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Blessed Are the Peacemakers

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Blessed are the Peacemakers . . .

RICHARD C. BOOTHMAN*

Thank you for your kind invitation. I must start with a confession: for the past dozen years, I've been immersed in this business of reducing patient injuries, and I've not kept abreast of emerging ideas like Restorative Justice, Social Justice, or Non-Adversarial Justice. You'll see right away that I'm no academic, and I'm not sure what label you would affix to our work at the University of Michigan—though, clearly, even I recognize that we share many principles.

In 2001, I left more than twenty years' experience in the courtroom trenches of Michigan and Ohio with simple ideas about changing the way health systems and providers respond to patient injuries. I was completely naïve about a lot of things but not about what wasn't working very well. Yet, I was naïve: I originally thought that I could put some basic, sensible architecture in place to help the University. I planned to return to private practice in two years.

I loved my work as a trial lawyer. I was reasonably good at it and had been blessed over time with some wonderful clients like the University of Michigan, the Cleveland Clinic, Kaiser Permanente, and others. I believed then, as I do today, in the critical importance of open access to courts where essential rights like due process and equal protection are protected, but over my 22 years, I was also intimately aware of some truths, some of them ugly truths—not only about our system but about those of us working within it and about how well, or not-so-well, it works for those who find themselves with no recourse but to rely on it. In many ways, little has changed since Charles Dickens' cynical portrait of the legal system in his novel, *Bleak House*. That novel should be required reading in every law school—actually, it should be required for all of us in practice, too.

I am humbled every day by the medical community I serve. Yet, I have always been proud to be a lawyer, less-than-flattering stereotypes

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notwithstanding. And believe me: the medical community in which I work loves the stereotype.

When I was given my newest title, Executive Director of Clinical Safety, six doctors called and wanted to know what we were doing having a lawyer in charge of clinical safety. My response to each of them was, “Because obviously doctors can’t do the job!”

I’ve never forgotten that ours is a service profession. Our allegiance moves through a time-honored sequence of priorities:

1. We are sworn to uphold our Constitution;
2. We owe a duty to adhere to the highest code of ethics;
3. We owe a duty to safeguard the integrity of our profession and the process; and
4. We owe an obligation to protect the interests of those we serve—their interests are supposed to transcend our own.

Contests dominate our culture—we elect our president via a contest. Litigation is really nothing more than a socially-acceptable way to resolve an intractable dispute, by way of a contest. As trial lawyers, our role is not necessarily to find the truth but to win the case, within the rules of course. We all know that five people can witness the same event and have five different memories of what happened—most of the time, we were not there when “it” happened. My goal as a trial lawyer was to win the case, not presume that I would know the truth of what happened in the past.

Litigation is limited in other ways; it does not and cannot attend to the wider demands, including psychological healing and broader interests like stirring improvement in patient safety or addressing health care costs. It can be misused—some businesses, for instance, use it strategically for competitive advantage. Unintended consequences of this social expedient were, in many ways, damaging; the list of collateral damages is lengthy and varied. I’m not alone in my assessment of litigation’s benefits, costs, and limits.

So why has “Deny and Defend,” as Medicine’s response to patient injury, persisted for decades when few believe it’s the best way to address the issues? Will Rogers’ admonition resonates: When you find yourself at the bottom of a hole, the first thing to do is to quit diggin’.

So for me, the dilemma became, “If we quit diggin’, what else are we to do?”

There are many confounding characteristics unique to medically-induced injury:

1. Health care providers work in inherently dangerous circumstances with intrinsically dangerous tools—from the seemingly benign to

the most complex and exotic. Everything a doctor does or elects not to do is fraught with risks, many risks he or she cannot control. Every year, kids get hurt and even die when they get a standard antibiotic for their first ear infection—nothing for health care providers is guaranteed to be benign.

2. The human dimension is complicated. Human beings are hopeful animals. Wishful thinking too often replaces what informed consent tries to accomplish, and patients' expectations are high and often unrealistic. Patients trust—sometimes to a fault.
3. Health care providers are the most committed group I've ever known. They don't do what they do just for the money; it's still easier to make more cash selling commercial real estate.
4. The backlash on both sides is complicated when things go wrong; it's laced with feelings of betrayal, shame, loss, and altered or lost lives that extend far beyond the patient or the caregiver in the trenches. It's not hyperbole to say that in my career, I've been equal parts lawyer and psychiatrist.
5. And yet the sad truth, of course, is that care givers, remarkable people that they are, still, in avoidable ways, hurt the very people they dedicate their lives to help.

Even with all its limitations, I believe litigation has its place, but over more than two decades, I came to realize that like medicine, the risk that lawyers and judges can actually cause injury or create unintended, unhelpful consequences to the people we serve is great—far more likely than the risks kids face when their parents take them to the doctor for their first ear infection.

Ethicists are comfortable talking about “doing the right thing.” “The right thing.” What a simple concept, eh? What *is* the right thing for an obstetrician who sits alone in a room and searches through the guilt and fear and self-recrimination after the neonatologists whisk the floppy, blue baby she just delivered to the Neonatal Intensive Care Unit? What *is* the right thing after a patient dies from a previously unknown reaction to dye infused for an elective procedure? That happened at Michigan just last week—first time anyone ever remembers an anaphylactic reaction to methylene blue.

There are other inherently dangerous occupations but none more punitive when things go wrong. And we've all contributed mightily to that punitive aspect.

So, why did we dig this hole? I believe “Deny and Defend,” in part, was the result of a Faustian bargain Medicine made a very long time ago.

In my mind's eye, I imagine that there was a time when disgruntled patients discussed their problems directly with their physicians or hospital administrators. I imagine they would listen to each other then—they probably knew each other from the local school or grocery store or church. The first time a physician or hospital administrator put up his hand and said, “Stop. Tell it to my lawyer. That’s what I have insurance for,” he made a Faustian bargain—in return for being spared a difficult discussion, “Deny and Defend” was born. As a substitute for accountability, Medicine turned to a profession contentious-by-nature, and now, the medical community deplores the adversarial nature of it. The irony would be amusing if it weren’t for the price that Faustian bargain has exacted on all of us.

Medical injury affects patients, caregivers, and health care systems but also companies and governments. “Deny and Defend” supports a broad and lucrative industry that has prospered as a result of that bargain, and more troubling, it supports a culture that has persisted for so long that no one remembers anything different.

How well does “Deny and Defend” serve those impacted by injuries from medical errors?

For some of us, it works well—extremely well. To borrow an observation I first heard from Don Berwick, it is a process that delivers precisely what it was designed to do.

It works well:

1. For some hospital risk managers who find job security by portraying themselves as the only thing between caregivers and the pinstriped barbarians at the hospital gates;
2. For an insurance industry that often markets its products by exaggerating the impact of malpractice claims on healthcare costs while continuing to increase premiums;
3. For some Plaintiffs’ lawyers who toss aside old-fashioned ideas of professionalism and compete with topless bars for billboard space around every airport in the country, creating unrealistic expectations of lottery-type winnings as they go;
4. For some Defense lawyers who whisper to doctors behind closed doors that being honest about errors will lead to financial ruin and who defend medical care that shouldn’t be defended, racking up hourly fees while fueling a self-serving “circle the wagons” mentality which impedes patient safety and meaningful peer review;

5. For a shameful cottage industry of experts *on both sides* who are dogmatically dishonest as they try to “snow” jurors deselected for any sophistication in the things to which they testify; and
6. For some judges who, as they preside over a system sick with self-interest, cannot imagine that caregivers or hospital representatives *can* talk honestly to patients and who insist that any resolution that didn’t involve litigation must be suspect.

Yes, “Deny and Defend” performs well for a pretty big group of us, but what about the people involved—the patients and caregivers? How well does it work for them? Consider two cases:

Consider Ahmed: Ahmed was a strapping twenty-eight-year-old Syrian man, six feet tall and engaged to be married. In the fall of 2009, he began to have nosebleeds. At first, he didn’t think anything of it, but they persisted, and he went to the emergency room of a small community hospital where he was examined and advised to see his primary care physician.

The nosebleeds continued, and in the winter, he presented himself to another emergency room—this time at a tertiary care center, and again, he was referred back to his primary care doctor. By the spring, he was noticing blood in his sputum. He showed up in our emergency room on June 2, 2010, and Ahmed was in real trouble. His lips were blue, he struggled to get a breath, and he was overtly bleeding from the nose and mouth. Imaging depicted a large mass in Ahmed’s right lung, but it wasn’t clear if it was a tumor or a clot. Bronchoscopy demonstrated active bleeding, but the origin was not clear. Interventional Radiology tried to identify the source of the bleeding and embolize it, but again, they could not identify the source of the bleeding.

In the meantime, ten members of the patient’s family assembled in the waiting room. Each was aware that Ahmed had been having nosebleeds. As they waited and the doctors met to discuss next steps, the enormous clot in Ahmed’s right lung eroded through his pulmonary artery, and with four beats of his heart, he exsanguinated and died. A code was called, but he could not be resuscitated.

When the family was informed of Ahmed’s death, they behaved badly. Furniture was broken, death threats were made, and police were called. The family was escorted off the premises, and the question of criminal charges was raised.

Lost in all of this were five different doctors stunned at the turn of events, one of whom was inconsolable. He struggled with his own helplessness as he watched this young man die.

What is the “right thing to do” here? And “right thing to do” for whom?

Consider Marie: Marie was born a little past term. Her mom came late to seek prenatal care—a scared 19 year-old, a foreign national who couldn't speak English. At every visit, she was accompanied by a man she identified as her cousin. Though no one could prove it, the strong suspicion was that Marie's mom was a victim of the sex trade. The cousin never behaved like a family member. Intentionally impregnating women brought here for the sex trade is a strategy for further enslaving them—the babies born on our soil are Americans, and any thought of independence from their pimps disappears with the leverage that a baby affords.

Marie's mom saw a relatively new member of the family medicine department four days before Marie was born, and that family medicine doctor missed obvious signs of fetal distress.

Marie was born with the awful constellation of problems that babies hurt by hypoxic ischemic encephalopathy demonstrate. The global brain injuries on the baby's imaging were classic for birth trauma.

How well would "Deny and Defend" work for Marie? Would it delay her care for years? Keep the cousin interested at the thought of a big payout? Perhaps get them deported as part of a cynical defense strategy? Maybe the baby would die while the litigation was ongoing, choking from aspiration, perhaps? People in my business actually think that way. Sick, isn't it? If we stop diggin', then what?

Patients deserve caregivers who don't run for cover when something goes wrong—who focus unflinchingly to maximize medical recovery while helping patients and families understand what happened—because we all are driven by a natural need to make sense of what happens to us. Talking to people who suffer these kinds of things is simple human decency. Shame on us for refusing to talk with them and tell them the truth of what happened to them or their loved ones. How compassionate is it to leave patients wondering what happened?

Caregivers. We ask a lot of them. They put themselves out there every day. They need support; they also need to be accountable. They deserve to be judged by the reasonableness of their efforts, not solely by the outcome. In other areas of personal injury, like automobile negligence, one can look at the wreckage and get an idea of who made what mistake; you can't do that in medicine. Doctors can do everything reasonably and still cause injury; that doesn't make them negligent. They're entitled to be judged in a way that is fair and understanding of the uncertain and dangerous world in which they live, judged against a just culture that fairly evaluates the reasonableness of their efforts in an accountable but non-punitive way, and in the meantime, in a way that is sensitive to their needs,

a way that helps them address the pain of it all—not in a way that adds to this pain with threats of financial, professional and personal ruin.

Lawyers, can you imagine helping clients navigate the complexities of these issues without the prolonged trauma of litigation, where they seek compensation only when it's honestly deserved, without delay, without incredible expense, and without you laying out astronomical costs for years? Can you imagine a role for yourself focused on helping your clients get to the right answer because you know that in the big picture, defending care that shouldn't be defended erodes the quality of health care for everyone? Because you know that ultimately, you've done your clients no favors by pushing them through litigation they shouldn't be in? Can you imagine a role for yourself that supports the greater goals of patient safety?

State officials and regulatory officers, can you imagine a world where you're not needed?

I can. I can imagine it all.

We are not there yet. But by renegeing on the Faustian bargain and eschewing "Deny and Defend," we're a lot closer today than we were twelve years ago at Michigan.

What about Ahmed's family? Resisting police pressure to press charges, two days after Ahmed's death, we invited this family back. An appointment was set for a family meeting to occur one week later. We made that call before we had autopsy results. We made that call because we knew that these poor people experienced the most awful loss while still believing the only thing wrong with this young man was nosebleeds. We called them out of simple human decency.

The autopsy showed that Ahmed had a long-standing clot in his pulmonary artery that eroded through the wall of the artery right after we tried to identify and embolize the bleeding. We had nothing to apologize for, we thought.

The family showed up accompanied—with no warning—by the most aggressive trial lawyer in Michigan, and frankly, I was grateful for his presence. We put five doctors in the room with images, records, and fresh autopsy results. The meeting started—with florid emotions and angry threats—not well, but their lawyer stopped it immediately by telling them: "Show some respect; you have no idea how remarkable it is that these people are willing to even talk to you. I don't know another hospital that would do this."

Over the course of three hours, doctor after doctor explained what they thought and saw and tried and hoped for. By the end, doctors were crying with the family—the family showed us pictures from Ahmed's

childhood, embraced the physicians, and they cried together. It was among the most dramatic, personal, human moments I've ever witnessed.

But we learned something troubling at that meeting, too—something for which we deeply apologized. We learned that in the midst of the code call and chaos of the failed resuscitation, this family, this poor family that thought this young man had nothing but nosebleeds, was left in the lobby with only a single person for answers—that person had an attitude about Arabs. In the midst of this intense tragedy, she played solitaire on her computer and couldn't give these foreigners the time of day. While we embarked on this meeting out of simple human decency, we learned something pretty disturbing about ourselves that day, but something valuable too.

What about Marie? And her mom? And her Mom's doctor? And her doctor's other patients?

The day Marie was born, we were notified about her. Before the baby was discharged, we knew Marie's problems were likely our problems. We picked up the phone and called the finest birth trauma lawyer in the state and referred Marie's mom to him. Working with us, he opened an estate and brought Marie's mom to the attention of the probate court. We wanted to ensure that Marie got the best rehab care we could provide while supporting her mom, but we needed to make sure she was free from the cousin.

We supported Marie and her mom with monthly payments and ensured she was seen regularly. At eighteen months, she swallowed water for the first time. Her motor development has shown serious improvement. Her nutrition is optimized. With help, her mom is turning out to be a pretty good mom, so far. And the cousin seems to be gone.

We hired a life care planner, an economist, and a financial planner and, with care, calculated what Marie is likely to need for the rest of her life and how to finance it.

I settled that case for several millions last Christmas. It is interesting to note that with this new paradigm, settlement discussions have changed materially. No longer do we play "chicken," holding out the specter of runaway jury verdicts or the chance of winning as a means of getting the other side to the table realistically. Instead, both sides were focused on what it would really take to take care of Marie. And the lawyer representing Marie and her mother admitted a startling fact—that in forty years of representing catastrophically injured people, he has never really *known* what it would take to take care of them; he has only known what arguments he could make. Think about it: isn't that a significant change?

That lawyers would focus on a real, evidence-based correction rather than beat our chests and try to exploit the weaknesses of our system?

We can't undo the harm, but we can pay for our mistakes responsibly. The savings in defense costs *and* in plaintiff's costs can be used for Marie.

Why is honesty so important to us? Because when we investigated Marie's case, it turned out that the family medicine physician's colleagues had been worried about the physician for four years. "Oh, you don't know the half of it," one chillingly told me. And yet in that time, despite receiving a total of fifty thousand incident reports, no one submitted one about their concerns.

The doctor has been embraced, not shunned or fired. Embraced immediately, not after the threat of litigation passed. Her practice was scaled back to the point at which we were confident she was safe. She's been mentored and reviewed and counseled and educated. We couldn't do that secretly; these changes would be evident to other caregivers and residents. So our residents were instructed in what happened, and the ripple of our healthy response will positively affect not only the physician involved but also two-dozen other young doctors. And maybe, just maybe, next time, we'll hear about their concerns for a similarly challenged doctor *before* someone else is brain-damaged.

Marie's injuries cost us a few million dollars. She's paid a higher price, of course. But we rescued a doctor in the process. We'll be better for the honesty. And most important are the patients who won't get hurt in the future.

To those skeptics schooled in "Deny and Defend," I'm happy to say that the sky hasn't fallen in on us—every metric has improved. The numbers are published, if you're interested.

But the most important change is this: instead of being trapped in the culture of victimhood, we own these problems. We can do something about them once they're identified. And our patients and their families—and our caregivers—will all be safer for it.

Reversing that Faustian bargain allows us to serve all the people we need to serve. And because being a lawyer means that we are here to serve others' interests, that's a good thing.

If we stop diggin', then what?

Be honest, forthright, compassionate, principled. Compensate fairly and quickly when inappropriate medical care causes injuries. Support our caregivers when they acted reasonably under the circumstances. And above all, learn from our patients' experiences.

Oddly, the last point was the most controversial. I represented some of the very best health systems in the country for more than twenty years, and not one ever asked me what they should have learned from the cases I handled.

What relevance does our experience have for you?

I'm often asked about physician resistance to the idea that they would actually benefit from openness and honesty; the question always makes me laugh. When I say that I actually had very little resistance from doctors, most quickly conclude that the explanation must be me—maybe I'm special, or maybe it was because I was a known quantity as an established trial lawyer that I had some street cred, as it were—and most trusted me because of that. I tend to think that after decades of telling doctors *not* to talk, which may have successfully fed their aversion to conflict but otherwise cut against all the instincts that drew most of them to medicine, I think they were just relieved to have permission, particularly from someone representing the profession that had, for decades before, issued dire predictions that honesty would bring the sky crashing down upon them.

By far, the greatest resistance has come from lawyers. I told you I was naïve when I started at the University of Michigan. It didn't occur to me to ask permission to do what I thought was best for the doctors and healthcare system I served. The General Counsel for the University was vehemently opposed to what I was doing. By the time he caught on, I had secured support from the medical leadership. During that time, he insisted that what I was doing crossed the boundaries—not only ethical ones, but even suggested that it was not lawyerly, that I crossed from being an institutional lawyer to inappropriately getting involved in operations. I had no resources, inadequate pay, and he undermined our success with claims that the reductions we were seeing were the result of normal industry fluctuation. Because of his views, it took our auditors five full years to recognize that they were really seeing a durable trend, not just a fluke.

I once was invited to give a keynote address for a large, multidisciplinary physicians' group in New England, and after talking for two hours, they asked me to participate with three other lawyers in a panel discussion—one lawyer, a defense lawyer, was so exorcised at me that they had to ask him to leave.

When I told my wife about it, she said, "Jeez! And they haven't even gotten to know you yet!"

Do not underestimate the number of those invested and dependent on the status quo. New ideas threaten. And the threat cuts deeper than you think because you're not just threatening their economic stake in the status quo; for many, you're threatening their very identities, their places in the

world. I continue to be impressed with the embedded resistance a dozen years later.

I can only imagine the kinds of attacks your new ideas are attracting—some call it unethical, some unlawful? With all these new ideas, are you proposing something unethical? Unlawful? Hardly. Doesn't the law exist to bring order to society? Aren't we here to *resolve* conflict, not to bank on them?

Stay the course. We didn't get here overnight, and we won't change overnight either.

Have courage. Do not be afraid to see things differently. Do not underestimate the impact you're likely to have when you approach conflict by first listening and understanding and respecting others' experiences.

To make my point, let me shift gears and ask you to envision a different scenario. Remember when the Iraqi journalist threw his shoes at President Bush? That happened in December 2008. In the Arab culture, showing someone the soles of your shoes is a sign of contempt. The journalist threw the first shoe, shouting, "This is a goodbye kiss from the Iraqi people!" As he threw the second shoe, he shouted, "This is for the widows and orphans and all those killed in Iraq." He was wrestled to the ground and hauled away.

Later, with some swagger at a press conference, President Bush quipped, "If you want the facts, it's a size ten shoe."

I think of that incident often. And I think, what if? What if, in the chaos that followed the incident, as that man was being wrestled and jostled, the United States President stepped off the dais, waded through the crowd, and helped him up? And what if the President of the United States, recognizing the depth of emotion that must have compelled that journalist to do something so risky, so dangerous, invited him to sit and talk about how *he*, the journalist, viewed the United States' occupation of his country? What if the President really had a genuine interest in understanding the people whose lives had been so affected? And what if our President sought to help the journalist understand our sacrifices as well?

What a stunning scene that might have been, don't you think?

That takes a lot more strength than it does to make light of that man's desperate act. It's not a sign of weakness; it's a sign of strength and compassion and moral conviction.

What a statement that might have made to the people of Iraq, to the people of the Middle East, to the world. It could have been a game-changer, don't you think?

Maybe I've seen too many movies. But honestly, isn't this all about showing each other respect? We're all in this together.

Have the courage to test the status quo. You never know what can happen, but in the simple way I think, nothing bad happens when you show respect for all and justice is your goal.

Blessed are the peacemakers. Thank you.