improvement).

feel empowered by getting permission to say what they wanted to say and are more satisfied with the process. See Shapiro article.

3) *Open up to your lawyers: certain disputes have key emotional dimensions*. In medical malpractice, the event and the resolution have an emotional impact on the plaintiff and doctor, e.g., grief, worry and anxiety, anger. The collaborative process is designed to promote healing—by both parties—yielding greater satisfaction to both parties after an adverse outcome occurs.

4) *Use a separate lawyer to settle*: in a true collaborative case, both attorneys agree to withdraw if the case cannot be settled without court processes. Thus both the collaborative process and Harvard experts on negotiation hold that you get the most use from your lawyer by tasking that lawyer to focus on settlement only. This frees the lawyer from having to maintain a litigation posture (the traditional deny-and-defend posture) while seeking to facilitate—and gain the better outcomes—of a process that affords open communication and the opportunity to satisfy other-than-dollar interests as well.

I promptly received this reply:

> With regard to your suggestion that we enter into some sort of collaborative process, this is very difficult considering that the insurance contract we have with our physicians has consent to settle clause. Second, most physicians have significant concerns about settling cases because of the reporting requirements to the National Practitioners Databank and the Texas Medical Board and the effect they may have on credentialing and insurance contracts.

And then came this reiteration of deny-and-defend:

> In addition, it has been my experience that the majority of the cases we handle are defensible and we generally vigorously defend our insured till the case is concluded. If a matter does merit some type of monetary response, we have found that mediation has been a very successful tool with the proper mediator of course.

The first two objections are easily met. Whether to engage in the collaborative process and whether or not to settle is always the doctor's voluntary decision. The second point, though explaining why a doctor may not wish to settle, does not answer the question why the defendant would reject all early discussions out of hand.[103] It also gives short shrift to some important details on reporting

[103] Behaviors rooted in deny-and-defend are described by Boothman et al. as "a self-perpetuating spiral that suppresses consideration of alternative approaches." *See* Boothman et al., *supra* note 74, at 15.

requirements—and potential risk avoidance—concerning the National Practitioner's Data Bank. A payment is not reportable if the physician pays out of personal funds. To be reportable, "a medical malpractice payment must be the result of a written complaint or a written claim demanding monetary payment for damages."[104] My pre-suit notice letter did not make a monetary demand. Rather, it made explicit that my client valued a conversation with the doctor, and if his explanation were satisfactory that the client may elect not to file suit.

But of course, the carrier's objection is probably not primarily about those factors. Rather, the crux of the issue is the mind-set that deny-and-defend is always the best option. Conventional mediation—usually after extensive discovery and close to a trial date—is the only alternative the carrier would consider recommending. This is coupled with a mindset that only after full, conventional discovery can the carrier assess its exposure, and be in a position to mediate. As noted, literature from the Harvard PON states 90% of what is useful from discovery comes from 10% of the discovery. One expert notes that discovery is far more targeted to meet underlying interests when the focus is settlement, not legal strategy.[105]

The Doctor's Response

Nonetheless, in the back and forth with the claims representative I agreed to send a four-inch binder of all the relevant medical records we had. Eventually, the carrier reported that "after the consulting expert reviewed the records, the client does not want to settle."

Thus, the opportunity to avoid suit was lost. Indeed, the carrier would not hire the defense attorney until we filed suit. In the instant case, the doctor had notified his attorney before she was hired, and thus she and I had some discussion about early settlement opportunities. But in the regular course of events, the carrier's refusal to hire counsel during the pre-suit notice period thwarts any opportunity for defense counsel to advise on early settlement opportunities. Ironically, this hollows out the presumed rationale for the pre-suit notice requirement, which is to encourage settlement without filing suit. I knew it was perhaps a bit daft to believe[106] a claims representative could make an exception to the prevailing culture. Nonetheless I persisted, suggesting the following to the defense attorney, who had been open to trying a collaborative meeting:

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[104] National Practitioner's Data Bank, NPDB Guidebook, pp. E-16-E17 (April 2015), https://www.npdb.hrsa.gov/resources/NPDBGuidebook.pdf.

[105] Kathy Bryan, supra note 97.

[106] "Why sometimes I've believed as many as six impossible things before breakfast." Lewis Carroll, Alice's Adventures in Wonderland 100 (new ed. 1897).

> I understand that the client feels he has a defense (though I don't know what that is yet). I'm sure he wants to tell the story from his perspective. I think he can do that, and my client can do that, most effectively in the collaborative process. (I envision that both clients get a consultation with someone who can prepare them on how to effectively express themselves in that meeting.) If we truly disagree on the liability issue and level of compensation (if any) then we could go to mediation—much earlier than I think would otherwise be possible.

I also included other statistics and quotes detailing the deleterious effect of litigation on doctors.

> I'm just thinking your client will best be served by not living in the shadow of litigation for the one to two years it might otherwise take to resolve this. The statistics show that doctors who are sued are more likely to pay out on a second insurance claim incurred during the year after the first lawsuit was filed. Once sued, physicians report that they begin seeing their patients as potential claimants, rather than partners in a therapeutic relationship. One doctor, Robert Wachter, M.D., states that "physicians worry more about the costs (financial and mental) of litigation than costs of settlement."[107]

Nothing came of the effort to try a joint meeting. Eventually, months later after full discovery, we tried mediation, which did not yield a settlement. After a weeklong trial and considerable deliberation, the jury was locked. Hours later, settlement discussions began in earnest and the case was settled.

The Refusal To Engage in Early-Settlement Discussions

At the crux of the decision-making in the case was the decision by the doctor that he did not want to settle, or even engage in early discussions about settlement. Physicians who have received the pre-suit notice letter apparently are persuaded by their advisors, presumably the carrier and perhaps their assigned attorney, to reject considering a settlement unless the risk of exposure is extremely high.

[107] Robert A. Wachter, *supra* note 53.

Perhaps they are persuaded alone by the statistics; a major malpractice carrier in Texas asserts it pays nothing on 87% of the claims it handles and has won 88% of its cases in the past 17 years.[108]

Suggestions on Overcoming the Obstacles to Participation

Of course, the doctors' concerns about being dropped by their carriers or being assessed exorbitant premiums resonates with their fears.[109] But whether those fears are well-founded warrants an objective reality check.[110] In a survey, the major stakeholders in experimental DA&O programs in Massachusetts were asked for their suggestions on overcoming the perceived obstacles in implementing DA&O programs. Those stakeholders included the two major liability insurers, state agencies, medical professional associations, and physicians. Addressing physician discomfort with disclosure, the researchers summarized the stakeholders' feedback as follows:

> [I]n order to avoid a "black mark" on their record, physicians may resist settlement efforts. However, as several respondents suggest, clinicians may not have a complete understanding of how often NPDB and [state medical board reporting] data are actually used and to what end. They believed that decisions to withdraw a physician's credential to practice at a hospital or to initiate disciplinary proceedings based on malpractice claims reports were more rare than physicians think. The stakeholders suggested clarifying actual implications of reporting, and assuring physicians that cases meeting the standard of care would not be compensated.[111]

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[108] *The Best Defense in Texas*, TMLT, https://www.tmlt.org/tmlt/member-benefits/claims-defense (last visited Apr, 12, 2015).

[109] Also, the question is frequently raised whether the physician's talking with the patient or family violates the "cooperation clause" in the malpractice insurance contract. Whether carriers actually can and do enforce such clauses to exclude coverage has been questioned. John D. Banja, *Does Medical Error Disclosure Violate the Medical Malpractice Insurance Cooperation Clause*, *in* Advances in Patient Safety: From Research to Implementation (Kerm Henriksen, James B. Battles, Eric S. Marks, & David I. Lewin, eds.,Vol. 3: Implementation Issues 2005).

[110] GAO studies show that availability and cost of malpractice insurance is correlated to the insurance companies' profitability from its investments in the market, which in turn drives the "insurance cycle" or "hard" market, where companies leave the market due to declining investment, thus creating a vacuum that drives up premiums. This supports the conclusion reached by many that claims do not drive premiums. *See Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, GAO-03-702 (June 2003), *available at* www.gao.gov/new.items/d03702.pdf [hereinafter Medical Malpractice Insurance]; *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, GAO-03-836 (Aug. 2003), available at www.gao.gov/new.items/d03836.pdf; *See* Boothman et al., *supra* note 74, at 130 –32. Bernard Black, Charles Silver, David A. Hyman & William M. Sage, *Stability, not Crisis: Medical Malpractice Claim, Outcomes in Texas 1998-2002*, 2 J. Empir. Leg. Stud. 207 (2005) (medical tort claims and payouts show stability over time).

[111] Sigall K. Bell, Peter B. Smulowitz, Alan C. Woodward, Michelle M. Mello, Anjali Mitter Duva, Richard C. Boothman & Kenneth Sands, *Disclosure, Apology, and Offer Programs: Stakeholders' View of Barriers to and Strategies for Broad Implementation*, 90 Milbank Q. 682, 695 (2012).

The respondents also addressed the issue of individual physicians being named in reporting, even when the error was systems-based:

> [T]he respondents noted that it would be important to emphasize to physicians that unlike the current system, proactive settlement would allow institutions to investigate the event and assign responsibility to the institution for systems-based error, which generally encompass the large majority of adverse events.

The stakeholders also addressed the generally lower sums awarded than those in court, while avoiding the vicissitudes of litigation:

> Even in those cases in which settlements were made on the behalf of a physician, the settlement amount was likely to be at a lower value than what it likely would be through the court system and the cases were also likely to be settled early and in a more predictable fashion than cases that proceeded to a lawsuit.[112]

One avenue to break through barriers to participation might be for physicians to retain their own private counsel to advise them before a lawsuit is filed. The attorney should be well informed of:

- the realities of insurance availability,
- patterns after an insured has been sued,
- real consequences of reporting a settlement to the NDPA and medical board reporting (and a risk-benefit assessment of settling),
- the availability of communication-and-resolution programs, and
- skilled professionals who can implement these processes.

Another avenue, if a physician has an opportunity to participate in a communication-and-resolution process, is to speak with other physicians who have been through the process. Perhaps a network of such coaching physicians might be assembled that are willing to speak with colleagues who have been sued.[113]

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[112] *Id.*

[113] One support organization for physicians facing adverse events involving error is Medically Induced Trauma Support Services (MITSS), which among other things, provides support services for patients, families, and clinicians after an adverse medical events.

What (Most) Doctors Really Fear and Really Want

As noted, the experience of UMHS indicates that 98% of doctors approve of their program. Administrators of the IACT program report the individual doctors who have participated have been pleased with the collaborative alternative as well. Robert Wachter, M.D. captures what doctors worry about when he states that, rather than the cost of settlement, doctors worry more about the costs of the litigation process, including "the expense and emotional costs, time lost to depositions, hand-wringing and demoralization, sleepless nights, and suppressed anger."[114]

Once physicians are generally more informed of the benefits of communication-and-resolution programs, the physicians themselves might gather strength in numbers to demand that their carriers respond to their real concerns and desires. If carriers persist in denying or discouraging face-to-face early-settlement discussions, the root cause might be that the economic model of traditional malpractice insurance is not compatible with what doctors truly desire, as well as their wish for lower premiums.[115] Perhaps physicians themselves need to gather a critical mass to create their own insurance program that values meaningful participation in early communication-and-resolution programs, to avoid litigation when possible.

In my case, where we failed to overcome the obstacles, we reached settlement only after full trial and during jury deliberations, when there was "some movement" after the jury had been stuck for hours. When my co-counsel and I queried jury members afterwards, they reported that the movement was toward a "no-causation" decision. Thus, the one who seemed to have lost the most in the process was the doctor. He had to endure months of litigation stress, yet ended up settling anyway.

My client had lost not just the sight in one of her eyes, but an important part of her social and work life. She was a charming extrovert in her mid-70s who had not yet retired. She had enjoyed a very active, social life before the event. She had been a leader in her profession. After losing her eyesight, she felt constrained by the fact that she could not navigate well unless in full sunlight—a constraint that, as a practical matter, restricted her work and freedom to move about as well as her evening social life. My client deeply desired to know why the doctor made the choices he did and what his true feelings about the event were. We never learned the doctor's side of the event.

Regardless of whether the court system would have labeled the doctor's choices as negligent or not, surely he must have had something authentic to say to my client that would have opened up a path-

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[114] Robert A. Wachter, *supra* note 53, at 205.

[115] *See Medical Malpractice Insurance*, *supra* note 106.

way to healing for both. That might have been possible had the two of them, after some coaching on communication, had an hour or two to talk to each other.

Instead, it seems the insurer's fear of what the client might "confess" in that conversation prevented any direct exchange between the two of them. This ignores the central fact that in most of these cases *money is a proxy to satisfy other compelling needs*. Those needs are rooted in the dynamics of the broken patient-caregiver relationship—needs that are often bound up with intense feelings around broken trust, betrayal, the need to give and receive forgiveness, and the need to make sense of a loss. Rick Boothman at UMHS observes,

> Unlike other personal injury cases (e.g., slip and fall, product liability, auto negligence), adverse medical outcomes are intensely personal to both patient and caregiver because the relationship that precedes an unanticipated outcome is so intimate and personal. And it's that intimacy on both sides of the table that's so important to understanding the dynamics here: money becomes a proxy for so many other aspects of the medical malpractice situation that you don't see in a trip and fall, for instance. By honoring that personal intimacy on both sides, you introduce the chance for healing psychologically and emotionally for both patient and caregiver, you speed the ability for the patient to connect the dots and understand not only what happened, but why, and realize that on the other side of the decisions or actions that caused injury there's a human being who is also hurting. Once those steps are taken, money-as-proxy fades and you can approach the financial component more rationally.[116]

[116] Comments from Richard C. Boothman to Ruth Rickard (Oct. 24, 2015) (on file with author).

In sum, while it may look prudent to gird the doctor (and institution and other healthcare professionals) with the armor of deny-and-defend to withstand the heat of battle, experience is showing that it does not benefit the healthcare giver—and that *it need not be a battle*. Though anger is inevitable, at bottom, the experience for the patient, family, and the doctor is a journey through pain. The collaborative face-to-face meeting with transparent communication is the piece of the process that allows authentic interaction between the parties, which in turn can meet the underlying needs of patients, families, and healthcare providers.

What does this intensely personal dynamic require of us as attorney-facilitators? We can model authenticity to the parties and thus help them trust in sharing their own authenticity with each other. Stepping out from the behind the conventional attorney's mask can take courage, but we have colleagues who model this for us. As experienced mediators David Hoffman and Richard Wolman observe,

> The paradox for mediators is that they can withstand the heat by removing their protective armor. Authenticity and being fully present with the parties are not only effective as dispute resolution strategies, they also create a model for the parties. By opening their hearts and souls to the parties, mediators may motivate similar openness in return.[117]

[117] David A. Hoffman & Richard N. Wolman, *Mediation as a Spiritual Practice*, Mediate.com, http://www.bostonlawcollaborative.com/blc/629-BLC/version/default/part/AttachmentData/data/Mediation%20as%20a%20Spiritual%20Practice%20(2011-10-01).pdf.