A Better Way to Settle Malpractice Suits?

Urgent message: Mediation could produce better outcomes than litigation for patients and physicians—if doctors would only show up.

CAROL B. LIEBMAN, JD

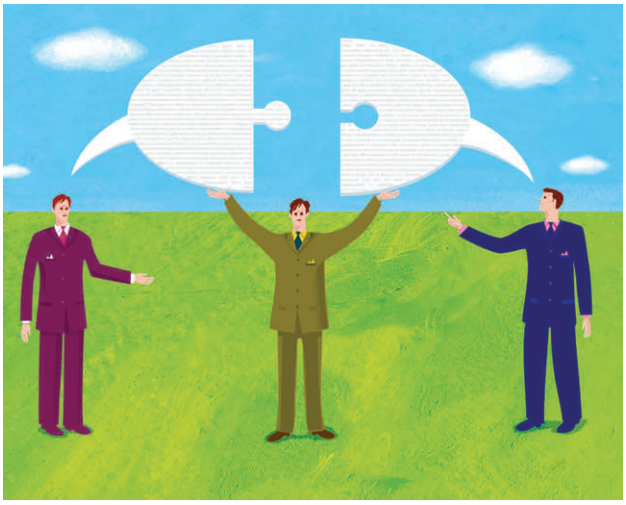
Introduction

- A stomach pain is misdiagnosed as viral gastroenteritis. The patient ends up in the hospital for six days with complications from a ruptured appendix.
- A physician prescribes penicillin to a woman with clearly documented allergies, which leads to anaphylaxis and a day in the ICU.
- A severe headache is labeled a migraine; the patient dies the next day from a ruptured cerebral aneurysm.
- A young person with chest pain is told he has costochondritis, but the pain, in fact, was caused by a pulmonary embolism.

Too often, as both the Institute of Medicine and Harvard Medical Practice Study have documented, patients are harmed by medical care intended to help. Sometimes that harm is the result of an unpreventable event; at other times, it is the result of error. Often, especially when communications break down, the result is a lawsuit.

A colleague, Chris Stern Hyman, and I have been involved in research testing whether mediation—a process in which parties to a dispute are assisted in resolving their conflict by an impartial third party—offers a better forum than litigation for resolving medical malpractice cases. We found that mediation can lead to a quicker, less costly, and more satisfying resolution than the adversarial litigation system.

Mediation can also offer emotional relief to plaintiffs by giving them an opportunity to be heard and to ask questions. And mediation can help urgent care centers and hospitals discover ways in which procedures might be changed to prevent recurrences of the error that sparked the lawsuit.



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Too often, however, that potential goes unrealized because of the failure of physicians to participate in the mediation process.

A Revealing Study

Our study, "Interest-Based Mediation of Medical Malpractice Lawsuits: A Route to Improved Patient Safety,"[1] looked at the results of 31 mediations of cases from 11 nonprofit hospitals in New York City that were referred to mediation in 2006 and 2007. The cases included claims for failure to diagnose, surgical error, failure to treat, inadequate care, improper treatment, and medication error. Just over 70% of the cases were resolved either during or after mediation, resulting in monetary

Carol B. Liebman is a Clinical Professor of Law at Columbia Law School in New York. This article is based on original research that was published in the Journal of *Health Politics, Policy and Law* in October 2010.

settlements of $35,000-$1.7 million. Possible changes in hospitals' practices or policies to improve patient safety were identified in four cases.

While defense lawyers were less likely to agree to mediation than were plaintiffs' lawyers, both groups of attorneys had positive reactions to participation in the mediation process, as did hospital representatives and insurers. Plaintiffs–either the injured patient or surviving family members—attended 25 of the 31 mediations and also gave their experience in mediation a positive rating.

We were unable to determine physician reaction to the mediation process since not a single physician attended a mediation.

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What Is Mediation?

Mediation is a process in which a neutral party tries to help people in conflict (or, sometimes, those trying to make a deal) work out their differences and reach an agreement that meets the needs of all. Unlike a judge or arbitrator, mediators do not decide who is right or wrong or tell the participants what they should do. Instead they facilitate a discussion among those at the table, helping them consider options for resolving the dispute.

Mediation is both voluntary and confidential. It is voluntary in the sense that, even when parties are required to mediate by courts or by a prior agreement, they are not required to reach an agreement and can end the mediation at any time. It is confidential in that what is said by participants during the mediation cannot (with very few exceptions) be used in any subsequent judicial or administrative proceeding. Because mediation communications are confidential, participants can offer information, explanations and, when appropriate, apologies without fear that what they say will be turned against them should the case go to trial.

Benefits of Mediation

Mediation is generally recognized as offering a number of benefits: quicker, less expensive resolution; fair compensation provided relatively soon after harm when it may be most needed by the plaintiffs; control of decision making by the litigants and their lawyers rather than judges; the opportunity to discuss all issues important to the parties, not just those relevant to their legal claims; the chance to repair relationships; avoidance of some, if not all, of the emotional and financial costs of litigation; and, as already mentioned, the ability to speak in a less-guarded way.

In the healthcare setting, mediation offers a number of special, additional benefits. Patients and families may, for the first time, learn exactly what happened to cause the harm. They may gain a greater understanding of the complexity and uncertainty of medical care. Hospitals and healthcare providers may learn about missed or ignored information that contributed to the harm, which may help avoid the re-occurrence of the error in the future.

But many of those benefits will not be realized unless physicians become full participants in the process.

The Mediation Process

Typically the mediator will begin the mediation by explaining the process, the mediator's role, and the role of the patient, family, doctors, and lawyers involved. The mediator then gives each participant an opportunity to explain his or her concerns and perspective on the problem. The initial statements of the parties and their lawyers are followed with information exchange and, ultimately, by discussions about both financial and non-economic options for resolution. Research shows that provisions for an apology (though when error is clear, one would hope that the patient would not have to wait until the mediation to receive an apology), continued care at no cost, a "memorial lecture" (ie, a lecture, generally annual, in a deceased patient's name, that the doctor would endow), or some other way to give meaning to a loss, may be especially important to the plaintiff and the family.

Mediators differ in their philosophies, the techniques they use during the mediation, and what they see as the goals of the process. Facilitative, interest-based mediators see their role as ensuring that all participants in the mediation process have the opportunity to speak, provide information, ask questions, and have their feelings and their concerns—including those that are not relevant to the legal claim—addressed. Facilitative mediators help the participants shape, evaluate, and reach an agreement. They do not make decisions for the parties.

Evaluative mediators tend to focus the discussion on facts relevant to the legal case, often make predictions about likely outcomes in court, ignore feelings, and

may push participants toward an agreement. In general, except in those few cases that are only about money, a mediator who takes a facilitative rather than an evaluative approach and is comfortable with expression of strong feelings is more likely to help participants achieve the full range of benefits offered by the process.

Communication That Helps to Heal

The type of communication encouraged in mediation is quite different from the healthcare system's traditional "deny-and-defend" mindset designed to enhance chances of winning should a lawsuit become one of the 5%-6% of cases that actually goes to trial. Until recently, physicians were advised to say as little as possible after an error and certainly not to apologize. This approach has begun to shift to disclosure and, when appropriate, apology and offer of fair compensation, thanks to the leadership of institutions like the University of Michigan Health System, the Lexington, Kentucky Veterans Administration Hospital, and the Colorado liability insurer COPIC, as well as to research documenting what patients seek after an adverse event.

This research has found that among the key outcomes patients seek are information about what went wrong, an apology, money to compensate for their injuries, and changes in clinic or hospital practice to better ensure that others do not suffer from similar harm. Patients often sue because they cannot get answers to their questions and suspect a cover-up because of evasive communication.

The negative reactions of patients and their families to inadequate communication that results from institutional deny-and-defend policies is no doubt heightened by the impact of an error on members of the medical team. In addition to fear of litigation and advice from their lawyers to be cautious about what they say, physicians and other members of the team must deal with the very normal human reactions of shame, guilt, and failure—feelings that make it hard to communicate at just the time that patients and family members are most in need of both emotional support and information.

Physician Participation Is Needed

Ideally medical practices and hospitals will have policies in place so that when things go wrong, patients receive initial expressions of empathy such as "I'm sorry this happened to you" and information about what is known at that point. Patients should also be told what will be done to investigate an adverse event and gather more information. And they should be kept apprised of the investigation's findings. If the investigation reveals that an error did occur, the policy would provide for an offer of fair compensation, and, when fault is clear, an apology that takes responsibility for the harm: "I'm sorry for my/our error." In addition, patients and family members would be told what is being done to prevent the error from happening again.

Even with such a policy, there will be lawsuits. And, when patients sue, mediation provides another opportunity to communicate, repair relationships, avoid economic and emotional cost, and learn from regrettable events. But most benefits of mediation are lost if one of the key players in the case, the physician, chooses not to attend or is advised not to by a trial lawyer who is professionally acculturated to prefer combat in court.

When we asked defense lawyers in our study why—despite being urged to bring their clients to the mediation during pre-mediation conference calls—physicians did not attend, we were told that the physicians were too busy or that the lawyers wanted to protect them from verbal attack by the plaintiffs. While both are understandable concerns, they reflect a narrow vision of the goals of mediation and, in most instances, ensure that the "treatment" offered by mediation will not be effective.

When physicians stay away from the mediation table, everyone loses. The physicians, the patients, and their families lose the opportunity to reconcile. The physician loses the opportunity to be forgiven and the patient or family the opportunity to forgive. The physician, hospital, patient, and patient's family all lose the chance for information giving and gathering and the opportunity to consider changes in institutional policies and practices to enhance both the quality of medical care and the delivery of caring services.

What is needed are physicians who partner with their lawyers to take full advantage of the mediation process by participating in the sessions. Failure to attend disappoints the plaintiffs and can be interpreted as a signal that, even after serious harm, the physician does not care enough to show respect by attending, listening, and providing information.

There will always be places for physicians at the mediation table. Even when attending is difficult, it is time for physicians to pull up their chairs. ■

Reference

1. Hymen CS, Liebman CB, Schechter CB, Sage WM. Interest-based mediation of medical malpractice lawsuits: a route to improved patient safety? *Journal of Health Politics, Policy and Law*. 2010;35(5):797-828. Available at: http://jhppl.dukejournals.org/content/35/5/797.abstract. Accessed September 10, 2011.