

The Project on 
Medical Liability in Pennsylvania
funded by The Pew Charitable Trusts

Medical Error Disclosure, Mediation Skills, and Malpractice Litigation

A Demonstration Project in Pennsylvania

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Printed in the United States of America.

ISBN 0-9741239-9-4

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Acknowledgments

The authors wish to thank Prof. William Sage for involving us in the work of the Project on Medical Liability in Pennsylvania; Julie Poll Blitzer, who provided invaluable logistical support; faculty assistant Mirlande Mersier; research assistants Linda Kwak, Emily Hirshbein, Kristen Kim, Dionne Franklin, and Alice Hsieh; and our colleagues from The Mediation Group in Boston, MA. Our special thanks goes to the remarkable people – clients, lawyers, and hospital representatives – who entrusted their disputes to us in the two cases described in this report and consented to our reporting on those experiences so others could benefit. While the cases were quite different, we remain moved by the courage, compassion, and conviction that each participant showed.



Executive Summary

In the past decade, the cost of medical malpractice insurance has skyrocketed in Pennsylvania. Physicians in high-risk specialties are reported to have moved out of the state, closed their practices, or retired, particularly in eastern Pennsylvania. Liability insurance companies have pulled out of the state. At the same time, serious medical errors continue to occur. Doctors and hospital officials, afraid of lawsuits and loss of insurance coverage, often stonewall patients and relatives, offering only barebones explanations of serious medical errors. Research shows this situation creates a vicious circle in which frustration, anger, and a search for information often motivate patients or their families to file medical malpractice suits.

Against this backdrop, the Project on Medical Liability in Pennsylvania, an independent initiative financed by The Pew Charitable Trusts, developed the Demonstration Mediation and ADR Project in 2002 to explore the value of mediation and open, frank communication about medical errors as a means to avoid bitter and protracted lawsuits. The demonstration project, designed and conducted by faculty of the Columbia Law School in New York, involved three hospitals in eastern Pennsylvania and was based on an extensive review of existing research.

Shortly after the demonstration project began, its potential findings gained significance because Pennsylvania enacted Section 308 of the Medical Care Availability

and Reduction of Error Act. This law, the first of its kind in the United States, requires hospitals to give written notice to patients or their family after a “serious event.” In effect, the state now obligates health care providers to explain the circumstances and repercussions of serious health complications caused by inpatient medical errors.

Innovative Solutions

Taking a comprehensive and innovative approach, the Demonstration Mediation and ADR Project offers four recommendations that hold potential for easing the medical liability crisis while benefiting patients, physicians, and hospitals:

- Provide communication training to doctors and administrators as part of changing hospital culture from one of defensiveness to one of openness.
- Create a “consult service” of communication experts within hospitals to help plan conversations with patients and family members and provide emotional support to health care providers involved in errors or adverse events.
- Offer apologies when appropriate.
- Offer early, non-evaluative mediation that brings patients or family members together with health professionals to share information and seek solutions.

Confrontational litigation is antithetical to meaningful communication after an error or adverse event. Instead of mistrust and anger, patients and survivors need to feel

understood and respected. Delay takes an emotional and financial toll on both sides. Timely communication helps physicians and hospitals receive valuable information relevant to patient safety. Both sides can receive emotional gratification from good communication, sometimes leading to non-monetary settlements such as lectures in the patient's name or improvements in hospital procedures. If a monetary payment is appropriate, it should be paid within weeks or months instead of years, as occurs in litigation.

Communication Training

Research shows that ineffective communication with patients — not negligence — puts physicians at greatest risk of malpractice lawsuits. But open communication runs counter to the defensiveness physicians often feel and the virtually uniform advice of attorneys to say as little as possible. In addition, health care professionals often make assumptions about a patient's concerns instead of listening or take a patient's words at face value instead of trying to determine the patient's true meaning. The resulting mistrust, anxiety, and suspicion can easily turn into protracted litigation.

Even training sessions that are compatible with busy professional schedules can help overcome these problems by familiarizing health care providers with the complexities of meaningful communication. They learn how to formulate the right

questions, to avoid defensiveness, and to express concern about the issues most important to patients — all techniques that tend to defuse anger.

Communication Consult Team

Over the course of his or her career, an individual health care professional will likely be involved in only a few events that require disclosure under the Pennsylvania law. As a result, doctors have few opportunities to practice and develop communication skills in real-life situations. Therefore, hospitals need to form teams of intensively-trained employees adept at communications. These teams serve several purposes:

- Helping plan the initial disclosure conversation, even when little time is available
- Accompanying the treating physician to make sure patients and family members have an opportunity to participate and their concerns are addressed
- Questioning patients and family members to identify procedural problems that the hospital needs to address for patient safety
- Debriefing health professionals involved in the error and offering emotional support
- Apologizing

Research indicates that when physicians take responsibility for an error and offer a genuine apology, patients and family members have less inclination to sue. Candor builds trust and makes patients and family members feel welcome in discussions about avoiding similar errors in the future. When physicians, conditioned by dire warnings from

attorneys, hesitate to admit fault, patients often interpret hesitation as lack of concern, compounding their resentment.

Apologies do carry a danger, because only a handful of states bar them as evidence in lawsuits. However, hospitals need to weigh the risks and benefits carefully because a growing body of evidence indicates apologies reduce litigation and offer great, though unquantifiable, emotional benefits for patients, families, and health care providers. After the University of Michigan Health System instituted an apology policy in 2002, malpractice claims decreased by half and the cost of handling them by two-thirds. More research is needed to quantify the benefits of apology, but results thus far are promising.

Mediation

Litigation is lengthy, expensive, stressful, and limited to monetary remedies. Mediation is fairer, more flexible, quicker, and significantly less expensive.

Mediation already is practiced by a handful of health care organizations, including the Drexel University College of Medicine in Philadelphia. In all cases, the proceedings are voluntary. They also remain confidential, meaning nothing said can be submitted into evidence. Patients unhappy with the results retain the option to go to court.

Most malpractice mediation follows the model developed in 1995 by Rush University Medical Center in Chicago, which has cut its defense costs by more than half. In the “Rush model,” mediators focus on the strengths and weaknesses of each party’s case when the parties’ attorneys meet to negotiate, and then propose a monetary settlement, shuttling between one side and the other. The sessions occur long after the care at issue, in order to give each side a chance to prepare its case. Settlements emphasize money and rarely include any hospital improvements or other non-monetary terms.

Although the Rush model has succeeded on its own terms, research establishing the importance of communication between physicians and patients supports a different approach to mediation. The Demonstration Mediation and ADR Project uses a facilitative rather than evaluative approach. The parties spend considerable time talking face-to-face, while the mediator helps them gain understanding of the situation, assess the strength of their positions, and reach a settlement together. Both sides have the opportunity to ask questions and to express feelings.

The Demonstration Mediation and ADR Project also recommends mediating as soon as both sides have enough information to assess the value of the case, rather than waiting years while both gather the very different information that would be needed as evidence should the case go to trial. Because the medical professionals hear the patients' concerns and complaints in a timely manner, improvements to hospital procedures can result as well as payment of damages.

Conclusion

The cost of medical malpractice insurance continues to increase in Pennsylvania, and errors continue to hurt patients. Open communication and mediation that offers emotional as well as financial satisfaction hold the promise of addressing both problems in a way that is fair to doctors, patients, and families.

However, changing the culture of hospitals from guarded to open will require strong and continuous efforts by medical leaders. Pennsylvania's disclosure requirement motivates health care providers to improve communication with patients and families. Changes in state law to protect apologies would give them another valuable tool.



Introduction

The Pennsylvania Demonstration Mediation and ADR Project (“ADR Project”), part of the Project on Medical Liability in Pennsylvania funded by The Pew Charitable Trusts, recently completed a study exploring the use of mediation and conflict management techniques in a hospital setting to enhance physician-patient communications following medical errors and adverse events. The study’s hypothesis

Our hypothesis was that skills used by mediators to help parties identify interests, exchange information, and craft resolutions can improve patient safety, patient relations, and liability risk management.

was that skills used by mediators to help parties identify interests, exchange information, and craft workable long-term resolutions can improve patient safety, patient relations, and liability risk management (Liebman and Hyman 2004).

Highly trained individuals tend to regard talking and listening as basic functions which need not be learned and seldom warrant particular attention in practice. Physicians generally lack formal training in these skills. Only 12 out of 125 medical schools have a required course on “communication skills” (Association of American Medical Colleges 2000-2001). Yet research findings demonstrate that ineffective communication between physicians and patients is the single most significant factor in explaining why physicians

are sued (Levinson et al. 1997). Research also demonstrates that silence (nondisclosure) contributes to medical errors and adverse events and impedes improvement of patient safety (Kohn et al. 2000).

The ADR Project was designed to help hospitals and physicians in Pennsylvania implement new legal requirements regarding provider-patient communication. As the ADR Project was beginning in early 2002, Pennsylvania adopted the Medical Care Availability and Reduction of Error (“MCARE”) Act (also known as “Act 13”). With

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the passage of the MCARE Act, Pennsylvania became the first state to impose a duty on hospitals to notify the patient or patient’s family in writing within seven days of a “serious event.”¹ The MCARE Act defines the term “serious event” as “[a]n event, occurrence or situation involving the clinical care of a patient in a medical facility that results in death or compromises patient safety and results in an unanticipated injury requiring the delivery of additional health care services to the patient” (Pennsylvania MCARE 2003). The notification requirement took effect on May 19, 2002.

¹ 40 P.S. § 1303. Nevada, New Jersey, and Florida followed Pennsylvania’s lead by imposing requirements that patients be notified in person (rather than in writing) by the medical facility after an event that causes serious injury (Fla. Stat. § 395.1051, Nev. Rev. Stat. § 439.835, N.J. Stat. § 26:2H-12.25). See Appendix A for text of the statutes.

Pennsylvania became the first state to impose a duty on hospitals to notify the patient or patient’s family in writing seven days of a “serious event.”

The MCARE Act was a response to Pennsylvania’s struggle with the effects of a medical liability crisis. Physicians and hospitals were reeling from increases in malpractice insurance premiums and unavailability of coverage (Bovbjerg and

Bartow 2003). The statute, possibly the first comprehensive malpractice reform law passed in the face of heightened public awareness of medical error (Institute of Medicine 1999), paired tort reform and insurance restructuring with a mandate to improve patient safety. The new disclosure requirement, which at the time of enactment was regarded skeptically by health care providers, in fact helped them assess and improve communications with patients when medical errors occur. Hospital administrators quickly understood that, without an open conversation about the “serious event” prior to receipt of a disclosure letter, patients and their families might be more likely to pursue litigation. The MCARE Act also prompted consideration of how to process claims for compensation in a fair and efficient manner and how to turn discussion of adverse events into opportunities to learn how to improve patient safety.

A Note About Terminology

“Medical error,” “adverse event,” and “serious event” all describe something going wrong in the care of a patient. “Adverse event” refers to an “unintentional, definable injury that was the result of medical management and not a disease process” (Pierluissi 2003, 2839, citing Reason 1990).

“Medical error” means “the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim” (*ibid.*). Often “medical error” refers to preventable systemic problems as well as poor performance by individual health care providers (Barach 2003).

Depending on the facts, a “serious event” could be a medical error or an adverse event. We use the phrase “medical error or adverse event” to capture the universe of system errors and injuries due to medical management. “Negligence” has a much narrower meaning under state malpractice law: a deviation from the “standard of care” defined by customary or reasonable practice among similarly situated professionals.

The boundaries of these definitions are not always obvious to patients and their families. For example, a patient may find it baffling that a central line placement that fatally punctures a lung may be within the legal standard of care. Patients often think that a poor outcome is evidence of a mistake. Although patients are told about foreseeable risks during the informed consent process, they cannot always absorb all that is said. Patients may also have a cognitive bias, and incorrectly assume that they will escape harm. Whatever the appropriate terminology, when the odds play out badly for a particular patient, poor communication about the risks before a procedure and poor communication afterwards increase the likelihood of litigation (Hickson et al. 1992).

Pennsylvania's medical liability crisis remained sufficiently acute after the MCARE Act that all three branches of state government took further action. These reforms included recommendations by the governor, issued in June 2003, for widespread mediation of medical malpractice cases (Rendell 2003). Mediation skills can be used in disclosure conversations as well as to resolve formal malpractice claims on the eve of trial.

The Pennsylvania Demonstration Mediation and ADR Project

Between 2002 and 2004, the ADR Project worked closely with three Pennsylvania hospitals/health care systems. The ADR Project examined how mediation and conflict resolution skills might be helpful in responding to both the new disclosure requirements and to actual malpractice claims against hospitals following medical errors and adverse events. In the initial phase of this participant-observer study, we reviewed the mediation and health care literature and met with physicians, risk managers, patient safety officers, counsel, nurses, and hospital administrators. Based on that work we identified three initiatives to improve health care professionals' ability to talk with and listen to patients and each other:

We reviewed the mediation and health care literature and met with physicians, risk managers, patient safety officers, counsel, nurses, and hospital administrators.

-
- Teach physicians and other health care professionals how to use key communication skills in disclosure conversations with patients and families after a “serious event” has occurred;
 - Mediate cases in which a medical malpractice claim is likely to be or has been filed; and
 - Use mediation and facilitation skills to improve the quality of a hospital’s internal conversations about a medical error or adverse event by shifting the focus from blame to discovery of the reasons why the event occurred and how practices and procedures can be changed to prevent such events in the future.

We offered these mediation services and conflict resolution training at no cost to a group of Pennsylvania hospitals. We eventually provided training services to three hospitals: a large, decentralized network of urban teaching and suburban hospitals with more than 2,500 staffed beds; a suburban community teaching hospital with approximately 500 beds; and a community teaching hospital with 800 beds, which serves as the tertiary care center for a portion of the state. We had extended discussions with a fourth hospital which was not an active participant in the project.

To our surprise only one hospital chose to participate in mediation; we assisted this hospital with two mediations. Another tried, in one instance, to convince plaintiff’s counsel to participate in mediation but failed. A third talked with its lawyers to see if cases could be identified that might be good candidates for mediation but could not identify any. None opted to use our services for the internal conversations, which we had thought might be the ADR Project’s greatest contribution to patient safety. We believe

the participants’ decisions to decline use of our services for this purpose reflect a concern that peer-review confidentiality might be compromised if outside third parties were allowed to participate. In at least some instances confidentiality of the exchange could have been protected by mediation confidentiality provisions.

As a result of our work, we recommend four measures that hospitals and physicians can take to help manage the fallout from a medical error or adverse event:

- Provide communication skills training to physicians and other health care professionals to prepare them for disclosure conversations.
- Create a consult service of expert communicators among the hospital’s professional staff who can help plan and conduct disclosure conversations with patients and families and provide debriefing and emotional support to the health care providers involved.
- Apologize when appropriate and attend to the form of apology most likely to be helpful in restoring trust between the patient and physician.
- Use mediation to resolve claims promptly, possibly before a claim is filed.

Our recommendations are designed to create a culture which supports candor, free exchange of information, fair outcomes for patients and physicians, and improved patient safety.

These recommendations are designed to create a culture which supports candor, the free exchange of information, fair outcomes for patients and physicians, and improved patient safety.



Recommendation 1

Train Physicians to Communicate Better During

Disclosure Conversations

Learning to talk openly with patients after a medical error or adverse event can be particularly difficult for physicians and other caregivers after years of reacting

One of the most striking initial findings was the range of approaches institutions are taking to the disclosure requirements.

defensively and following the virtually uniform advice of lawyers and risk managers to say as little as possible. The importance of changing physicians' approach to disclosure communication is suggested by research showing that stonewalling produces anger (Dauer and Marcus 1997), whereas promptly acknowledging the error and apologizing may tend to decrease litigation (Cohen 1999).

In order to identify which mediation skills might be most helpful to physicians and other health care professionals during disclosure conversations, we needed to understand the context in which physicians and hospitals are struggling to provide care and to comply with myriad reporting, disclosure, and patient safety requirements. We also sought to be sensitive to the distinct cultures of individual hospitals. Therefore we arranged meetings with the

staff identified by each hospital's senior management as appropriate to involve in the ADR Project.

As a result of these meetings and additional secondary research, we found that the following responses by physicians are likely to be helpful during disclosure conversations:

- Apologizing
- Describing the error instead of avoiding specifics
- Giving basic information known at the time of the error, but not guessing
- Explaining what additional inquiries will be made and what questions need to be answered
- Showing the feelings they have experienced as a result of the error

One of the most striking initial findings was the range of approaches institutions are taking to the disclosure requirements. Hospital disclosure policies seemed to be influenced by differences in cultures arising from the organization of the hospital or health system – centrally controlled or loosely affiliated - and the patient population – inner city, suburban, or rural. Differences also seem to grow from the philosophy of the institutions' leadership. The approaches to disclosure ranged from an open and transparent approach (*i.e.*, share information, be available to patients and their families,

provide explanations, and apologize) to what we characterize as a guarded litigation approach (*i.e.*, reveal little and treat each event as a potential lawsuit to be defended).

The MCARE Act requires Pennsylvania hospitals to respond to the typical questions families and patients ask after a serious event: what happened to the patient, what is going to happen next, why did the event happen, and what is being done to

Hospitals recognize that the requirement of written disclosure has the potential to provoke litigation unless there is empathetic communication before the written disclosure is received.

prevent it from happening again? Gallagher and colleagues (2003) point out that patients prefer that physicians volunteer this information rather than waiting for patients to ask questions. The same study also found that patients want to know that the physician and institution regret what happened, have learned from the event, and have made plans to prevent a recurrence. The

MCARE Act motivates hospitals to ensure that physicians and other staff respond to patient concerns after a serious event. Hospital leaders recognize that the Act's requirement of written disclosure within seven days has the potential to provoke litigation unless there is empathetic communication about the event before the written disclosure is received.

Providing Training where Time is a Scarce Resource

An initial challenge and a subject of negotiation with participating hospitals was how to adjust training to the realities of the hospital setting where most educational programs last only an hour or two. Typically, introductory training about conflict resolution or mediation takes two to four full days. Training involves a mix of exercises and simulations designed to develop both skills and a theoretical understanding of the process. Trainees have multiple opportunities to practice, observe, and receive coaching and feedback. For this study, training sessions had to be adjusted to the time pressures of hospital operations and medical practice.²

A challenge was how to adjust training to the realities of the hospital setting where most educational programs last only an hour or two.

We provided training targeted at one hospital’s medical leadership in ninety-minute sessions. The hospital administration felt ninety minutes was short enough to allow attendance by physicians who are, for the most part, private practitioners unlikely to give up a full day’s work. We presented enough key material to give participants a few rudimentary tools for better quality discussions with

patients. A year later we provided a follow-up “advanced” four-hour role play based

² See Appendix B for the agendas of the training sessions conducted at three hospitals as of May 2004.

training for 25 physicians who had attended the brief trainings. The hospital has continued to provide 90-minute training sessions for its medical staff. Despite strong positive responses from participants in the short sessions we conducted, we remain skeptical that training of this length has lasting value unless, as discussed below, hospitals develop a consult service of communication experts.

Another health care system had a broader cross-section of its staff participate in a two-day training. Physicians received continuing medical education (CME) credit, which

Active and reflective listening skills, used routinely by mediators but less familiar to most physicians, can improve communication during disclosure conversations.

provides a strong incentive for participation and should be considered for nurses and other professionals as well. A training of this length provides time to introduce more complex theoretical material, to conduct exercises illustrating the theories, and to practice skills in a variety of role-plays where critiques and coaching are provided. In addition, the longer sessions allowed participants to play different parts (*e.g.*,

patient, family, other health care provider) which can supply insight into the dynamics and the emotional reality of an actual disclosure conversation.³

³ See Appendix C for a copy of the handout for this training.

A third participant chose a one-day training for risk managers, lawyers, and a few physicians from its constituent hospitals. A significant additional benefit of this training session was the opportunity for a mix of staff to hear the perspectives of their colleagues.

Why Physicians are Sued and How They Communicate with

Patients

Each training began with a review of the counterintuitive information about why physicians are sued. Researchers have found that after a medical error the factors that put physicians at risk of being sued are not the quality of medical care (Entman et al. 1994), not chart documentation (*ibid.*), and not technical negligence (Harvard Medical Practice

Study 1990), but ineffective communication with patients (Lester et al. 1993, Levinson et al. 1997).

Moreover, what the physician says is less important than the process and tone of the conversation (Levinson et al. 1997).

Active and reflective listening skills, used routinely by mediators but less familiar to most physicians, can improve communication during disclosure conversations.

Hickson's survey of the reasons parents sued physicians after a perinatal injury to a child

emphasizes ineffective communication. He found that 33% sued because they were advised to do so by a third party, often another health care provider; 24% felt the doctor

was not completely honest or had lied to them; 24% needed money for the child’s future care; 20% couldn’t get anyone to tell them what had happened; and 19% wanted revenge or to protect others from harm. Many of those suing felt their physician would not listen (13%), would not talk openly (32%), attempted to mislead them (48%), and did not warn them of potential long-term neurodevelopmental problems (70%) (Hickson et al. 1992).

In another major study, Gallagher looked at the attitudes of patients and physicians after a medical error. His findings highlight the mismatch between what patients want and what physicians provide after an adverse event or medical error. Patients want “basic information”: an explanation of what happened and why, the health implications of the error, and how the problem will be corrected so future errors can be prevented (Gallagher et al. 2003). By contrast, for understandable reasons, physicians tend to choose their words carefully, are likely to mention the adverse event but not that an error has occurred, and are unlikely to tell the patient what caused the error and how it might be prevented from recurring.

Skills Training

Physicians are trained to diagnose medical problems, deliver bad news to patients, and discuss hard choices about treatment options. The communication skills physicians use in these tasks are helpful when disclosing a medical error or explaining an adverse event, but communication in such situations is more difficult, complex, and demanding

than in ordinary situations. Active and reflective listening skills, used routinely by mediators but less familiar to most physicians, can improve communication during disclosure conversations.

Active Listening Skills

Active listening shows attentiveness to the person speaking. Following an adverse event, active listening by the health care provider can head off mistrust, anxiety, and suspicion that will often follow a bad outcome. When a health care provider uses active listening, he or she demonstrates understanding of the meaning of the event to the patient and family and invites them to participate in figuring out why the event occurred and how to deal with the consequences. The techniques of a health care provider who is an effective active listener include:

- Maintaining appropriate body language;
- Keeping eye contact;⁴
- Asking the patient or family members clarifying questions rather than assuming what they intend by a statement;
- Identifying and responding to the patient's or family member's interests, not just to the stated position;
- Reflecting to the patient or family member in neutral language what he or she has said; and

⁴ In Western culture eye contact is a way of showing attention. In other cultures it may be seen as too direct and therefore impolite.

-
- Acknowledging the patient's or family member's feelings.

Health care providers can learn how to distinguish between a patient or family member's position and the underlying interest.

The first two techniques are non-verbal responses by the listener which may seem minor but which can significantly change the patient's perception about the level of concern of the health care provider who is speaking. For example, research has shown that physicians who enter a room and sit down to talk with patients are perceived as spending considerably more time with the patient than physicians who are actually present for longer but stand during the conversation (Strasser 2003).

One of the most draining and time-consuming tasks of health care providers is responding to the demands of a patient or family member. Health care providers can benefit by being trained how to distinguish between a position and the underlying interest. Positions are demands or assertions often expressed with strong feelings. Interests are the needs and concerns represented by the positions. Distinguishing interests from positions is a skill that usually takes mediators considerable practice to learn. For example, a parent demanding that a teenager be home by 11 p.m. is expressing

a position. The parent's underlying interest may be the child's safety or respect for the parent as authority figure.

Once the interests underlying a position are identified, it can be helpful for the active listener to rephrase hostile language into a statement of concern which makes the underlying interest explicit. Reframing often allows the participants in the conversation to avoid becoming mired in defensive, reactive, angry, and accusatory language, and instead to listen, to consider the point of view expressed, and possibly to collaborate in resolving the problem. For example, a patient with a tracheostomy might demand a change in the nurse assigned to her – a position – after several slow responses to the call bell used to request suctioning. The patient's underlying interests are prompt attention to her need for nursing care and limiting how long she experiences frightening and uncomfortable difficulty in breathing when her tube needs to be suctioned.

Reflective listening involves using summary or paraphrase to acknowledge what has been said, to check on understanding, and to acknowledge the feelings expressed.

Reflective Listening Skills

Reflective listening involves responding to the patient or family member by using summary or paraphrase to acknowledge what has been said, and to check on the accuracy

of the listener’s understanding, while also identifying and acknowledging the feelings expressed by the statements. It is a powerful tool for demonstrating that a speaker has

Even physicians who are committed to full disclosure after adverse events are not very skilled at reflective listening.

been heard. One of our most striking observations is that even physicians who are committed to full disclosure after adverse events, driven primarily by a sense of ethical duty, were not very skilled at reflective listening. They showed concern and shared information but did not reflect what they had heard or acknowledge the feelings of patients

or their family members. They tended to make assumptions about the patient’s or family member’s concerns without taking time to check on the accuracy of those assumptions.

They failed to ask clarifying questions – a critical tool for identifying interests.

Consider the case of Mrs. X:⁵

Mrs. X was given the wrong medication and as a result spent a day in the ICU. She is now doing well and the error is not expected to have long-term consequences. During the disclosure conversation among the physician, the patient, and her husband, the husband said in an agitated tone, “What is going to happen to the nurse who made the mistake? Will she be fired? Will she continue to care for my wife?”

When asked to identify the interests of Mr. X, participants in our training typically responded by assuming the husband wanted no further contact between the nurse and his

⁵ Hospital and Healthsystem Association of Pennsylvania 2002.

wife. Participants did not ask additional questions to clarify his and his wife's interests.

Brief introductory training for medical nursing should aim to increase their awareness of communication needs, to give them elementary tools, and to sensitize them to the value of consulting with communication experts.

In further elucidating the underlying interests, participants might discover that Mr. X indeed does want the nurse off the case, but he also may want assurance that the nurse is not punished unfairly. Alternatively, they may discover that Mrs. X and her husband feel that the nurse has otherwise provided good care and shown warmth and concern throughout her hospitalization, and they may wish that the nurse remain on the case.

A response demonstrating reflective listening and using a clarifying question would be: "I can understand that you are upset about this error and that you have questions about future involvement of the nurse in your wife's care. What do you think should happen?" This type of response allows insight into what the husband actually wants, *i.e.*, his interest, as opposed to operating on the basis of an assumption that may be inaccurate.

Goals of Communication Skills Training

Given the limited number of disclosure conversations in which any individual health care provider will be engaged over the course of his or her career, the time needed to master these communication skills, and the need to use the skills in order to maintain them, we have concluded that there should be two main goals of training health care providers:

- Briefly introduce members of the hospital staff to the skills used in disclosure conversations; and
- Train a core group of staff members to act as an expert communication consult service, to be available to help others prepare for the conversations, to participate when appropriate, and to debrief afterwards with the health care providers involved in the event.

Brief introductory training for as many members of the staff as possible should aim to increase their awareness of the complexity of the communication needs surrounding medical errors or adverse events, to give them elementary tools, and to sensitize them to the value of consulting with communication experts.



Recommendation 2

Create a Consult Service of Communication Experts

Mediators spend a great deal of time developing their active listening skills. Physicians, other health care professionals, and hospital administrators face an even greater challenge using these skills effectively. Whereas mediators are, by definition, neutral about the outcome of the discussion, health care professionals have obvious stakes in a disclosure conversation. A physician is also likely to be preoccupied with the medical reality of the situation and not be well equipped to concentrate on the communication needs of the patient or family. After an adverse event or medical error, the physician or nurse may experience strong emotions such as guilt, failure, shame, remorse, or fear about the impact on his or her career (Shapiro 2003). Thus, active listening during these critical times can be understandably extremely difficult for health care professionals.

In the stress of the moment, physicians may not be able to evaluate whether a disclosure conversation has gone well. For example, at one training session, a hospital administrator described a physician who had been involved in a serious event. The physician had told the hospital administrator he was pleased with the disclosure

conversation. A few hours later, the administrator received an angry call from the patient’s daughter. She was upset with the physician because she felt that he had talked “at” them, had not listened, and had not answered their questions.

We recommend using a consult service model in which an expert communication consultant, who has been trained to facilitate disclosure conversations and to gauge the reactions of the patient and family, aids in planning and conducting disclosure conversations. After an adverse event it should be just as routine to call for a consult about communication process as it is in other contexts to call for a cardiology or geriatrics consult. It is the consultant who can make certain that the patient and family are clear about the next steps the hospital will be taking and about whom to contact with questions and concerns. The consultant can confirm the hospital’s commitment to openness and information sharing. The consult service may also be in the best position to link the disclosure conversations and what is learned during them to other institutional processes intended to improve patient safety.

Members of the communication consult service can be drawn from throughout the hospital. Chiefs of service, nurse managers, patient safety officers, risk managers, and members of bioethics committees are obvious candidates, but other individuals may have

interest in and aptitude for the task. Research suggests that successful mediators are individuals who are perceived to be natural problem solvers and conflict resolvers within the institution and who exhibit the skills needed during disclosure conversations, regardless of title or status (Kressel et al. 2002).

Planning the Disclosure Conversation

Even when time is limited, taking a few minutes to speak with a communication expert will improve the disclosure conversation.

Planning a disclosure conversation in the aftermath of a medical error or adverse event is often thought of by health care professionals as an unachievable luxury. However, even when time is limited, taking a few minutes to speak with a communication expert about the following considerations will improve the disclosure conversation:

- Who has the best-established relationship with the patient or family?
- Who has the best information about the event?
- What are the best words to use in explaining the event?
- Who is emotionally able to participate in the conversation?
- Who will have the answers to patients' questions about their treatment and prognosis?

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- Who will have the answers about payment for additional treatment?
 - What is known about the event and what further investigation will be conducted?
 - Who should lead the discussion?
 - What questions are the patient and family likely to have?
 - Who will be the follow-up contact person?

If the physician most involved in the adverse event is unable to participate in disclosure, it is essential that the reason for non-attendance be made clear.

Having the person with the best available information at the disclosure conversation is important for three reasons. First, patients expect to hear from the physician most involved and may become suspicious should that person not attend the meeting. Second, having the person with the best information present avoids having others succumb to the temptation to fill in the information blanks by speculating about what happened. Finally, receiving information and explanations can change the way those involved in the event view each others' motives. If, for some reason, the physician most involved in the adverse event or error is unable to participate in the disclosure conversation, it is essential that the reason for non-attendance be made clear. In most cases an opportunity for a future conversation with that physician should be offered. Even though it is difficult for a professional to admit that he or she does not have answers

to significant questions, speculation often proves wrong. The subsequent provision of correct information that is inconsistent with the initial speculation may be seen as “changing the story” or “covering up.”

When patients and their family members receive information about what happened and why, they may react to an error or adverse event with less anger and blame.

Receiving information can change the negative motivations which the patient attributes to the health care providers.

Attribution theory research examines both how people interpret the causes of observed behavior and the implications of attribution for their emotions and reactions (Allred 2000). Most people tend to attribute another person’s negative behavior to innate disposition or character while attributing their own behavior to circumstances. The person who is harmed assigns the negative behavior to causes under the control of the other and responds with anger. At the same time, the person who has caused injury attributes his or her own behavior to circumstances beyond his or her control. The resulting difference “in judgment of the harm doer’s responsibility ... can lead to the most destructive kinds of anger-driven-conflict” (*ibid.*).

Given attribution theory research, it seems important during disclosure conversations to provide all of the available information known at that moment. The patient and family should be told the causes of harm, including if those causes were

beyond the control of the physician or other caregivers. Receiving information can change the negative motivations which the patient attributes to the health care providers; e.g., the physician made a mistake because she is uncaring or incompetent. This can avoid, or at least reduce, anger and blame.

The conversation should not overwhelm the patient or family with too many “white coats.” Some commentators advise having the patient’s attending physician or, under some circumstances, a hospital representative such as the risk manager lead the conversation (Hébert 2001, Wu 1997). Others advise against having the physician closest to the patient disclose and would designate the chief of the medical staff as the representative best able to lead the conversation (Liang 2002, Kraman 1999). Inevitably, the decision about who attends the disclosure conference must be made by the institution case – by – case.

Consider the case of Mr. B.

Mr. B, a retired husband and father, with end-stage chronic obstructive pulmonary disease was admitted to the hospital’s Intensive Care Unit. A medical resident supervised by a surgical resident inserted a subclavian central line (an IV placed in a vein under the collarbone). As the line was being placed, the needle nicked the patient’s lung, which collapsed. Mr. B went into cardiac arrest and died.

The resident called Mrs. B at home and urged her to come to the hospital immediately. When she arrived the attending physician informed her of her husband’s death. She was then left standing alone in the hall outside her husband’s room. No one explained what had happened then or in the days and weeks that followed. She filed a lawsuit partly in search of an explanation. She had no communication with the physician

or hospital representative between the time that she was informed of her husband's death and the beginning of a mediation session, at which the case was settled.

In Mr. B's case, both the attending physician who delivered the bad news to Mrs. B and the medical resident could have benefited from a communication consult to help them, in the brief time before Mrs. B arrived at the hospital, to think through how to deliver the tragic news and support her at that moment. A communication consultant could also help the physicians plan and conduct a follow-up discussion with the family. As is all too common, the attending physician and the resident took what seemed the easiest and least painful way out and avoided further communication with the family. While it is impossible to know whether additional skilled and empathetic conversations would have avoided the lawsuit, such conversations certainly would not have made things worse.

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Acknowledging Different Goals for Participants

The goals and motivations of the treating physicians and other members of the care team during a disclosure conversation may differ from those of department heads or hospital administrators, a fact which makes planning and coordination essential. The health care professional may be anxious to get the conversation over with as quickly and

painlessly as possible with minimal damage to the relationship with the patient and to the provider's reputation and self-image. The hospital, on the other hand, may be interested

Recurrence of an error can only be prevented if all those with information contribute what they know. Family members or the patient may have observed details not seen by a health care provider.

in additional goals such as gathering information, complying with legal requirements, and maintaining the institution's standing in the community. Expert consultants themselves may want to learn about system failure, communication problems among caregivers, or failure to listen to the patient's or family's attempts to understand what was going on. Being aware of the possible diversity of goals and motivations among the participants allows disclosure planning to be responsive to the interests of each participant.

It will most likely be the expert consultant who will be aware that three conversations tend to occur within any "difficult conversation." Stone, Patton, and Heen (1999) explain that each difficult conversation is really a conversation about what happened factually; a second conversation about the feelings being experienced by the participants; and a third "identity conversation," which is the internal conversation we each have with ourselves about what a situation means to us. The consultant will be equipped to address the issues raised by these three simultaneous conversations.

Encouraging Patient and Family Participation in the Disclosure Conversation

The patient and family should be involved in the process of information – gathering and problem – solving after an error or adverse event has occurred for several

Disclosure conversations are often referred to as if they were single events. In fact, in most cases there will be several sequential conversations.

reasons. First, recurrence of an error can only be prevented if all those with information about what has happened contribute what they know. Family members or the patient may have observed details not seen by a health care provider. Did the patient or family try to question a procedure, only to be ignored or rebuffed? Did they observe poor communication among their caregivers? Did they hear treatment ordered which was

not entered in the chart? Were family concerns about deterioration in the patient’s condition ignored?

Second, asking for suggestions may lessen the sense of powerlessness patients and their families feel when dealing with the consequences of an adverse event or medical error. One technique used to draw out frightened, confused, or disempowered

patients or family members is to ask, “What questions do you have?” instead of “Do you have any questions?”

Third, including the patient and family members in the fact-finding effort makes them feel as if they are part of the problem-solving team and may reduce their anger and their fear of a cover-up.

Disclosure conversations are often referred to as if they were single events. In fact, in most cases there will be several sequential conversations. We suggest ending the initial conversation with the promise of future communication from a specific staff member by a date certain, along with information about whom patients and family members can contact by telephone or e-mail with questions, concerns, or additional information (or if the promised follow-up contact fails to occur). This clarity about future communication confirms the medical team’s commitment to openness and continued dialogue until there is a mutually acceptable resolution.

Grief, which is an extreme expression of more frequently acknowledged feelings, is an occupational reality for health care professionals.

Debriefing after Disclosure Conversations and Providing Emotional Support for Health Care Professionals

The communication consultant’s empathy and experience is also valuable when debriefing health care providers after an adverse event. During training sessions, the discussion following the question, “When a medical error or adverse event has occurred, what feelings are experienced by the health care provider and by the patient?” was free-

Acknowledging grief and encouraging discussions about medical error are essential ingredients in changing the culture of health care facility from one of blame to one of learning.

flowing and illuminating. Participants listed similar feelings for the physicians and nurses as for the patient, including sadness, anger, anxiety, vulnerability, and worry.

Grief, which is an extreme expression of more frequently acknowledged feelings, is an occupational reality for health care professionals. Although less commonly articulated than feelings of shame, guilt, and failure, grief-related job stress can be activated by witnessing a patient suffering, by failure of a treatment, or treatment error (Redinbaugh 2001). Without the opportunity to process their own emotions, health care

providers struggle to focus on the needs of the patient or family and may be unable to learn from the event in order to improve patient care.

Acknowledging grief and encouraging discussions about error and adverse events are essential ingredients in changing the culture of a health care facility from one of blame to one of learning (Wu et al. 1997). Research also shows that health care professionals develop a variety of coping strategies for dealing with stress and suggests that a hospital can meet the emotional needs of its staff by understanding and supporting these coping strategies (Redinbaugh 2001). A referral to a generic employee counseling service is not a substitute for the benefits staff would receive from being able to share their experiences with colleagues. If senior staff members responded to news of an adverse event by discussing their own past mistakes, such openness would be a powerful source of support for other physicians (Vincent 2003). Rather than remaining emotionally isolated and left on their own to deal with their emotions, physicians could learn from each other how to manage the intense emotional impact of error (Leape 1994, citing Christensen et al. 1992). In addition, health care providers who feel emotionally supported are more likely to feel comfortable talking to patients after an error, explaining what happened, answering questions, and expressing their own feelings.

Consider again the case of Mr. B. The physicians might have benefited from a consultation with a communication expert who could have helped them deal with their own emotions, plan a follow-up conversation with the widow, consider what type of apology might be appropriate, and tell the widow that they too were grieving. A follow-up conversation would have provided a setting where the physicians could answer the family's questions about what happened to its loved one including, in this case, why a medical student rather than a senior physician was performing the procedure.



Recommendation 3

Apologize When Appropriate

The doctor-patient relationship is built on trust. Patients trust their doctors to diagnose their problems and design appropriate treatment plans – plans that may involve

difficult and uncomfortable interventions. When an error occurs this trust is violated. When the physician fails to acknowledge the error and to apologize, the injury is compounded. We expect that someone worthy of our trust will behave ethically by taking responsibility for harming us.

The doctor-patient relationship is built on trust. We expect that someone worthy of our trust will behave ethically by taking responsibility for harming us.

Traditionally, lawyers and risk managers have told physicians: “Say as little as possible after an adverse event and do not apologize but, if you do, be sure you do not admit fault.” For example, although Fiesta recognizes that what often most upsets patients and family members is “the physician’s lack of communication and apparent lack of concern,” she also cautions that “The healthcare provider should never admit liability, *i.e.*, never state or imply that the poor outcome was his or her fault, or the fault of others”

(Fiesta 1994, 14). This advice flies in the face of what research tells us patients are seeking after an adverse event (Gallagher et al. 2003, Cohen 1999, Levi 1997, Hickson et al. 1992, Levinson et al. 1997, Wu et al. 1997). In particular, recent empirical studies by Robbenolt (2003) and Mazor and colleagues (2004a) demonstrate the value of an appropriate apology and disclosure of information.

At the one-day training session, a physician spoke eloquently about a case with a bad outcome in which he and his partner decided to call in the family, meet at length with

them, answer their questions, and apologize. The

**We are not advocating
apologies simply to
avoid malpractice suits.**

physician had elected this course of action even

though he was not sure it was the hospital's policy

because he believed it was the right thing to do. He

thinks that apologizing and providing information to

the family led them to drop him and his partner from their lawsuit.

We are not advocating apologies simply as a tactic to avoid malpractice suits. We do believe, however, that appropriate apologies accompanied, when warranted, by a fair offer of compensation can reduce the emotional and financial costs of litigation, begin to repair the physician-patient relationship, and set a tone that allows patients and their families to be part of a discussion about how to avoid future errors. See Berlinger (2003) for a discussion of the difference between “cheap grace” and a relational approach to

forgiveness which requires involvement of the injured party in the aftermath of medical harm. Berlinger argues that patient safety systems can avoid the “cheap grace of presuming that it is enough for the institution to confess to and forgive itself for harms done to those in its care” by being attentive to the perspective of the injured patients and their families (Berlinger 2003, 35).

When Partial Apology May be Worse than No Apology

Apologies of responsibility – “I’m sorry I did this to you” – are full apologies.
Apologies of sympathy – “I’m sorry this happened to you” – are partial apologies.

Apologies usually take one of two forms. Apologies of responsibility – “I’m sorry I did this to you” – are also referred to as full apologies. Apologies of sympathy – “I’m sorry this happened to you” – are also called partial apologies. Until recently many people thought a partial apology would always be preferable to saying nothing. But research by Robbenolt (2003), in the context of a non-medical

tort, suggests that where fault is clear a partial apology may have a worse effect than saying nothing. If an individual who was clearly responsible for an injury fails to take responsibility, the injured party is less likely to accept a settlement. In that situation, no apology may be preferable to a partial apology.

By contrast, Robbenolt’s findings regarding the impact of a full apology show that the offerer “was seen as having offered a more sufficient apology, as experiencing more regret, as being more moral, as being more likely to be careful in the future, as believing that he or she was more responsible for the incident, and as having behaved less

If fault is clear, an apology of responsibility should be offered.

badly.” In addition, participants who received a full apology expressed greater sympathy, less anger, and more willingness to forgive the offender (Robbenolt 2004), as well as greater satisfaction with the monetary settlements that were offered.

Research by Mazor and colleagues (2004a) had similar findings in the medical context. Mazor found that after full disclosure and an apology, respondents were more trusting, more satisfied, and less likely to change physicians than when they received incomplete and evasive explanations. The Mazor study found that the form of disclosure did not reduce the likelihood that the patient would consult a lawyer, at least in the case of serious harm. But seeking that sort of expertise did not inevitably lead to adversarial litigation.

If further studies support these findings, and we anticipate that they will, physicians and hospitals will need to think carefully about the words they use when disclosing an error and apologizing. Situations in which a mistake has been made but the

health care provider was not negligent, or in which the patient suffers from an adverse event after being warned that the event might occur, provide special challenges. For example, what is the appropriate response when a mistake has been made but the physician was not negligent? When a surgeon nicks the bowel during surgery, a mistake has been made but the physician's conduct may have been well within acceptable standards of care. What is the best response when the appropriate treatment is selected and provided correctly but the patient is among that group for whom the consequence of the treatment is harm? The physician may feel he or she has nothing to apologize for since the patient and family were warned of the risks of the treatment. But the patient may have failed to hear (or have been emotionally unable to hear) the warnings and instead may believe that someone must have done something wrong. If the communication is seen as evasive, the already damaged relationship between the medical professionals and the family is likely to be further harmed and the risk of litigation and the cost of settlement will increase.

More research is needed on the impact of disclosure and apology, but our advice is always to disclose when harm has occurred for several reasons. First, it is the proper thing to do. Patients have the right – legal and moral - to know what has happened to them and why. They need that information in order make informed decisions about further treatment. In addition, full disclosure invites the kind of conversation with the

patient and family members that can reveal critical information for avoiding recurrent harm.

Further, if the hospital and health care provider have enough information to know that they caused the adverse event or medical error, an apology is warranted from both a pragmatic and an ethical standpoint. If fault is clear, an apology of responsibility should

In our work as mediators in non-malpractice cases, we have observed the damaging effect of grudging or hollow apologies.

be offered. The best course of action is a clear explanation about what happened that adjusts the content and pace of discussion to the ability of the patient or family to absorb what is being said and allows time and opportunity for questions.

It is also important that whatever is said be authentic.

In our work as mediators in non-malpractice cases, we have observed the damaging effect of grudging or hollow apologies, what Lazare (1995) refers to as a “botched apology.” Insincere apologies offered only for strategic advantage may do more harm than good (Partnership for Patient Safety 2004).

Barriers to Apology

In meetings with administrators and physicians at our participating hospitals and during training, discussion of the value of apology was heated. Lawyers, risk managers, and insurers continue to be leery of apologies despite research favoring them because

apologies are admissible in court as evidence of wrongdoing in most jurisdictions. Physicians and hospital leaders, schooled by their lawyers in a defensive adversarial response to litigation, still fear that apologies will come back to bite them at trial should the case be one of the small group of cases that actually go to trial (Galanter 2004, Lande 2004).

Responding to these concerns, eleven states have enacted statutes protecting certain apologies from use against the apologizer at trial.⁶ Nine of these states bar

Colorado law renders all health care providers' apologies, whether of sympathy or responsibility, inadmissible in litigation. We support this approach.

admissibility only for apologies of sympathy or partial apologies, likely a result of political compromise (Serviansky 2004). In 1986, Massachusetts became the first state to enact a statute that precluded an apology of sympathy from being admitted as evidence of an admission of liability in a civil action (Mass. Gen. Laws ch. 233, § 23D). Several other states followed: Texas in 1999 (Tex. Civ. Prac. and Rem.

Code § 18.061), California in 2000 (Cal. Evid. Code § 1160), Florida in 2001 (Fla. Stat. § 90.4026), Washington in 2002 (Rev. Code Wash. §5.66.010), and Tennessee in 2003 (Tenn. Evid. Rule §409.1). Three states, Ohio (ORC Ann. § 2317.43), Wyoming (Wyo.

⁶ See Appendix A for text of some of these apology statutes.

Stat. § 1-1-130) and Oklahoma (63 Okl. St. § 1-1708.1H), specifically protect apologies of sympathy made by health care providers in response to unanticipated outcomes.

In 2003, Colorado enacted a statute that renders all health care providers' apologies, whether of sympathy or of responsibility, inadmissible as an admission of liability or as an admission against interest (Colo. Rev. Stat. § 13-25-135). Recently Oregon enacted a law providing similar protection in the medical context (Or. Rev. Stat. § 677.082). We support this approach. There is growing evidence that full apologies reduce litigation, save money, and have great, though unquantifiable benefits for patients, families, and health care providers who have made mistakes. Laws that protect only partial apologies discourage the most desirable form of apology, from both the moral and the pragmatic perspective, while encouraging a type of apology that may be counterproductive in many situations (Robbenolt 2004). Given the variations in state law, however, health care providers should consult with risk managers or with counsel before offering an apology of responsibility. Although, lawyers can best advise their clients about the *legal* consequences of an apology, the clients – physicians and hospital administrators – are the ones best qualified to analyze the all of the benefits and risks. The clients may, in some cases, decide that the gains from an apology outweigh the possible costs.

Apology in Practice⁷

Lexington VA

Apology plays a key role in the pioneering program adopted by the Veterans Administration Medical Center in Lexington, Kentucky (“Lexington VA”) (Cohen 2000). In 1986, a year after the hospital lost two medical malpractice suits at trial with verdicts totaling \$1.5 million, an unusually high amount for a federal hospital, the Lexington VA instituted a radical policy of apologizing to patients as soon as possible after the occurrence of a medical error and, when appropriate, offering a fair settlement. The Lexington VA does this even if the disclosure requires tracking down the patient after discharge. The chief of staff acknowledges the error or event, apologizes, and gives a full explanation of the harm caused and the steps the hospital has taken to correct the problem and prevent future harm. The patient and family have the opportunity to ask questions and are advised to seek legal counsel to help them in this process of resolution. Options are reviewed and settlement discussions are initiated.

Apparently as a result of this policy, the Lexington VA has experienced a sharp increase in settlements and a reduction in the mean malpractice settlement (Hamm and Kraman 2001). The savings in litigation costs have been significant and the policy of

⁷ A new organization, Sorry Works! Coalition, provides continuing information about programs to encourage the use of apology after an adverse event. See www.sorryworks.net.

“assuming responsibility” for its errors has made it more likely that health care providers within the hospital promptly report errors. In 1995 the Department of Veterans Affairs adopted a policy requiring all its medical centers to inform patients or their families when medical errors result in injury, to offer appropriate medical treatment, and to advise them of their right to file a claim. While the federal hospital system and its employees have less exposure to liability than physicians and hospitals in the private sector, the rationale for apologizing to patients should apply equally.

University of Michigan Health System

The University of Michigan Health System in 2002 began a program in which physicians report errors and, after review by risk management, disclose the error and apologize. The impact on the health system’s rate of litigation has been dramatic. In June 2001 the average number of open claims against the system was 250-260 and it took an average of 1,100 days to dispose of cases (Boothman 2004). In December 2004 Rick Boothman, Assistant General Counsel at the University of Michigan, reported that the number of open claims had fallen to the 120 to 130 range and that claims were resolved in 320 days (*ibid.*). The annual cost of handling claims has declined from approximately \$3 million to \$1 million (Berg 2004).

COPIC

In 2000, the physician-owned medical professional liability insurer in Colorado, COPIC Insurance Company (“COPIC”), launched a post-incident risk management program called the 3Rs Program. Within 48 to 72 hours of a complication or injury to a patient, this program seeks to have the physician and patient engage in open, honest, empathic conversation. In appropriate cases, COPIC offers patients immediate monetary compensation for out-of-pocket losses without requiring a release of legal claims. Because no plaintiff’s attorney is involved and no lawsuit has been threatened or filed, these payments are not reportable to the National Practitioners Data Bank.

In its initial phase, approximately 1,600 physicians (23% of COPIC’s insureds) participated in the 3Rs Program. After evaluating the actuarial data for the program COPIC is now targeting 1,500 additional physicians in procedurally based specialties such as general surgery, obstetrics/gynecology, and gastroenterology (Taylor 2003, 2005, COPIC 2000).

Catholic Healthcare West

Catholic Healthcare West (“CHW”), a 48-hospital non-profit health care system in the western United States, also incorporates fair compensation into its disclosure process (Berlinger 2003a). After an adverse event, patients and their families are given a

copy of the medical record and all relevant information about the event. They are told about the extent and the cause of the harm and their right to fair compensation. CHW takes responsibility for any mistakes and apologizes for harm that has occurred (CHW Board of Directors 2001). A risk manager initiates the discussion of fair compensation and focuses on out-of-pocket expenses, lost wages, reduction in income, disability, and other relevant factors (Berlinger 2003a, Bayley 2001). CHW is aware that families trying to cope with serious injury or loss of a loved one may need help deciding whether an offer of compensation is fair, and therefore includes the obligation to advise patients and family members to consult a lawyer to represent them in their statement of principles for managing error (Bayley 2001, Appendix). As Carol Bayley (2004), CHW's ethicist, put it:

Because families may need help deciding whether an offer of compensation is fair, CHW includes in their statement of principles the obligation to advise patients and family members to consult a lawyer.

Recommendation 4

Use Mediation to Resolve Claims Promptly

When a medical malpractice claim is filed, the plaintiff typically believes that something went terribly wrong in the way medical care was rendered, that the defendant

Mediation is based on three core values: autonomy, informed decision-making, and confidentiality.

should be held accountable, and that the tort system will be able to provide redress. However, the litigation process is lengthy, expensive, stressful, and focused on monetary remedies. Mediation offers an alternative that is fair, quicker, and significantly less expensive. Mediation also provides participants the

opportunity to acknowledge error, apologize, gain information, and consider non-monetary forms of compensation.

Mediation Basics

Mediation is a confidential, voluntary process in which an impartial third party – the mediator – helps the participants negotiate their differences and either craft a mutually acceptable resolution to their dispute or decide to deal with their problems in

some other manner, including litigation. Mediation is based on three core values: autonomy, informed decision-making, and confidentiality. The participants may end the

mediation at any time without adverse consequences.

Though mediation styles differ, we regard mediators as facilitators, not as fact-finders or decision-makers.

If, however, the resolution is a settlement, it is memorialized in writing, signed by the disputants, and becomes a binding contract. Mediation has a number of advantages over other dispute resolution processes, both in general and specifically with respect to the health care setting:

- The parties make decisions about the resolution rather than having it imposed on them by a judge or arbitrator, which tends to increase the durability of the agreement.
- Participants can discuss all issues which are important to them, not just those that provide the basis for a legal claim.
- Because mediation is a confidential process, apologies made during mediation will not be admissible in subsequent litigation should the parties fail to reach agreement.
- The mediation process helps the parties overcome some of the barriers that prevent agreement in unmediated settlement negotiations.
- When used shortly after an injury, mediation can enable both patients and physicians to avoid the added emotional and economic costs of the litigation discovery process.
- Where appropriate, injured patients can receive compensation sooner.

-
- Participants have the opportunity to exchange information, which may be critical both to repairing the relationship between the physician and the patient and to making changes that will improve patient safety.
 - Mediation agreements can be more nuanced than judgments obtained from a court proceeding and can include provisions, such as changes in a policy, that otherwise would not constitute a typical legal remedy.

Mediators believe most people enmeshed in a conflict have the ability, given the proper

setting and access to necessary information, to

consider options and select resolutions that meet their

needs. Introducing a mediator into a dispute does not

change the fact that the participants are negotiating. A

mediator adds value as a guide and coach, helping the

disputants move from position-based negotiation (*e.g.*,

I want \$1 million and the doctor to lose his license) to

interest-based negotiation (*e.g.*, I need to be sure I can

get the necessary care for my loved one and I don't want others to go through what happened to my family).

In the mediation setting participants can offer and request information. Mediators encourage the exchange of information. In medical malpractice cases, plaintiffs may come to understand the complexities and uncertainties of medical care in addition to learning exactly what happened to them or their loved ones. Hospitals and health care

providers may learn from the patient or family that missed or ignored information contributed to the error or adverse event, or that insensitive treatment of the patient or family influenced the decision to file suit.

Though mediation styles differ (see discussion below), we regard mediators as facilitators, not as fact-finders or decision-makers. Unlike a judge, jury, or arbitrator, the mediator is not interested in acquiring information in order to determine what happened, who is at fault, or what is the appropriate solution. Instead, the mediator focuses on information that helps participants understand their own and each other's perspectives and needs, and therefore provides the building blocks for resolution. The participants themselves are the decision-makers.

Mediation in Medical Malpractice Settings

Several programs have been established that utilize mediation to handle the aftermath of an adverse event or medical error and to resolve medical malpractice claims.

- The best known program is the Medical Claim Mediation Program started by the Rush University Medical Center in Chicago in 1995 (the "Rush Model").
- Johns Hopkins Health System in Baltimore and Drexel University College of Medicine in Philadelphia have programs similar to the Rush model.
- COPIC, in addition to its 3Rs Program discussed above, uses mediation for cases in which a written claim has been received. Between five and eight COPIC cases

are mediated each month using external mediators with a high rate of success (May 2003, 2004).

In 2004, New York City agreed to participate in a demonstration project in which medical malpractice cases filed against health care facilities operated by the New York City Health and Hospitals Corporation are being referred to mediation.⁸ As of December 2004, the city had referred 29 cases. Five plaintiff's attorneys declined to mediate. Nineteen cases have been co-mediated and two-thirds of these have settled at mediation with some settlements including non-monetary as well as monetary remedies. In Appendix D, we describe how mediation is being used to resolve conflicts in a variety of health care contexts outside of medical malpractice.

Approach to Mediation Used by the ADR Project

The ADR Project's approach to mediation is designed to encourage settlement of claims as soon as the parties have enough information to evaluate the case. The mediation process aims to give the participants the opportunity to consider non-economic aspects of a settlement, to facilitate the exchange of information, and to provide all participants with the opportunity to learn from the experience and avoid similar errors or events in the future. In the mediation world our approach would be considered "broad facilitative

⁸ A study of this project is funded by a grant to Columbia Law School. Chris Stern Hyman is the principal investigator. A report is expected in spring 2005.

While informed decision-making is a core value in mediation, the information needed by parties in order to settle a case is quite different from that needed to try a case.

mediation” (Riskin 2003). This approach also provides opportunities for participants to gain empowerment and recognition (Bush and Folger 1994).

While informed decision-making is a core value in mediation, the type of information needed by parties in order to settle a case is quite different from that needed to try a case. The discovery process that

constitutes the initial phase of litigation is expensive, usually escalates hostility, and can erode the remnants of the prior trusting relationship between patient and physician. Although there are cases in which, for various reasons, it is not possible to make a decision about liability without conducting a limited amount of discovery, we believe that mediation should occur as soon as possible after the hospital makes an assessment of its liability and its likely financial exposure and both parties have enough information to make an informed decision about the fairness of proposed resolutions. Although early mediation may limit discovery, the benefits to all parties of early resolution generally outweigh the risks.

In some cases early mediation is not advisable. Examples include cases in which the long-term consequences of an error, such as future costs of care for a brain-damaged

child, remain unclear, the plaintiff is not emotionally ready to consider settlement, or there are concerns that information is being withheld.

In the ADR Project’s mediation model, both lawyers and the parties themselves are encouraged to speak and ask questions. For the two mediations conducted as part of the project, a significant amount of time was devoted to a physician’s description of the medical facts of the case and the events that caused harm to the patient. This was the plaintiff’s first opportunity to hear a detailed explanation of what happened and to ask previously unanswered questions. Plaintiffs spoke extensively during both joint and private sessions (known as caucuses) asking and answering questions and expressing their grief, their anger, their understanding, and their empathy. Questions asked by the plaintiff also may reveal to the hospital new information about how the system failed. This information exchange can be a key to preventing recurrence of the error or adverse event.

In the second phase of the ADR Project’s mediation model, parties usually discuss possible remedies including both monetary and non-monetary options. If an injury will require lifelong care or where there has been the death of a primary wage earner, money is critically important. In other situations, however, mediation can

encourage consideration of a non-monetary remedy, such as a new checklist for a procedure, staff training to address a specific problem, or a memorial lecture on a particular topic. In these cases, both the grieving family and the hospital representatives may feel that the resolution has given meaning to a tragic event. Often all participants respond to the non-monetary remedies with greater enthusiasm and emotional relief than they do to the financial terms.

Consider again the case of Mr. B who died after the insertion of a subclavian central line collapsed a lung.

Questions asked by the plaintiff also may reveal to the hospital new information about how the system failed.

The settlement agreement included both monetary and non-monetary remedies. Even though the hospital thought the resident had made an appropriate choice, the hospital subsequently developed a checklist to aid in deciding where to place central lines. During the mediation the hospital proposed continuing training for staff on appropriate care for family members whose loved ones die in the hospital. These non-monetary remedies, especially training about how to treat family members, were crucial elements of the settlement for the widow who wanted to ensure that other families did not have to go through what she had.

Also consider the case of Mr. D.

Mr. D, an elderly man on Coumadin, arrived in the ER the morning after a fall. He was accompanied by his wife. Contrary to hospital policy, Mrs. D was not

allowed to be with her husband during his final hours of life in the emergency room.

Mr. D was initially misdiagnosed as having an infection rather than internal bleeding. After a second reading of a CT scan later in the day the correct diagnosis was made, but he died before remedial steps could be taken.

As soon as the hospital's leaders learned of the error they talked to the attending physician who met with the widow to disclose what had happened.

At the mediation, the chief of medicine was able to listen empathically to the widow and respond with a full apology, acknowledging the hospital's complete responsibility for the misdiagnosis and explaining exactly what treatment had been administered. He became the embodiment of the hospital for the plaintiff, which gave her the opportunity to express her rage and sadness and then her gratitude for his apology, his patience, and his clarifications. The widow at one point wondered whether events might have taken a different course had she been able to persuade her husband to go the ER immediately after his fall. She was reassured that she had done all that she could have and that had he gone to the ER the night of the accident it would have been too early for the bleed to show up on tests.

The presence and participation of the chief of medicine was healing for the widow, which probably could not have been accomplished by the hospital's attorney or risk manager. His stature and his commitment of time to the mediation eloquently conveyed the hospital's determination to accept responsibility and learn from its mistakes.

Early in the negotiation, the chief of medicine indicated in private session that he was not satisfied with simply working out a monetary settlement. It was important to him to give meaning to the loss of life. He suggested that the hospital fund an annual lecture in memory of the deceased. The plaintiff seemed moved by the idea and ultimately decided that a lecture would be an excellent memorial and that it should be on emergency medicine.

This mediation lasted five and a half hours. Attending were the plaintiff, her brother, her lawyer, defense counsel, the chief of medicine, the director of risk management, and two representatives from the hospital's insurance company.

Analysis of the ADR Project Mediations

We were surprised that only one hospital took advantage of the opportunity to try mediation at no cost. Nonetheless, there were instructive similarities and differences between the two cases, both of which involved suits brought by wives after the death of their husbands.

Similarities

(1) Mediations took place relatively early in the litigation process

The hospital representatives were willing to apologize, at the beginning of the mediation, although not necessarily to admit legal liability.

One mediation occurred three months after the complaint was filed and 11 months after the patient's death. The other occurred eight months after the complaint was filed and 13 months after the death. As discussed earlier, mediations that occur relatively early in the litigation process generally work better because they avoid having the initial harm compounded by the discovery process.

(2) Both claims were below the Pennsylvania MCARE Fund’s \$500,000 threshold

Pennsylvania, like several other states, employs a state-administered patient compensation fund to provide excess malpractice coverage to health care providers.

Representatives of the Medical Care Availability and Reduction of Error Fund (“MCARE

It is often helpful to give family members the opportunity to describe their loved one to the mediator and hospital representatives as something more than just a “patient” or “victim.”

Fund”) are active participants in all settlements exceeding \$500,000. In theory, the MCARE Fund should not be a barrier to mediation. However, both plaintiff and defense lawyers report difficulties getting the attention of MCARE Fund staff before the eve of trial. Because the two claims brought to early mediation by the ADR Project were below the MCARE Fund’s threshold, a fund representative did

not need to approve a settlement.

The MCARE Fund’s Director of Claims Administration, while enthusiastic about mediation, explains that the MCARE Fund cannot participate in negotiations until the primary malpractice carrier has sent written notification of tender of that carrier’s policy limit. According to the MCARE Fund, over 70% of these tenders are given within 30 days of a scheduled settlement conference or trial. As a result, very few of the 17

mediations in which the MCARE Fund participated in 2003 took place in the early stages of litigation (Persun 2003).

(3) The physician who was the lead spokesperson for the hospital began with an apology

The hospital representatives were willing to apologize, at the beginning of the mediation, although not necessarily to admit legal liability. The hospital representatives looked for ways to restore ruptured relationships and learn more about how systems had failed as they also worked out a fair monetary offer.

Consider once again the case of Mr. B who died after the insertion of a subclavian central line collapsed a lung.

During the mediation, Mrs. B expressed her grief and anger, asked questions about her husband's care (specifically why a resident had been allowed to place the central line), and told representatives from the hospital how she had been treated during and after the event.

The chief of medicine, speaking for the hospital, started his response to Mrs. B by apologizing for what she had been through. He explained the reason a central line was needed and factors that go into deciding where to place it. He also discussed medical training and supervision of residents. The patience and empathy exhibited by the chief of medicine set a tone which began to repair the broken trust. The hospital representatives were shocked to learn that, contrary to hospital policy, no one had ever contacted the plaintiff to explain what had happened and to give her an opportunity to have her questions answered. Acquiring this information allowed the hospital representatives to go back and figure out exactly where the system had broken down.

This mediation lasted seven and a half hours spread over two consecutive days.⁹ The participants included the plaintiff, her son, her attorney, defense counsel, the chief of medicine, the director of risk management, and a representative from the hospital's insurance company.

Similar to bioethics mediations and unlike conventional mediations, our experience in medical malpractice mediations suggests that in some cases it is helpful to begin with a physician explaining the medical events to the family or patient (Dubler and Liebman 2004). This structure also gives physicians the opportunity to offer an immediate apology. In medical malpractice cases we mediated, the physician spokesperson was the chief of medicine. It is not clear how this approach would have played out had the spokesperson been a physician directly involved in the event.

If mediators decide to follow this order, we recommend letting all parties know ahead of time so, if they are familiar with traditional mediation in which the plaintiff speaks first, they will not be caught by surprise. It can also be helpful to coach the physician and his or her lawyer about the type of factual, non-defensive presentation that is most likely to be helpful.

⁹ Ordinarily one starts mediations in the morning so there is an opportunity to capitalize on the momentum established during the day. In this case, however, the schedules of participants allowed for a relatively brief two – hour initial session. As it turned out, having time overnight to digest new information, absorb differing perspectives, and get additional answers to one of the plaintiff's questions seemed to aid the resolution process. Some mediators teach that once progress toward resolution begins, it is best to keep going to maintain momentum. Our experience in this case, limited though it is, suggests that time for reflection may be important in settling some cases.

(4) The plaintiffs' lawyers were willing to take the risk of trying a new process. Neither of the lawyers for plaintiffs had previously participated in mediation but both recognized the potential benefits to their clients and were willing to advise their clients to participate. In addition, they were able to join in problem-solving during mediation, listening to their clients' concerns, and putting aside (with only occasional relapses) the litigator's adversarial approach.

While we would have preferred that the physicians involved in the events participate in the mediation, they chose not to. Their non-participation raised questions for families who were looking for indications that the doctors cared about what happened.

(5) The plaintiffs had the opportunity to "introduce" the deceased patient to the other participants in the mediation

In these cases the central figures in the dispute had passed away. In other cases the patient may not be able to participate. In such situations it is often helpful to give family members the opportunity to describe their loved one to the mediator and hospital representatives as something more than just a "patient" or "victim." Doing so humanizes the discussion and shows respect for the injured person.

(6) Both sides had the opportunity to acquire important information The widows had the opportunity to ask questions, sometimes repeatedly, about things that were

important to them though not always relevant to the legal case. They acquired information which seemed to be critical in helping them understand what had happened and cope with their loss. The information facilitated settlement of the lawsuits. At the same time, hospital representatives learned about “real life” practices that strayed from their vision of quality care.

(7) The plaintiffs were given the opportunity to express their anger and grief to those ultimately responsible for their loved ones’ care. Mediation gives participants a forum in which their feelings can be aired and they can tell their story in a way that is meaningful to them, without the constraints of courtroom evidentiary rules. Similarly, hospital leaders were able to respond to the plaintiffs’ anger and grief without becoming hostile or defensive.

(8) The physicians directly involved in the adverse event were not at the table.

While we would have preferred that the physicians involved in the events participate in the mediation, they chose not to. Their non-participation raised questions for families who were looking for indications that the doctors cared about what happened. In one case the chief of medicine explained that he had spoken with the former resident that morning and had learned he was still haunted by the memory of what had gone wrong and still grieved for the patient. Undoubtedly it would have been painful for the

physicians to sit at the mediation table without getting emotional or defensive, but they also lost an opportunity for healing and learning by choosing to stay away.

Differences

(1) One case involved a misdiagnosis, the other a non-negligent mistake

In one case, the hospital acknowledged its diagnostic error. In the other case,

while there was a poor outcome, the hospital's

view was that no negligence had occurred.

The Rush model focuses almost exclusively on reaching a monetary settlement. Our model aims to repair relationships, explore non-monetary remedies, and discover information which will improve patient safety.

(2) The nature of apologies differed

In the misdiagnosis case, the chief of medicine offered an apology of responsibility, admitting the error and saying, "We failed you." In the other, he offered an apology of sympathy, expressing regret at the outcome while explaining why the hospital felt that appropriate procedures had been followed.

(3) The extent of communication with the widows after the event differed

The communication between the health care providers and the widows prior to mediation differed significantly. In one case there had been no direct communication between any health care provider and the widow from the moment she had been told of

her husband’s death until she walked into the mediation, although information garnered from the hospital grapevine had increased her suspicions about wrongdoing and cover-up. In the other case there was prompt, forthright communication by the attending physician as soon as the hospital discovered the error, which conveyed a level of trustworthiness that aided settlement discussions.

Comparing the ADR Project to the Rush Approach

The Rush model is what mediators would call “evaluative mediation.” Typically the parties are already deep into the litigation process.

During the course of the ADR Project, Pennsylvania moved toward adopting the “Rush model” for mediating medical malpractice cases. We believe, for the reasons below, that the Rush model fails to realize the full benefits of mediation compared to the ADR Project model we present. The Rush model focuses almost exclusively on reaching a monetary settlement. In contrast, the ADR Project’s model includes among its goals providing an opportunity to repair relationships, explore non-monetary remedies, and discover information which will improve patient safety. Interestingly, the Drexel University College of Medicine has established a mediation program which is described as “Rush-

style” but which differs in significant and positive ways from that approach (Oxholm 2005).

The Rush Model

Rush University Medical Center (“Rush”) is a self-insured 1,000 bed academic facility in Chicago with 1,200 physicians on its staff. Each year Rush is a defendant in 30 to 35 medical malpractice cases. Rush established a mediation program in 1995 to provide a more predictable procedure for settlement of medical malpractice disputes and to lower defense costs (Brown 1998).

As of 2003 Rush had mediated 80 cases and reached settlements that ranged from \$21,500 to \$15,000,000 (Brown 2003, Cooley 2002). More than 80% of the cases were successfully resolved, most in two to three hours. Rush found that it was settling cases at monetary levels consistent with its established reserves and that its defense costs have been reduced by more than half (Brown 1998).

The Rush model is what mediators would call “evaluative mediation” (Riskin 2003). The mediators focus on the strengths and weaknesses of the parties’ positions, propose a value range for settlement, and spend little time in joint session. Rush maintains two panels of neutral mediators, one comprised of retired judges and the other of experienced plaintiff and defense medical malpractice attorneys. Typically the parties are already deep into the litigation process, having completed considerable discovery by

the time of mediation. Each side has a clear understanding of the other side's case. These mediations, which typically occur several years after filing, feel familiar to the attorneys because they resemble judges' settlement conferences.

The Rush mediations begin in joint session, where each side makes a brief opening presentation. Usually the attorneys speak first and then the parties are given an opportunity to make a presentation. However, as of November 2003, no party had chosen to speak (Brown 2003). The mediators then meet with each side separately in a caucus, shuttling from one side to another. If the parties agree on a settlement figure, they reconvene in a joint session, affirm the terms of the settlement, and exchange personal comments.

Originally the hospital representative offered an apology to the plaintiff only after a settlement agreement. In 2003, Rush began to include an apology of sympathy in their opening statement to help set the tone for the mediations and build trust. Neither the opening nor post-settlement apology includes an acknowledgement of liability. Only if the case has been settled does the hospital inform the patient or family members of any changes in practices or procedures that have been made in response to the event (Brown 2003).

Critique of the Rush Model

Mediators vary in their styles – their philosophies, the techniques they use, what they see as the goals of the process, how they deal with feelings, and whether or not they evaluate cases (Riskin 2003). It is important for hospitals and physicians to consider which approach is appropriate for a particular case and select a mediator accordingly.

If the mediator is evaluating a case to predict the outcome in a courtroom, participants will spend a good deal of time and energy in an adversarial posture.

The Rush model tends to be “evaluative,” while we generally advocate using the “facilitative” approach. Because evaluative mediation tends to occur much later in the litigation process, any information about medical practices that may have led to

the harm is so dated as to have little use in improving patient safety (Sage 2004). It is noteworthy that Max Brown, general counsel of Rush and the designer of the program, reports that if he were designing the program now, he would concentrate on early mediation, and he is moving the program in that direction (Brown 2003).

An “evaluative” approach to medical malpractice mediation is risky for several reasons. First, our experience as litigators tells us it is unlikely that in a few hours or even a few days of mediation, we would be able to acquire all necessary information to

make an accurate prediction of outcome. Counsel or parties may withhold facts that might be valuable at trial should mediation be unsuccessful. In addition, the information presented at mediation may not be admissible at trial. Second, if the mediator is evaluating a case to predict the outcome in a courtroom, participants will spend a good deal of time and energy in an adversarial posture, trying to “win” their case instead of

Our focus was on helping the parties gain an understanding of their own and each other’s interests, assess and reassess the strength of their positions, and engage in joint problem-solving.

working collaboratively towards a solution. Third, evaluative mediators are likely to focus on types of information relevant to a determination of liability rather than on information that would aid in shaping a resolution that satisfies both economic and non-economic interests of the participants or contributes to patient safety.

Because of this focus on money, evaluative mediators too often fail to help the participants realize the broader, often healing, benefits of mediation.

Money is, of course, significant in most medical malpractice cases. Some cases are only about money; the plaintiff does not want to interact with representatives from the hospital and is focused exclusively on obtaining sufficient funds to take care of her family.

However, many cases are about both money and being heard. Plaintiffs want to recount what they experienced and want to ask questions; hospital representatives want to explain what happened and even to apologize. Focusing only on a dollar agreement limits the salutary effects of mediation. At the beginning of mediation, one does not know how fully the process will be used by the participants at the table. But given the range of concerns the parties may want to discuss, the decision to focus only, or primarily, on money should be made by the participants, rather than being predetermined by the mediators' method of conducting the mediation.

In the ADR Project model, mediators used a range of facilitative skills to assist the participants to share information, to ask and answer questions, and to express feelings. Participants were encouraged to talk with each other during both the initial and the later joint sessions. The mediators' focus was on helping the parties gain an understanding of their own and each other's interests, assess and reassess the strength of their positions, and engage in joint problem-solving. ADR Project mediators did not see their job as evaluating legal claims but were prepared to engage in "reality testing" to help the participants be more realistic about the strengths and weaknesses of their cases.

Retired judges and practicing trial lawyers rarely have sufficient training in the facilitative techniques that tend to be most effective at discovering underlying interests and drawing out information useful for changing hospital systems and policies even if it is irrelevant to questions of liability. Nor are they likely to have patience for or comfort with the expression of strong emotions by the parties.

Drexel's Mediation Program

Drexel University College of Medicine established a mediation program in February 2004. While the program is described as “Rush-style,” it differs in significant ways from the Rush model. Both patients and physicians attend and speak, the focus appears to be on repairing the physician-patient relationship, and Drexel’s general counsel, Carl Tobey Oxholm, reports that Drexel is considering offering mediation much earlier in the process, perhaps even before a lawsuit has been filed. The program is similar to Rush model in that its mediators are drawn from the medical malpractice bar (Oxholm 2005).

The lines drawn between the two styles represented by the Rush model and the ADR Project model are not absolute. In a particular case, a facilitative mediator may respond to a party’s request for an opinion of the case’s value or, after some hours of work, make a mediator’s proposal. It is less likely that an evaluative mediator will be able to expand her style to include areas of inquiry used by a facilitative mediator. It is

important for physicians, hospital leaders, and their lawyers to be aware of the benefits of different mediator approaches, to resist the temptation to select the evaluative approach because it seems familiar, and to choose mediators with the skills to match the needs of the parties and the case.

Conclusion

Three years after the Pennsylvania legislature passed the MCARE Act, the national press is still actively covering proposals to curb medical malpractice costs. At the same time, articles appear about patients who have been severely harmed or killed by a medical error. Both problems are serious, both will be difficult to resolve in a way that is fair to physicians and patients, and it is unlikely that either problem can be solved without addressing the other. Error disclosure using mediation skills has the potential to help. Creating an expert communication consult service to plan and facilitate disclosure conversations, providing communication training to heighten physicians' and other caregivers' awareness of the complexity of disclosure conversations, offering apologies when appropriate, and using facilitative mediation soon after an error all have the potential to decrease the volume of litigation, reduce the cost of settlement, and turn unhappy events into opportunities to learn from patients and families how to improve care and safety.

When medical care does not proceed as expected, disclosure of information to patients and their families is the right thing to do. Moreover, disclosure increasingly is required by ethical, self-regulatory, and statutory mandates. In Pennsylvania, the MCARE Act's disclosure requirement provides impetus for improving communication between physicians and patients reconsidering litigious, defensive responses to medical

error, and experimenting with non-litigation dispute resolution processes such as mediation. States with laws that protect apologies of responsibility give added support to physicians who want to take responsibility for their actions, and encourage the type of communication which can provide solace to patients.

It is too early to measure the impact of the MCARE Act's disclosure requirement on medical malpractice litigation. If disclosure is made with skill and compassion, includes an appropriate apology, and generates a fair offer of compensation and steps to avoid recurrent harm, we predict that litigation will decrease and patient safety will improve. But old habits are hard to shed. Strong, persistent efforts by hospital leaders will be required to change the institutional and professional response to an error that is made or a claim that is filed.

Appendix A

State Disclosure and Apology Statutes

States with Disclosure Statutes

Florida

TITLE 29. PUBLIC HEALTH
CHAPTER 395. HOSPITAL LICENSING AND REGULATION
PART I. HOSPITALS AND OTHER LICENSED FACILITIES

§ 395.1051. Duty to notify patients

An appropriately trained person designated by each licensed facility shall inform each patient, or an individual identified pursuant to s. 765.401(1), in person about adverse incidents that result in serious harm to the patient. Notification of outcomes of care that result in harm to the patient under this section shall not constitute an acknowledgment or admission of liability, nor can it be introduced as evidence.

Nevada

TITLE 40. PUBLIC HEALTH AND SAFETY
CHAPTER 439. ADMINISTRATION OF PUBLIC HEALTH
GENERAL PROVISIONS

§ 439.855. Notification of patients involved in sentinel events

1. Each medical facility that is located within this state shall designate a representative for the notification of patients who have been involved in sentinel events at that medical facility.

2. A representative designated pursuant to subsection 1 shall, not later than 7 days after discovering or becoming aware of a sentinel event that occurred at the medical facility, provide notice of that fact to each patient who was involved in that sentinel event.

New Jersey

TITLE 26. HEALTH AND VITAL STATISTICS CHAPTER 2H. HEALTH CARE FACILITIES

N.J. Stat. § 26:2H-12.25 (2004)

d. A health care facility shall assure that the patient affected by a serious preventable adverse event or an adverse event specifically related to an allergic reaction, or, in the case of a minor or a patient who is incapacitated, the patient's parent or guardian or other family member, as appropriate, is informed of the serious preventable adverse event or adverse event specifically related to an allergic reaction, no later than the end of the episode of care, or, if discovery occurs after the end of the episode of care, in a timely fashion as established by the commissioner by regulation. The time, date, participants and content of the notification shall be documented in the patient's medical record in accordance with rules and regulations adopted by the commissioner. The content of the documentation shall be determined in accordance with the rules and regulations of the commissioner. If the patient's physician determines that the disclosure would seriously and adversely affect the patient's health, then the facility shall assure that the family member, if available, is notified in accordance with rules and regulations adopted by the commissioner. In the event that an adult patient is not informed of the serious preventable adverse event or adverse event specifically related to an allergic reaction, the facility shall assure that the physician includes a statement in the patient's medical record that provides the reason for not informing the patient pursuant to this section.

Pennsylvania

TITLE 40. INSURANCE CHAPTER 5C. MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR (MCARE) ACT

§ 1303.308. Reporting and notification

(b) DUTY TO NOTIFY PATIENT.-- A medical facility through an appropriate designee shall provide written notification to a patient affected by a serious event or, with the consent of the patient, to an available family member or designee within seven days of the occurrence or discovery of a serious event. If the patient is unable to give consent, the notification shall be given to an adult member of the immediate family. If an adult member of the immediate family cannot be identified or located, notification shall be given to the closest adult family member. For unemancipated patients who are under 18 years of age, the parent or guardian shall be notified in accordance with this subsection. The notification requirements of this subsection shall not be subject to the provisions of section 311(a). Notification under this subsection shall not constitute an acknowledgment or admission of liability.

States with Apology Statutes

1. Statutes protecting apologies of responsibility (full apologies) in the medical context

Colorado

TITLE 13. COURTS AND COURT PROCEDURE
EVIDENCE
ARTICLE 25. EVIDENCE - GENERAL PROVISIONS

13-25-135. Evidence of admissions - civil proceedings - unanticipated outcomes - medical care

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

Oregon

TITLE 52. OCCUPATIONS AND PROFESSIONS
CHAPTER 677. REGULATION OF MEDICINE, PODIATRY AND ACUPUNCTURE
GENERAL PROVISIONS

§ 677.082. Expression of regret or apology by licensee.

(1) For the purposes of any civil action against a person licensed by the Board of Medical Examiners, any expression of regret or apology made by or on behalf of the person, including an expression of regret or apology that is made in writing, orally or by conduct, does not constitute an admission of liability for any purpose.(2) A person who is licensed by the Board of Medical Examiners, or any other person who makes an expression of regret or apology on behalf of a person who is licensed by the Board of Medical Examiners, may not be examined by deposition or otherwise in any civil or administrative proceeding, including any arbitration or mediation proceeding, with respect to an expression of regret or apology made by or on behalf of the person, including expressions of regret or apology that are made in writing, orally or by conduct.

2. *Representative statutes protecting apologies of sympathy (partial apologies)*

Massachusetts

PART III. COURTS, JUDICIAL OFFICERS AND PROCEEDINGS IN CIVIL CASES
TITLE II. ACTIONS AND PROCEEDINGS THEREIN
CHAPTER 233. WITNESSES AND EVIDENCE
WITNESSES

§ 23D. Admissibility of Benevolent Gestures Related to Accident Victim or His Family Statements, writings or benevolent gestures expressing sympathy or a general sense of benevolence relating to the pain, suffering or death of a person involved in an accident and made to such person or to the family of such person shall be inadmissible as evidence of an admission of liability in a civil action.

California

EVIDENCE CODE
DIVISION 9. Evidence Affected or Excluded by Extrinsic Policies
CHAPTER 3. Other Evidence Affected or Excluded by Extrinsic Policies

§ 1160. Statement of benevolence
(a) The portion of statements, writings, or benevolent gestures expressing sympathy or a general sense of benevolence relating to the pain, suffering, or death of a person involved in an accident and made to that person or to the family of that person shall be inadmissible as evidence of an admission of liability in a civil action. A statement of fault, however, which is part of, or in addition to, any of the above shall not be inadmissible pursuant to this section.

Texas

CIVIL PRACTICE AND REMEDIES CODE
TITLE 2. TRIAL, JUDGMENT, AND APPEAL
SUBTITLE B. TRIAL MATTERS
CHAPTER 18. EVIDENCE
SUBCHAPTER C. ADMISSIBILITY

§ 18.061. Communications of Sympathy

- (a) A court in a civil action may not admit a communication that:
- (1) expresses sympathy or a general sense of benevolence relating to the pain, suffering, or death of an individual involved in an accident;
 - (2) is made to the individual or a person related to the individual within the second degree by consanguinity or affinity, as determined under Subchapter B, Chapter 573, Government Code; and
 - (3) is offered to prove liability of the communicator in relation to the individual.
- (b) In this section, "communication" means:
- (1) a statement;
 - (2) a writing; or
 - (3) a gesture that conveys a sense of compassion or commiseration emanating from humane impulses.
- (c) Notwithstanding the provisions of Subsections (a) and (b), a communication, including an excited utterance as defined by Rule 803(2) of the Texas Rules of Evidence, which also includes a statement or statements concerning negligence or culpable conduct pertaining to an accident or event, is admissible to prove liability of the communicator.



Appendix B

Training Agendas

Agenda One – Two-Day Training

COMMUNICATING ABOUT MEDICAL ERROR: CHALLENGING ASSUMPTIONS AND ENHANCING SKILLS

June 5 and 6, 2003

DAY ONE

- I. Introduction
- II. Why Patients Sue
- III. Communication Skills
 - a. Exercise
 - b. Sample Dialogue

Break

- IV. Communication Skills Continued
 - a. Active listening
 - b. Positions/Interests
 - c. Kim role play
 - d. Reflective listening

Lunch (12pm – 1pm)

- e. Talking openly
- V. Medical Error – patients' and physicians' attitudes
- VI. Dealing with medical error
- VII. Grief, job stress and coping

DAY TWO

- I. Video: First Do No Harm Part 2: Taking the Lead (produced by P4PS (Partners for Patient Safety)
 - a. Communicating about adverse events

Break

- b. Planning for disclosure conversations
- II. Sullivan role play
- III. Difficult Conversations

Lunch (12pm – 1pm)

- IV. Structure of disclosure conversations
- V. Introduction to mediation – a demonstration
- VI. Questions, comments and wrap-up

Agenda Two – One-Day Training

DEMONSTRATION MEDIATION AND ADR PROJECT

COMMUNICATING ABOUT MEDICAL ERROR: CHALLENGING ASSUMPTIONS AND ENHANCING SKILLS

September 24, 2003

- I. Introductions
- II. Review research on factors that put physicians at risk of being sued
- III. Review communication skills necessary for an effective disclosure conversation
- IV. Role play a sample dialogue
- V. *Break*
- VI. Discuss positions versus interests and communication skills
- VII. Role play the Kim scenario.
- VIII. *Lunch*
- IX. Review research on medical error and attitudes towards it
- X. Discuss how errors were dealt with in their training
- XI. Role play the Sullivan scenario
- XII. *Break*
- XIII. Planning a disclosure conversation
- XIV. Key words and phrases
- XV. Closings and evaluations

Agenda Three – 90-Minute Training

INTRODUCTORY DISCLOSURE COMMUNICATION TRAINING

Various dates

- I. Introduction to ADR Project
- II. Why Patients Sue Physicians
- III. Skill Development
 - a. Exercises
 - b. Role Play
- IV. Discussion

Agenda Four – Follow – up Half - Day Training

COMMUNICATING ABOUT MEDICAL ERROR: ADVANCED TRAINING

May 26, 2004

- I. Introduction
 - II. Review: Research on factors that put physicians at risk of being sued
 - III. Critical skills for participation in an effective disclosure conversation
 - IV. Skills
 - a. Distinguishing between positions and interests
 - b. Clarifying
 - c. Reflective Listening
 - d. Identifying and acknowledging feelings
 - e. Encouraging participation of patients and families
 - V. Role play the Kim scenario
 - VI. Apology
- Dinner Break*
- VII. Planning for Disclosure Conversation
 - a. Video
 - b. Planning
 - c. Conducting the conversation
 - VIII. Wrap-up and Evaluation



Appendix C

Two-Day Training Handout

Demonstration Mediation and ADR Project



Communicating about Medical Error: Challenging Assumptions and Enhancing Skills

Copyright Carol B. Liebman and Chris Stern Hyman

WHAT FACTORS PUT PHYSICIANS AT RISK OF BEING SUED?

- ❖ Not the quality of medical care (Entman et al. *JAMA* 1994)
- ❖ Not their chart documentation (Entman et al. *JAMA* 1994)
- ❖ Not negligent treatment (Harvard Medical Practice Study)
- ❖ It is **ineffective communication** with patients
(Lester et al. *West J Med.* 1993; Levinson et al *JAMA* 1997)
- ❖ What the physician says is less important than the
process and tone of the conversation (Levinson et al. *JAMA*
1997)

Levinson et al. Physician-Patient Communication The Relationship With Malpractice Claims Among Primary Care Physicians and Surgeons. *JAMA.* 1997;277:553-559.

WHY PEOPLE SUE PHYSICIANS #1

- ❖ Advised to by a 3rd party (33%)
- ❖ Doctor not completely honest or lied (24%)
- ❖ Needed money for child's future care (24%)
- ❖ Couldn't get anyone to tell them what had happened (20%)
- ❖ Decided to seek revenge or protect others from harm (19%)

Hickson et al. *Factors that Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries*, JAMA 1992; 267:1359.

WHY PEOPLE SUE PHYSICIANS #2

- ❖ Physician would not listen (13%)
- ❖ Physician would not talk openly (32%)
- ❖ Physician attempted to mislead them (48%)
- ❖ Physician did not warn them of the long-term neurodevelopmental problems of their child (70%)

Hickson et al. *Factors that Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries*, JAMA 1992; 267:1359.

COMMUNICATION SKILLS #1

❖ **Active Listening:**

How do you show you are listening?

❖ **Talking Openly:**

How do you build trust?

❖ **Inviting Participation:**

How and why do you include patient/family in fact finding?

❖ **Exploring Next Steps:**

How do you discuss next steps?

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EXISTING SKILLS OF HEALTH CARE PROFESSIONALS

❖ Delivering bad news

❖ Explaining complex information

❖ Listening for significant information

❖ Drawing on expertise to solve problems

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SAMPLE DIALOGUE FACTS

The physician ordered heparin and insulin was given by mistake. It is unclear why the mistake was made but the order for the heparin was a verbal order. The patient became severely hypoglycemic and was transferred to ICU for treatment and stabilization.

COMMUNICATION SKILLS #2

Active Listening:

How do you show you are listening?

- ❖ Body language
- ❖ Eye contact
- ❖ Ask a clarifying questions – don't assume
- ❖ Identify and Respond to interests not positions
- ❖ Reflect what others have said
- ❖ Acknowledge feelings

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POSITIONS/INTERESTS #1

- ❖ Positions are demands or assertions.
- ❖ Interests are the needs and concerns represented by the Positions.

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POSITIONS/INTERESTS #2

- ❖ Positions:
 - Mother: I am your mother and I make the rules around here. You get home by 10 p.m. like you said you would or you are grounded.
 - Child: Lighten up. I'm not a baby any more. I'm 14 years old and I can take care of myself.

COMMUNICATION SKILLS #3

Talking Openly: How do you build trust?

- ❖ Give basic information known at the time in understandable terms – but do not guess
- ❖ Describe what additional inquiries and questions need to be answered
- ❖ Don't avoid describing the error
- ❖ Show feelings experienced as a result of the error
- ❖ Apologize

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SLOW DOWN TO SAVE TIME

- ❖ Sit down
- ❖ Ask don't assume
- ❖ Acknowledge interests
- ❖ Acknowledge feelings – theirs AND yours

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COMMUNICATION SKILLS #4

Exploring Next Steps: How do you discuss next steps?

- ❖ Explain plans for gathering additional information
- ❖ Ask patient/family what they think about the plans
- ❖ Ask for additional suggestions
- ❖ Discuss follow-up by asking what they would like
- ❖ Provide telephone number of staff member for any follow-up questions or meeting

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KIM SCENARIO

Paul Kim, a 12-year-old boy had surgery at a large Teaching hospital to repair a ventral hernia. At a critical moment Dr. Smith's hand slipped, nicking his spleen. There was severe bleeding and the Spleen had to be removed. Paul's parents immigrated to the US ten years ago. They appear to be intelligent and are devoted to Paul, their oldest child and only son. But communication with them can be difficult as they aren't very sophisticated about western medicine.

You are Dr. Smith/ the Patient Safety officer. What should you tell the patient and his family about the surgery?

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MEDICAL ERROR

Attitudes of Patients and Physicians

What Patients Want:

❖ Patients want the basic information:

- What happened
- Why it happened
- Implications for their health
- How the problem will be corrected
- How future errors will be corrected

❖ Patients want:

- Assurances they won't suffer financially due to the error
- An apology
- Prevention of similar errors in the future

Gallagher, et al. *Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Error*, JAMA 2003; 289:1001-1007.

MEDICAL ERROR

Attitudes of Patients and Physicians

How Physicians Communicate:

- ❖ Physicians choose their words carefully and put a positive “spin” on the event.
- ❖ Physicians mention the adverse event but not that an error occurred.
- ❖ Physicians are unlikely to tell patient what caused the error and how it might be prevented.

Gallagher, et al. *Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Error*, JAMA 2003; 289:1001-1007.

MEDICAL ERROR

Attitudes of Patients and Physicians

How Physicians and Patients Feel:

- ❖ **Patients and physicians** experience powerful emotions following an error.
- ❖ **Patients** want emotional support from the physician and an apology.
- ❖ **Physicians** want to apologize but worry about an admission of legal liability.
- ❖ **Physicians** are upset but unsure where to get emotional support.

Gallagher, et al. *Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Error*, JAMA 2003; 289:1001-1007.

GRIEF, JOB STRESS AND COPING # 1

Grief reactions can be caused by:

- ❖ Witnessing patient suffering
- ❖ Dealing with treatment errors

E. Redinbaugh et al., *Health Care Professionals Grief*, Psycho-Oncology 10:187-198 (2001).

GRIEF, JOB STRESS AND COPING #2

- ❖ Grief reaction can cause burnout.
- ❖ Burnout causes unsatisfactory communication with patients, families, colleagues and hospital staff.

E. Redinbaugh et al., Health Care Professionals Grief, Psycho-Oncology 10:187-198 (2001)

GRIEF, JOB STRESS AND COPING #3

COPING STRATEGIES WORK BEST IF THEY MATCH THE PERSONALITY OF THE HEALTH CARE PROVIDER

- ❖ The typical physician prefers problem-solving strategies for coping.
 - Example: outline a thoughtful plan
- ❖ The typical general duty nurse prefers self-expression of feelings and emotion-focused strategies.
 - Example: Talk to people, attend funeral

E. Redinbaugh et al., Health Care Professionals Grief, Psycho-Oncology 10:187-198 (2001)

PLANNING THE DISCLOSURE CONVERSATION

- ❖ Who should attend
- ❖ Who should speak
- ❖ When should conversation occur
- ❖ Anticipate what patient will want to know
- ❖ Consider the concerns and needs of the health care professionals
- ❖ What should be said and how to say it
- ❖ Apology
- ❖ Plan next steps

SULLIVAN SCENARIO

Jim Sullivan, a 45 year old self-employed carpenter, was admitted to the Emergency Room late one afternoon with closed fractures of the tibia and fibula of the left leg and multiple other injuries from an automobile accident. Dr. Malin applied a cast and Mr. Sullivan was admitted to the hospital. Over the next 12 hours the cast became too tight as the leg swelled. Mr. Sullivan was sedated and slept through the night. The nurses and residents did not check for or notice changes in the color and temperature of the foot. When the attending physician saw the patient on rounds the next morning he discovered the problem and was able to release the cast pressure. Tests a few days later indicate possible neurological damage.

You are Dr. Malin. What do you say to Mr. Sullivan?

Based on a case in Roscoe and Krizek "Reporting Medical Errors"

DIFFICULT CONVERSATIONS

Every conversation is really three conversations:

1. What Happened

2. Feelings

3. Identity

Stone et al. Difficult Conversations, Viking, 1999

THE THOUGHT PROCESS OF A DISCLOSURE CONVERSATION

- ❖ What you are thinking
- ❖ What you want to say
- ❖ What “lawyers” advise you to say
- ❖ What you actually say

Based on Stone et al. Difficult Conversations, Viking, 1999

WAYS EVERYONE CAN CONTRIBUTE TO PROBLEMS

- ❖ Avoid dealing with difficult, complex, or uncomfortable issues
- ❖ Be difficult to approach
- ❖ Ignore differences in ways people communicate or respond to stress
- ❖ Be trapped in role assumptions

Stone et.al. Difficult Conversations, Viking, 1999

LEARNING CONVERSATIONS #1

- ❖ Goal after an adverse event is to engage in a learning conversation
- ❖ Explain your views
- ❖ Understand other's perspective
- ❖ Address feelings – yours and theirs
- ❖ Make joint decisions about how to handle problem

Stone et.al. Difficult Conversations, Viking, 1999, pp16/17.

LEARNING CONVERSATIONS #2

Learning conversations focus on:

- ❖ What each participant did or failed to do
- ❖ What can be changed or corrected to avoid the problem in future

Stone et.al. Difficult Conversations, Viking, 1999

Appendix D

Use of Mediation in Health Care Disputes Not Involving Malpractice

Setting	Description
Bioethics disputes	Some hospitals use bioethical consultation services to help resolve difficult treatment and end-of-life decisions. The consultant acts as a mediator, remaining neutral as to outcome so long as the resolution comports with legal and ethical norms (Dubler and Liebman 2004). Mediation is also used to resolve bioethics disputes in some nursing homes (Reynolds 2004, Hyman 2001).
Long-term care facilities	Some nursing homes also use mediation to resolve quality of life disputes between staff, residents, and their families and, and other disputes between residents or between a resident and a staff member (Karp and Wood 1997). In Pennsylvania, the Montgomery County Mediation Center conducts mediations in both nursing homes and assisted living facilities and conducts conflict management training for staff in long-term care facilities (Mariani 2003).
Provider reimbursement	The Department of Health and Human Services' Provider Reimbursement Review Board (PRRB) has a mediation program to resolve disputes between providers and fiscal intermediaries that are responsible for payment of Medicare claims. Since the program's inception in 1988, PRRB has mediated approximately 500 cases. Mediation typically occurs within six months, compared to the three years the parties typically must wait for a hearing (Hyman 2001).
Medicare beneficiaries' complaints	The Centers for Medicare and Medicaid Services (CMS) contract with Quality Improvement Organizations (QIO) in each state to promote quality health care services for Medicare beneficiaries and to determine whether the services rendered are medically necessary and appropriate. Since August 1, 2003, mediation has been offered as an option to resolve some of the complaints filed by Medicare beneficiaries against the QIO in their state (CMS 2003).

Physician misconduct complaints	<p>In the 1990s, the Massachusetts Board of Registration in Medicine, in cooperation with the Program for Health Care Negotiation and Conflict Resolution at Harvard University, created a pilot mediation program for complaints against physicians that appeared to stem from poor communication skills rather than from serious misconduct (Dauer and Marcus 1997). In nine out of ten mediations, a mutually satisfactory agreement was reached, often with an apology from the physician and with the physician having gained insight into how her behavior was problematic (Fleming 1998). Despite the success of the pilot, the program was discontinued because of lack of funding.</p> <p>In 1992, the Canadian College of Physicians and Surgeons of Ontario started a mediation program for the full range of physician misconduct complaints. By 1997, the program had referred 266 cases to mediation with an 84% rate of agreement (Feld and Simm 1998). In 1999, the program was discontinued because of a drop in settlement rates and the amount of time it took to convene the mediations (McCulloch 2004).</p>
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California Evidence Code § 1160. Statement of Benevolence.

Colorado Revised Statutes 13-25-135. Evidence of admissions - civil proceedings - unanticipated outcomes - medical care.

Florida Statutes § 90.4026. Statements expressing sympathy; admissibility; definitions.

Florida Statutes § 395.0197(1)(d). Internal Risk Management Program.

Florida Statutes § 395.1051. Duty to Notify Patients.

Massachusetts General Laws Chapter 233, § 23D. Admissibility of benevolent statements, writings or gestures relating to accident victims.

Nevada Revised Statutes § 439.855. Notification of patients involved in sentinel events.

New Jersey Statutes § 26:2H-12.25. Definitions relative to patient safety; plans; reports; documentation, notification of adverse events, etc.

Oklahoma Statutes Title 63, § 1-1708.1H. Statements, conduct, etc. expressing apology, sympathy, etc.--Admissibility--Definitions.

Ohio Revised Code Annotated § 2317.43. Use of defendant's statement of sympathy as evidence in medical liability action prohibited.

Oregon Revised Statutes § 677.082. Expression of regret or apology by licensee.

Pennsylvania Statutes Title 40, § 1303. Medical Care Availability and Reduction of Error Act (MCARE) Act.

Tennessee Rules of Evidence Rule § 409.1. Expressions of sympathy or benevolence.

Texas Civil Practice and Remedies Code § 18.061. Communications of Sympathy.

Washington, Annotated Revised Code of, § 5.66.010. Admissibility of sympathetic gestures.

Wyoming Statutes § 1-1-130. Actions against health care providers; admissibility of evidence.

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About the Project

The project on Medical Liability in Pennsylvania (www.medliabilitypa.org) is a two-year program of research, consultation and communication funded by The Pew Charitable Trusts that seeks to provide decision-makers with objective information about the ways in which medical, legal, and insurance-related issues affect the medical liability system, to broaden participation in the debate to include new constituencies and perspectives, and to focus attention on the relationship between medical liability and the overall health and prosperity of the Commonwealth.

The Pew Charitable Trusts (www.pewtrusts.org) serves the public interest by providing information, advancing policy solutions and supporting civic life. Based in Philadelphia, with an office in Washington, D.C., the Trusts will invest \$177 million in fiscal year 2005 to provide organizations and citizens with fact-based research and practical solutions for challenging issues.

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