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Mediating Medical Malpractice Lawsuits: The Need for Plaintiff and Physician Participation

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The Need for Plaintiff and Physician Participation

By Chris Stern Hyman and Carol B. Liebman

At this moment in history, tort reform and new approaches to resolving medical malpractice claims are part of the national debate about how to improve health care. Federal funding is available for pilot projects to test new approaches to medical malpractice litigation. There is increased pressure from health care regulators to disclose adverse events and communicate better with patients and their families. These all present opportunities to increase the use of mediation, particularly to address medical malpractice lawsuits and to improve patient safety.

For the past seven years, we have been studying ways in which mediation and mediation skills can resolve health care disputes in a way that enhances patient safety and quality of care. We have discovered that conventional ways of thinking, unjustified fear, and institutional and professional cultures are all barriers to realizing the full benefit of mediation. Hospital leaders and lawyers need to rethink conventional ways of responding when a patient is harmed by medical care. In particular, attention should be given to ways to bring not only lawyers but also patients, family members, and especially physicians to the mediation table. As the use of mediation in health care increases, mediators have a special opportunity, and therefore a responsibility, to educate participants about the full range of benefits available through mediation and to encourage participants to think about how what they learn during mediation can contribute to patient safety.

The general benefits of using mediation are well known in the legal world: prompt, less expensive resolution; party and lawyer decision-making and control over the shape of any outcome; agreements that can be more nuanced than court judgments and can include provisions that a court could not order; and, because mediation discussions are confidential, more candid and less strategic communication. Mediation provides special additional benefits in the health care setting. In mediation, health care providers may learn about missed or ignored information that contributed to the harm or about ways that established procedures were ignored. Eliciting this sort of information can allow institutional changes to improve patient safety. In addition, participants may, for the first time, learn exactly what happened to them or their loved ones, and patients and family members may come to understand the complexities and uncertainties of medical care. The mediation process can also encourage the kind of communication that allows healing for both patients and physicians and can even lead to a repaired relationship.

We have conducted three research projects using mediation to resolve health care disputes. The first, a demonstration project based in Pennsylvania, was in part a response to an Institute of Medicine study that suggested that as many as 98,000 patients die each year in hospitals due to medical error.[1] The project focused on using mediation skills to enhance physician and hospital communication with patients and families after

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an adverse event.[2] Later, our studies evaluated the use of interest-based mediation to resolve medical malpractice cases. The first of these studies involved lawsuits filed against municipal hospitals within the New York City Health and Hospitals Corporation (HHC study).[3] The second, larger study, Mediating Suits against Hospitals (MeSH), mediated lawsuits referred from private, nonprofit hospitals in New York City.[4]

Many cases get to litigation because of poor communication when patients are harmed by medical care. Even though hospitals and physicians are under increasing pressure to disclose unanticipated outcomes to patients and their families,[5] studies find a low rate of disclosure.[6] Typically, conversations following an adverse event are guarded and strategic—the result of long-standing belief that the best protection against litigation is to say as little as possible to the patient and family members. Research suggests just the opposite: litigation is more likely if patients and their families feel they have not gotten answers to their questions.[7]

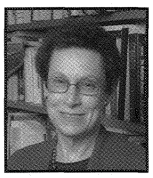
Given the central role that poor communication plays in the decision to file a medical malpractice lawsuit, we wanted to look at whether mediation could do more than just resolve individual cases—valuable as that is to individual litigants. We used an interest-based mediation style and chose mediators for their skill in facilitating discussions of both economic and noneconomic interests. The mediators were comfortable with emotional conversations, knew how to encourage active participation of plaintiffs and defendants, and viewed the expression of emotions as contributing to settlement and healing. We chose this interest-based approach knowing that most medical malpractice lawyers were less likely to be at ease with this style of mediator, being more familiar with the evaluative, settlement-conference mediation in which mediators preside over a position-based negotiation over money. Evaluative mediators focus primarily on the economic value of the case, spend relatively short amounts of time in joint session, and do not encourage the active participation of the plaintiff and defendant. Litigators may prefer the settlement conference approach because it is familiar. In addition, they do not need to be concerned about how well clients will present in the mediation or about emotional outbursts. They also control the negotiation because their clients are either not present or do not participate actively.

Prior to the mediations in our studies, the comediators had conference calls with the plaintiff and defense attorneys, during which the mediators discussed the value of participation of the plaintiff and, in MeSH, the defendant physician. We achieved a high level of plaintiff participation in both studies. Attempts to persuade HHC representatives during discussions setting up that study and the MeSH defense attorneys during the conference calls that it would be constructive to have the physicians present were unsuccessful. In the HHC study, we were aware from the beginning that physicians would not be attending. Not a single physician participated in any of the 31 MeSH mediations. Defense attorneys in the MeSH study gave a number of reasons for not bringing their physician clients to the mediation. They said it was not usual practice, that the physicians were too busy, and that they desired to protect their clients from the discomfort of being the target of the plaintiff's anger and pain.

In both studies research assistants conducted postmediation telephone interviews with all participants during which they asked both scaled and open-ended questions. All participants indicated moderate to high level of satisfaction with the mediation process. In the HHC study, 29 lawsuits were referred for mediation, and 19 were mediated. Sixty-eight percent of the mediated cases were settled as a result of mediation. In the MeSH study, 67 cases were referred, and 31 were mediated. Sixty-eight percent of those cases settled during or as a result of mediation. Those settlement rates are consistent with other studies of mediation.

For many of the attorneys, the studies were their first exposure to interest-based mediation. Most reactions were positive, although a few attorneys were critical of the mediators' reluctance to value the cases. Similarly, most plaintiffs were satisfied with the mediation. Despite the general "success" of the studies' mediations, as measured by participant satisfaction, comments of participants, and settlement rates, we find the results disappointing. Because of the lack of physician participation, as far as we could determine, none of the mediation discussions contributed to improved patient safety or quality of care.

By contrast, the authors mediated two pending wrongful death lawsuits against one hospital as part of the Pennsylvania demonstration project.[8] In both cases, the chief of medicine participated, as did representatives from the hospital's insurer, the director of patient safety, the hospital's outside counsel, the plaintiffs, and the



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plaintiffs' lawyers. The physicians directly involved in the patient's care did not participate in either mediation. In one case, the patient with end-stage chronic obstructive pulmonary disease (COPD) died after a resident inserted a subclavian central line (an IV placed in a vein under the collarbone) and nicked the patient's lung. At the mediation, the plaintiff—the patient's widow—expressed her grief and anger, asked questions about her husband's care, and told the hospital's representatives how she had been, in effect, abandoned after being told of her husband's death. The physician responded first with an apology for what she had been through and then explained to her that from his perspective the placement of the line was not negligent. He acknowledged it might have been better to have inserted the central line in the patient's neck, avoiding the lung that had become enlarged as a result of COPD, but the choice of placement was within the standard of care. However, he also explained that as a result of reviewing the facts of this case, the department of medicine had adopted a new decision tree for the placement of central lines to avoid this harm in the future. The mediation lasted seven and a half hours over two days. Between the first and second day, the chief of medicine spoke with the former resident, who stated that he was still haunted by the case and grieves for the patient every day. Learning about the impact on the resident of her husband's death, even though it was secondhand, seemed to give significant comfort to the widow and raised a question for us about the possible healing that might have occurred had the resident been able to attend.

During the mediation, the widow also told how she had arrived at the hospital in the early morning in response to the resident's urgent call and learned from the attending physician that her husband had died. She was then left standing alone in the hall outside her husband's room. Until the mediation, no one had explained to her what had happened. She filed the lawsuit in part to get answers to her questions. The chief of medicine and the director of patient safety were appalled at how the widow had been treated. The settlement agreement included a monetary remedy and commitment to conduct ongoing staff training on how to respond to family members grieving as a result of the death of a loved one in the hospital. Neither a litigation mind-set prior to mediation nor an evaluative approach during mediation would have produced the new decision tree guide for placing a central line, an improvement in medical care, nor training in care for grieving family members, an improvement in caring delivery of services. And neither change would have been possible without participation of a physician.

The second case involved an elderly man on Coumadin, a blood thinner used to prevent and treat clots, who was admitted to the emergency room the morning after a fall. Contrary to hospital policy, the wife was not allowed to be with her husband in the ER for his final hours. The patient was initially misdiagnosed with an infection rather than internal bleeding. After a second reading of the CT scan, the correct diagnosis was made, but he died before remedial steps could be taken. At the mediation, the chief of medicine listened empathically to the widow and responded to her rage and pain with an apology that acknowledged the hospital's complete responsibility for the misdiagnosis. He then explained exactly what treatment had been administered to her husband. In the course of the five-and-a-half-hour mediation, the widow moved from rage to sadness and ultimately expressed gratitude for the physician's apology. She wondered if the outcome might have been different if she had brought her husband to the ER immediately after his fall. She was reassured that it would not have made a difference because it would have been too early to detect the bleed. That response seemed to free her from the burden of feeling that, had she acted differently, she could have prevented the tragic outcome.

It was the chief of medicine in a caucus who suggested that a nonmonetary remedy was necessary to give meaning to this loss of life and suggested an annual lecture in honor of the deceased. The widow, when told of the suggestion, seemed moved and ultimately decided that a lecture on emergency medicine would be an excellent memorial. The hospital also changed its procedures so that a patient on Coumadin who has fallen and enters the hospital through the ER is seen by a trauma surgeon.

Physicians often fail to tell the patient or family member about a misdiagnosis or a wrong treatment because of fear of the consequences of doing so or lack of training and experience in having these sorts of difficult conversations. When these conversations occur in a mediation, a confidential process, the mediator, experienced in the needed communication skills, can coach both parties to ensure productive dialogue. The expression of emotions by both parties is an essential ingredient for healing and restoration of trust.

What initiatives might encourage physician participation in medical malpractice mediations, thereby providing the chance to turn tragic outcomes into learning opportunities that can improve quality of medical care? Pilot mediation programs, sponsored by hospitals in which treating physicians or another physician familiar with the case participate, would give hospitals firsthand experience with direct patient-physician conversations, assisted as needed by the mediator. For hospitals that are not entirely self-insured, the hospital and physicians' insurers need to concur with the decision that physicians will participate in the mediations. With the benefit of hindsight, in the MeSH study, perhaps we, the principal investigators, should have discussed this issue with the hospitals and insurers prior to the mediations. If they had agreed that, in certain cases, it would be useful for the physician to attend the mediation, they could have conveyed their preference for physician participation

to the lawyers representing them at the mediations. However, hospital leaders and insurers are not likely to take the step of encouraging physician participation in mediations until they see the benefits as outweighing the risks.

In addition, mediators can continue to educate lawyers, physicians, patients, hospital leaders, and insurers about the research on the benefits of direct communication between patients and physicians after something goes wrong in medical care, even after a lawsuit has been filed. The ultimate decision to change the way mediation is used in medical malpractice cases depends on the willingness of hospital leaders, physicians, and insurers to undertake the challenge of a different, more imaginative approach to mediation. ◆

Note

A full report on the MeSH study is forthcoming in the Journal for Health Politics Policy and Law.

Endnotes

1. To Err Is Human: Building a Safer Health System 1 (Linda T. Kohn, Janet M. Corrigan & Molla S. Donaldson eds., 2000).
2. Carol B. Liebman & Chris S. Hyman, *Medical Error Disclosure, Mediation Skills, and Malpractice Litigation: A Demonstration Project in Pennsylvania*, (2005) www.pewtrusts.org/our_work_report_detail.aspx?id=24398.
3. Chris S. Hyman & Clyde B. Schechter, *Mediating Medical Malpractice Lawsuits Against Hospitals: New York City's Pilot Project*, 25 Health Aff. 5 (2006).
4. An article reporting on the MeSH study is forthcoming.
5. The following state laws require medical facilities to disclose adverse events and medical errors to patients: Cal. Health and Safety Codes div. 2, § 1279.1(c) (2007); Fla. Stat. Ann. tit. 29, § 395.1051 (2003); Nev. Rev. Stat. tit. 40, § 439.855 (2003); N.J. Ann. Code tit. 8, § 8.43E-10.7 (2008); Or. Rev. Stat. tit. 36, § 4 (2005); Pa. Rev. Stat. tit. 40, § 1303.308 (2002); Tenn. Rev. Stat. tit. 68, § 68-11-211 (2007); Vt. Rev. Stat. tit. 18, § 1915 (2006); and Wash. Rev. Code Ann. tit. 70, § 70.41.380 (2005); The Joint Commission, Comprehensive Accreditation Manual for Hospitals: The Official Handbook, Standards RI.1.1.2, LD.3.40, & 4.260 (2009).
6. Rae M. Lamb, David M. Studdert, Richard M.J. Bohmer, Donald M. Berwick & Troyen A. Brennan, *Hospital Disclosure Practices: Results of a National Survey*, 22 Health Aff. 2 (2003); Lauris C. Kaldjian, Elizabeth W. Jones, Barry J. Wu, Valerie L. Forman-Hoffman, Benjamin H. Levi & Gary E. Rosenthal, *Disclosing Medical Errors to Patients: Attitudes and Practices of Physicians and Trainees*, 22 J.G.I.M. 9 (2007).
7. Gerald B. Hickson, Ellen W. Clayton, Penny B. Githens & Frank A. Sloan, *Factors That Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries*, 267 JAMA 10 (1992).
8. *See* Carol B. Liebman & Chris S. Hyman, *Medical Error Disclosure, Mediation Skills, and Malpractice Litigation* for more details of the two mediations.