July 2009

Newsletter of Physicians Reimbursement Fund, Inc.

PRF NEWS

Volume 12, Number 2

Covering Practice and Risk Management Issues for Physicians

Collaborative Law

BY KATHLEEN CLARK, JD, PHD

Collaborative law (CL) is a voluntary, structured, non-adversarial dispute resolution process individualized to the case. At the first meeting of the parties and attorneys, a Participation Agreement, which provides for confidentiality, is discussed and signed. All parties and attorneys work collaboratively toward a resolution unique to the facts of the case at issue and not limited by legal remedies.

CL recognizes concepts of fairness and focuses more on finding solutions than on finding fault. Legal remedies involve only money. Collaborative law encourages remedies the parties agree upon. These may include disclosure, apology, compensation, and joint efforts to establish safety initiatives to benefit future patients. If the collaborative process does not resolve the matter, there is the potential for some healing, as the parties have had an opportunity to talk, listen, propose potential solutions, and generally see each other's humanity. Litigation, following an unsuccessful collaborative process, will likely be less adversarial

The CL process is controlled by the parties and involves both transparency and total respect for all involved. CL offers a "natural fit" in the adverse event context, encouraging immediate participation of the parties, in consultation with their attorneys, once an adverse event has been alleged. It is a group process, wide open as to options; all participants are members of the decision-making process.

Litigation involves certainty of view and takes responsibility and decision-making away from the parties and gives it, instead, to a judge, jury or arbitrator. CL leaves resolution to the parties and their attorneys. The process encourages early discussions that can involve listening, disclosure (see the article on page 2), apology (to the extent appropriate), proposed future patient safety solutions, compensation and healing.

Patient safety is a primary concern of CL, bringing as it does the private interest of the injured person into alignment with the public interest in preventing injuries to the general public in the future. Unlike litigation, the collaborative process permits and encourages patient safety issues to be addressed immediately on a global, rather than an individual, basis.

CL can be very effective in dealing with medical errors. It enables everyone with a stake in the resolution of a medical error to collaborate to provide a fair process to all parties. The stakeholders include the patient, the patient's attorney, the physician, and the physician's attorney.

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Inside PRF News

This issue of PRF News examines Collaborative Law (CL), a **non-adversarial** dispute resolution process originally innovated in Family Law courts to negotiate better out-of-court settlements. CL is now being used successfully in civil and business matters. There are similarities between CL and PRF's Code Green Policy which, when appropriate, works to make the patient whole through disclosure, apology and restitution. The collaborative process, however, adds another dimension by trying to achieve a deeper understanding of what transpired and improve patient safety outcomes for the greater good.

"Through this process, we can expand our knowledge and skills to communicate more effectively with our patients and expand our focus on patient safety, while saving our precious emotional and financial resources," says Kathleen Clark, the author for this issue.

Kathleen Clark is a practicing attorney and mediator in the San Francisco Bay Area. She has a masters degree in business management and recently completed her PhD with a dissertation on "Bringing Dialogue and Collaborative Law to Health Care." The author's keen interest in the use of collaboration and insights into medical malpractice have made her a powerful advocate for change in the way medical malpractice is approached. Her advocacy activities include training, writing and speaking on the collaborative process, including communication and disclosure.

MICRA laws have been in effect for more than 30 years and, while successful, are under constant challenge. As members of PRF, we need to understand the importance of protecting these reforms and be part of the drive for future reforms such as the application of CL. As practitioners, an understanding of the principles of CL, especially those of communication and disclosure, when applied to our daily practice, will decrease our individual risk.

This issue features:

Disclosure Is Effective on Several Fronts

BY KATHLEEN CLARK, JD, PHD

Disclosure includes acknowledgement of the error or injury, apology, and assurances that steps will be taken to avoid such an error in the future. Disclosure promotes patient safety by creating a cultural shift from an adversarial to a collaborative process. Stakeholders, including patients, physicians, insurers, attorneys, and others, work together to resolve the situation at hand and find new ways to promote patient safety.

Disclosure is a process over time. It continues until all parties are satisfied with the resolution. The process of disclosure has several benefits. It:

- encourages clinicians to explain what happened and to apologize;
- supports patients in telling first-hand stories from their unique perspective and allows them to participate in the development of new patient safety initiatives;
- provides an opportunity to strengthen the physician-patient relationship;
- gives support to clinicians, health care professionals, patients and their families;
- saves considerable money; and
- provides a process for institutional stakeholders (health care professionals, the disclosure team, the risk management team) to work together more effectively.

Disclosure is one aspect of physician-patient communication. As was stated by the American Medical Association: "Only through full disclosure is a patient able to make informed decisions regarding future medical care."[1] An expression of physicians' compassion and humanity, disclosure requires openness and transparency. The Joint Commission has also concluded that: "There is increasing awareness that openness has the potential to heal, rather than harm, the physician-patient relationship."[2] For disclosure to become **the** accepted and respected response after adverse medical events, a shift in the traditional health care culture from silence, fear and obfuscation to openness and transparency must take place. That will take time and energy. The good news is it is already happening in several health care systems, as discussed below, where it has been shown to be very effective at considerable cost savings.

DISCLOSURE PROTECTS PHYSICIANS

Medical malpractice litigation takes an *average* of five years from injury to resolution, an almost interminable length of time to live and work in the shadow of litigation. When disclosure takes place within the collaborative law framework (as discussed in "Collaborative Law" on page 1 of this issue), it often eliminates the need for litigation. When it doesn't, the adversarial process is less adversarial, takes less time, and costs less money. The physician has informed, consulted and respected the patient. All that will be left to litigate is damages. Without disclosure, the battle lines are drawn, the litigation process consumes, and the physician's ability to practice may be compromised. The physician becomes, truly, the "second victim."

Edward Dauer has written: "It has been suspected for some years that the stress physicians experience while being subject to malpractice claims may result in a degradation of their performance. Partial isolation from peers and patients (self-imposed or otherwise), excessive rumination, self-doubt, anger, and hostility contribute to altered mental states and concomitant effects on judgment and performance. One major liability insurer that has examined its own claims records found evidence strongly suggestive of these effects. Specifically, physicians against whom a malpractice claim had been made exhibited a sharply elevated risk of incurring a second 'loss' (insurance payment on a claim) during the year after the first claim was brought. In the first two quarters after the filing of the first claim, the odds ratio is as high as three-to-one. The fact that the loss experience declines to normal levels after eighteen to twenty-four months suggests, although it does not prove, that the effect is attributable to the pendency of the first claim rather than to an unusual propensity toward error."[3]

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DISCLOSURE SAVES MONEY

The University of Michigan Health System instituted an apology policy in 2002, placing the emphasis on improving patient safety and physician-patient communication. Rick Boothman, Chief Risk Officer, in testifying before the U.S. Senate, stated: "There is no question in my mind that the culture of open disclosure paves the way for clinical improvement in ways that we have never seen before. The culture of deny-and-defend prevents us from improving. Being open with patients starts with being honest with ourselves about our failings—that is a necessary prerequisite to any real improvement." The admonition to physicians was, "If we make a mistake, the best way to avoid litigation is to make it right, right now." Claims against the University of Michigan dropped every year since, despite increased clinical activity, and the cost of handling them dropped by two-thirds.[4]

The Veterans Administration Medical Center in Lexington, Kentucky began, in 1987, a process of disclosure and apology when a patient was injured through medical error or negligence. The goal was to improve patient safety through a systems approach with emphasis on prevention, not punishment. Steve Kraman, MD, who initiated the program, later stated: "We didn't start doing this to try to limit payments . . . We started doing it because it was the right thing to do, and, after a decade of doing it, decided to look back to see what the experience had been. *The indication that it cost us less money was really unexpected.*" (emphasis added.)[5]

Also, a word about "defensive medicine." Assuming that much of it is practiced as protection from litigation, before the fact, why not shift the conversation and the process toward disclosure, openness and transparency? The result would be less litigation and less defensive medicine with its associated (and appalling) expense, which was estimated to be as much as 120 billion dollars during the 2009 White House Physicians Health Care Stakeholder Discussion.

DISCLOSURE/ COMMUNICATION TRAINING

"Lack of disclosure and communication is the most prominent complaint of patients and their families. . . ." according to Kraman.[6] Furthermore, the 2007 Project on Medical Liability in Pennsylvania stated: "[I]neffective communication between physicians and patients is the single most significant factor in explaining why physicians are sued."[7]

Enhanced communication skills, including disclosure, will bring physicians and their patients into a more healing, open relationship, enhance trust, provide alternatives to litigation, save money and other resources, and support patient safety and learning. Disclosure training is an ongoing process that emphasizes prevention and accountability, not punishment and blame. It involves:

- the philosophy of disclosure, (a new way of thinking for many health care providers),
- accountability,
- who should disclose,
- who to contact,
- what to say,
- when to say it,
- how to apologize,
- how to document the process,
- how to keep the patient informed,
- how to enlist the patient and family in patient safety concerns,
- how to respectfully verbalize the disclosure and continuing conversation,
- how to rethink and structure patient safety improvements, and
- how to think in terms of systems, rather than individuals.

The disclosure process is a giant step from defensive to preventive medicine. ■

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[1] AMA Council on Ethical and Judicial Affairs and Southern Illinois University School of Law, Code of Medical Ethics, Annotated Current opinions. Chicago, IL; American Medical Association, 1994.

[2] *Health Care At The Crossroad: Strategies For Improving the Medical Liability System and Preventing Patient Injury,* Joint Commission on Accreditation of Healthcare Organizations, p. 27.

[3] Dauer, Edward, *Accountability, Patient Safety and Policy Reform,* 2004, Georgetown University Press: Washington, D.C., Chapter 11, p. 188.

[4] Eve Shapiro, *Disclosing Medical Errors: Best Practices From The "Leading Edge",* 2008, p. 12.

[5] Dauer, *Accountability*, p. 7.

[6] Ibid, p. 26.

[7] Carol B. Liebman and Chris Sterns Hyman, *Medical Error Disclosure, Mediation Skills, and Malpractice Litigation: The Project on Medical Liability in Pennsylvania, pp. 9-10.*

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PRF News is produced by Knox Communications

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Collaborative Law *(continued from page 1)*

Depending on circumstances, the involvement of other parties (such as the physician's insurer, hospital administrators, risk managers, or counsel) may be required.

This approach is much more conducive to looking at health care from a systemic point of view, rather than putting one individual plaintiff's case under the microscope. The collaborative law process encourages examination of the big picture. This is not to say that the physician or hospital is free of responsibility. Often, difficulties in the system play a significant role in the error and those difficulties, under typical modes of litigation, go unexamined or are examined only for purposes of negligence, rather than for purposes of protecting future patients.

The CL process gives all parties the support, advocacy and advice of collaboratively trained attorneys. Collaborative law training involves dispute resolution through listening, while encouraging the questions and participation of all parties. Interest-based negotiation employs transparency, with concepts of both patient safety and systems thinking. One approach to collaborative law training is to bring physicians into a portion of the process to discuss patient safety concepts and principles with attorneys, share real life work experiences, develop trust between the professions, and discuss common goals. When we see each other's humanity, we listen and find opportunities to help each other.

Even if a medical error claim does not resolve through the collaborative process and moves on to litigation, changes in patient safety procedures, even unrelated to the medical error, can still arise benefiting future patients. Examples include: changes in night security procedures at a hospital, changes in charting procedures, improvements in computerized recordkeeping and alert systems, and changes in the interactions of interns, residents and other hospital personnel with patients and families. In addition, with attempts to collaborate, barriers to experiencing the humanity of each other may have dissolved such that some healing can take place.

To physicians, the process gives immediate access to a collaborative attorney who understands and is trained in the process, including disclosure, and understands the issues that arise after an adverse event or medical error. It also provides:

- confidentiality
- control of the process
- an early opportunity to offer an explanation and to answer questions
- a chance to offer an apology, if appropriate.[1] (Expression of sympathy [but **not** expression of **fault**] is protected from disclosure in California.
- an early opportunity to strengthen the relationship with one's patient
- an atmosphere less inclined to blame
- an opportunity to begin healing
- a chance to examine, in collaboration with the injured party, patient safety issues quickly, thereby providing opportunities for improvement in the health care process
- savings of emotional energy and time because there is no lengthy, stressful, expensive and painful litigation process
- potential extensive cost savings
- peace of mind when issues are resolved quickly without a written claim having been filed. (Although reporting to the National Practitioner Data Bank may not be required, absent a written claim or complaint, incidents can still be subject to peer review, if specified in the Participation Agreement.)

Many of these benefits to the physicians also benefit their insurers. The opportunity to address patient safety issues quickly lessens future claims based on similar mistakes.

The collaborative law process makes the experience of loss a more compassionate process, primarily for the patient and family, but also for physicians, attorneys and the larger community. Jonathan Todres says that "care and healing . . . must be center stage in any system that seeks to remedy medical errors."[2] For this process to take hold, a shift in thinking will be necessary for physicians, attorneys, insurers and other health care providers. Physicians and attorneys, to use the CL process effectively, should be trained in both disclosure and collaborative law. Insurers could, to support these processes, develop incentives for those physicians who have been trained in either or both processes. ■

[1] See *Should Physicians Apologize For Medical Errors?*, Norman G. Tabler, Jr., Esq., The Health Lawyer, Volume 19, Number 3, January, 2007

[2] Todres, Jonathan, *Toward Healing and Restoration for All: Reframing Medical Malpractice Reform*, Connecticut Law Review, Volume 39, Number 2, December, 2006, pp. 675-676.