Companion Piece to Presentation

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Bringing Healing to Law and Medicine After Adverse Events:

Dialogue, Disclosure and Collaborative Law

Helen Keller said: "There is just one thing worse than being blind and that is having sight but no vision."[1] Can we, physicians[2] and attorneys all, create a common vision in the arena of responding to adverse events/medical errors? Do we already have one, perhaps unspoken? What if we, as lawyers, saw law and legal processes differently, or more expansively, "as an opportunity for forgiveness, for healing and for coming into touch with a true sense of community."[3] The ABA Model Rules of Professional Conduct, Preamble: A Lawyer's Responsibilities, states: "A lawyer, as a member of the legal profession, is a representative of clients, an officer of the legal system and *a public citizen having special responsibility for the quality of justice."*[4] We have a special responsibility to our communities, to build and expand a true sense of community, including working to improve the quality of justice. "A professional lawyer is an expert in the law, pursuing a learned art in service to clients and in the spirit of public service and engaging in these pursuits as a part of a common calling to promote justice and the public good."[5] Chief Justice of the United States Warren Burger has said, "The healing function ought to be the primary role of the lawyer in the highest conception of our profession…."[6]

Similarly, the American Medical Association's Declaration of Professional Responsibility: Medicine's Social Contract With Humanity, states that physicians "…commit themselves to *advocate for social, economic, educational and political changes that ameliorate*

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[1] Quoted by Margaret Murphy in her keynote address at the MITSS Annual Fundraiser, November, 2008.

[2] Although I refer to "physicians" throughout, the term, depending on the context, includes other health care professionals, including their insurance carriers.

[3] Alan Reid, *Seeing Law Differently: Views Form a Spiritual Path,* Borderland Publishing, Ontario, 1992.

[4] <http://www.abanet.org/cpr/mrpc/preamble.html/>, accessed January 31, 2009.

[5] David Link, *Shifting the Fields of Law and Justice: A Collection of Essays Reshaping the Lawyer's Identity,* Volume 1, Center For Law and Renewal, Kalamazoo, MI, 2007, p. 18.

[6] Chief Justice Warren E. Burger, *The Role of the Lawyer Today,* Volume 59, Notre Dame Law Review, 1983, p. 1.

suffering and contribute to human well-being."[7] The first principle of the Code of Medical Ethics of the American Medical Association reads, "A physician shall be dedicated to providing competent medical care, *with compassion and respect for human dignity and rights."*[8] Richard Horton comments, "Competence, knowledge, judgment, commitment, vocation, altruism and a moral contract with society remain at the heart of what it means to be a doctor…Doctors have to be stewards of the [health care] system…"[9]

The common threads between physicians and lawyers are many: human well-being, healing, justice, a moral contract with society, and commitment to our communities. All this suggests that physicians and lawyers already have a common vision. Taking that common vision and expanding it into our respective roles after adverse event/medical error situations will be a giant step forward.[10] Perhaps a place to start with the expansion of our collective vision is with the words of President Obama, spoken in his inaugural address: we "will do our business in the light of day".[11] Think about that for a minute: we will do our business in the light of day. What a healing, open, compassionate, respectful vision. Let all of us, coming from our various professions, building upon our common vision, do our business in the light of day, particularly when it is most difficult to do so, after adverse medical events. A culture of transparency, practicing in the light of day, particularly when the consequences for physicians can be very serious indeed, already exists in some health care facilities. However, the cultures in many others still involve secrecy, obfuscation, and non-disclosure. These practices often are supported and enforced by insurers and attorneys, among others.

Processes that will assist physicians, health care facilities and their attorneys/counselors/ advocates in getting to the light of day, in doing our business in the light of day, rather than under the cover of darkness, include dialogue, disclosure and collaborative law. Dialogue, as described below, provides the opportunity to bring together a variety of health care stakeholders to examine new options to traditional medical malpractice litigation practices, to work through misunderstandings and misconceptions, and to develop trust, such that teamwork across professions is workable. Dialogue affords us the opportunity to reach out and engage each

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[7] <http://www.ama-assn.org/ama/upload/mm/369/decofprofessional.pdf., accessed February 2, 2009.

[8] Rinpoche, Chokyi Nyimma, *Medicine & Compassion: A Tibetan Lama's Guidance for Caregivers*, *Forward,* Wisdom Publications, Somerville, MA, 2006.

[9] Richard Horton, *What's Wrong with Doctors,* New York Review of Books, May 31, 2007, reviewing Jerome Groopman, *How Doctors Think,* Houghton Mifflin: New York, 2007.

[10] This is NOT to suggest that such vision is not a part of many cultures in health care already, just that it is not as widespread as it could be.

[11] Inaugural Address, Barack Obama, <http://news/yahoo.com/s/ap/20090120/ap_on_go_pr_wh/ inauguration_obama_text. >

other, across our misunderstandings and differences. Disclosure[12], [13] and disclosure training are other processes which can provide the same results. Both disclosure training and collaborative law training, as explained herein, bringing together physicians and attorneys and other health care providers, as necessary, are other opportunities to break down barriers and develop community and working groups, such that, when an adverse event occurs, knowledgeable and trained professionals, including physicians, attorneys, insurers and other health care providers, can act quickly to work together, provide information, answer questions, improve patient safety practices, apologize, and provide compensation, as necessary. All these processes, dialogue, disclosure and collaborative law, as well as training in these processes, allow the participants to set aside blame, expedite change, and focus on moving forward. They all focus on the future, not the past. They help us learn from the past and take that learning into the future to help others.

Dialogue

> "[w]hat we need to do is to remove the blocks that separate…people. Then you can operate as a single intelligence for the good of the community or the region."
>
> - David Bohm[14]

The dialogue process is collaborative, involving the posing of questions that encourage participants to reflect on their experiences of the medical error/malpractice conflict. It promotes communication across misconceptions, misunderstanding and differences. It is about listening, thinking and talking together to find creative options that allow all stakeholders and interested parties to build community, build common understanding and work together.

The dialogue process seemed appropriate to examine alternatives to medical malpractice litigation for several reasons. It is "not to solve what had been seen as a problem, but to develop from our new reactions new socially intelligible ways forward, in which the old problems

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[12] Fairness in the context of medical error includes respect and dignity for all parties, prevention of future harm rather than punishment of individuals, health care provider accountability, adequate representation of all parties, a voice for each and every party in the process, and disclosure and apology, as appropriate.

[13] The term "disclosure" suggests first withholding, then disclosing, and is traditionally defined as uncovering, displaying something that was previously hidden. The Massachusetts Coalition for the Prevention of Medical Errors' Study, states "Because this term [disclosure] suggests revealing of privileged information and implies an element of choice, in this document we use instead the term *communication*, by which we wish to convey a sense of openness and reciprocity."

[14] Quoted in *The Heart is the Key to All of This, Conversation with Joseph Jaworski,* October 29, 1999, <http://www.dialogonleadership.org/WhitePaper.html#one>, accessed on February 2, 2009.

become irrelevant."[15] According to Bohm[16], communication should not be understood as the "attempt to make common certain ideas or items of information", but as the effort of two or more people to "make something in common, i.e. [create] something new together."[17] It is a process that encourages different conversations to take place, different especially for attorneys. It is inquiry to learn, rather than telling, selling, and/or persuading. It is a process intended to create conversational space, to integrate multiple perspectives. It is not about right and wrong; win versus lose. It is an opportunity to chip away at our assumptions and stereotypes.

In the context of medical error, dialogue is an opportunity to bring together professionals/practitioners who normally don't work together and generally see issues and events through different lenses. The practitioners/professionals include attorneys for plaintiffs, attorneys for defendants, attorneys for drug manufacturers, physicians, insurers, risk managers, hospital administrators, patients, patient advocates, nurses, and other health care providers. Here are just a few examples of the sentiments the various professionals/practitioners express about each other:

> The only people benefiting from the current system are the attorneys who file lawsuits against doctors and their insurers. (insurer)[18]
> Rather than meeting the needs of patients, medical malpractice litigation just lines the pockets of personal injury lawyers. (insurer)[19]
> Very often, lawyers aren't looking after the best interests of society, the medical profession or the health care system. (non-litigation attorney)[20]
> Except for lawyers, this system [med mal litigation] does no one any good. (insurer)[21]
> The chief cause of the med mal crisis is the "scorched earth" policies of insurance companies, denying and fighting all claims, even the most legitimate claims. (attorney)[22]
> Lawyers are modern-day mercenaries. (non med mal attorney)[23]
> If there is a barrier to the adoption of a humanistic risk management policy by

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[15] Shotter, John, quoted in Powerpoint handout, Taos Institute, Collaborative Practices, October, 2005.

[16] David Bohm, a physicist, wrote, spoke and practiced dialogue. He is so well-known and respected in dialogue circles that dialogue is often referred to as "Bohmian Dialogue". He was a creative and innovative thinker on the subject of dialogue.

[17] Stewart, John and Zediker, Karen, *Dialogue as Tensional, Ethical Practice, Southern Communication Journal, Volume 65, Numbers 2&3, Winter-Spring, 2000, citing David Bohm.(1996).*

[18] Smarr, Lawrence E., President of Physicians Insurers Association of America (PIAA).

[19] Ibid.

[20] Pate, Randolph W., *How Should Malpractice Policy Put Patients First,* http://www.AARP.org/health/doctors/articles/medical_malpractice.html. AARP Bulletin, dated posted: 4/6/2006.

[21] Ibid.

[22] Sorry Works, attorney board member, www.sorryworks.net.

[23] Supra at F/N 9.

nongovernmental hospitals, it may be the involvement of many private malpractice insurers, *each of which is interested in paying as little money in settlements as possible.* (general counsel, hospital)

The deeper problem with medical malpractice suits is that, by demonizing errors, they prevent doctors from acknowledging and discussing them publicly. (physician/author)[24]

Risk management is an effort to avoid liability, rather than an effort to avoid error. It is focused on managing risks of financial loss associated with malpractice suits, rather than on error analysis, safety principles, and corrective action associated with health delivery systems and care. (med mal plaintiff's attorney)[25]

"We are at war, with the very survival of the practitioner and the specialty at stake; under these circumstances, customary rules of engagement can be temporarily suspended." (physician, as identified by a physician/medical malpractice expert, discussing litigation and physicians' insurance rates.)[26]

How do we reconcile these statements with the following: (and more)

The profile of non-error claims we observed does not square with the notion of opportunistic trial lawyers pursuing questionable lawsuits in circumstances in which their chances of winning are reasonable and prospective returns in the event of a win are high. (academic study report)[27]

Our findings underscore how difficult it may be for plaintiffs and their attorneys to discern what has happened before the initiation of a claim and the acquisition of knowledge that comes from the investigations, consultation with experts, and sharing of information that litigation triggers. Previous research has described tort litigation as a process in which information is cumulatively acquired. (academic study report)[28]

Nearly eighty percent of the administrative costs of the malpractice system are tied to resolving claims that *have* merit. Finding ways to streamline the lengthy and costly processing of meritorious claims should be in the bulls eye of reform efforts. (academic study report).[29]

Claimants are often simply attempting to ensure that the error is not repeated. (academic

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[24] Horan, David Wm, MD, JD, *Risk Reduction From A Plaintiff Attorney's Perspective,* Chapter 3 from *Medical Malpractice: A Physician's Sourcebook*, edited by Richard E. Anderson, MD, FACP, Humana Press (2005).

[25] Sharpe, Virginia, *Accountability and Justice in Patient Safety Reform*, Accountability, citing Sloan and Hsieh 1990; Vidmar 1995; Weiler, Hiatt, and Newhouse 1993; Burstin et al 1993

[26] Lebed, Marc R., McCauley, John J., *Mediation Within the Health Care Industry: Hurdles and Opportunities,* Georgia State University Law Review, Volume 21, Number, 4, Summer, 2005, pps. 911, 923.

[27] Studdert, David, Mello, Michelle, Gawande, Atul, Gandhi, Tejal, Kachalia, Allen, Yoon, Catherine, Puopolo, Ann Louise, Brennan, Troyen, *Claims, Errors, and Compensation Payments In Medical Malpractice Litigation,* New England Journal of Medicine, Volume 354: 2024-2033, Number 19, May 11, 2006.

[28] Ibid.

[29] Harvard School of Public Health: Press Releases, 2006 Releases, *Study Casts Doubt on Claims That the Medical Malpractice System Is Plagued by Frivolous Lawsuits.*

study report)[30]

At some point we must all bring medical mistakes out of the closet. (physician)[31]

A transformation in how the medical profession communicates with patients about harmful medical errors has begun. (academic journal)[32]

We can't reconcile these statements. How can we stop the finger pointing, the blaming? How can we change the conversation so that we can change the culture? It seems, based on the foregoing comments, that many of the stakeholders, such as insurers, are still thinking and talking in the old ways of blame and finger-pointing, while new evidence of change and new ways of thinking are leading us to a cultural shift. How do we bring all the stakeholders into the room, such that they can discuss new ideas and new evidence, leading all of us to a healthier, more healing place in the medical error context? The way we do that is through what I think of as appreciative dialogue, an infusion of appreciative inquiry[33] into dialogue.[34] Appreciative inquiry, very simply, is a process that focuses on what is working and what unites us; once we determine what is working, we can think together to determine steps to move forward together.

How do we take blame out of the typical conversation? Mutual blame is divisive and erects walls between us. We can define blame out of bounds by setting rules in our conversations that blame talk is not permitted, not even disguised as questions.[35] We can set aside blame in favor of interdependent relationships.[36] Rather than: it's the lawyers who want to line their pockets, it's the insurance companies who never want to pay any claims, etc., the conversation becomes: how do we move forward toward our common goal: patient safety/quality improvement in health care/protection of the injured party? How do we find new ways of relating? A useful approach is telling our stories about our roles in the process (litigation, claims, medical error), because our stories are generally straightforward, easy to tell, not threatening to

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[30] Dauer, Edward, Marcus, Leonard, *Adapting Mediation To Link Resolution of Medical Malpractice Disputes With Health Care Quality Improvement,* 60 Law & Contemp. Probs. 185 (Winter 1997).

[31] Hilfiker, David, *Facing Our Mistakes,* New England Journal of Medicine, January, 1984

[32] Gallagher, Thomas H, Studdert, David, Levinson, Wendy, *Disclosing Harmful Medical Errors to Patients,* N Engl J 356:26, June 28, 2007.

[33] David Cooperrider, et al, *Appreciative Inquiry Handbook, the First In A Series of AI Workbooks For Leaders of Change,* Lakeshore Communications, Inc.: Bedford Heights, OH, 2007; Kathleen Clark, *Appreciative Inquiry: It's Not Easy, But It Is Simple,* Law Practice Management On Line, 2004, <www.abanet.org/lpm/lpt/articles/mgt09041.html.>

[34] For instance, pose a question using the quote "A transformation in how the medical profession communicates with patients about harmful medical errors has begun." (NEJM, 356:2713-9) Is this accurate in the experience of the health care providers/participants in this dialogue? How does it manifest itself? Tell a story about it in your experience? How can we expand on that process? If not accurate, why do you think that is? How would you start that process? How would you dialogue in the workplace about it?

[35] This is particularly difficult for an attorney; after all, we either wear the white hat or the black hat!

[36] Gergen, Kenneth, *An Invitation to Social Construction,* Sage Publications Ltd: California, 1999.

other participants, blame-free, and tend to generate acceptance. If I'm telling my story, no one can say I'm wrong. It's very affirming to be heard, without judgment. It's very respectful to listen. If we can continue to suspend our differences while in dialogue, we may be able to join in an effort we all support. If we praise others' intentions, we can keep the conversation going, even while finding others' arguments wrong-headed. We can shift the conversation from combat to cooperation. We can work toward mutuality in language, such as: we have tension between us, rather than antagonism between us.

We have the option to add a voice that broadens our concerns to the ways in which we participate as a society in creating the conditions for most of what we devalue, in this case, destructive litigation. In dialogue, we may ask participants to talk about gray areas, doubts in their beliefs and to suspend their differences in order to work toward a goal we all support. For example: ask the insurer ("personal injury attorneys just want to line their pockets") versus the physicians/medical practitioners ("The profile of non-error claims we observed does not square with the notion of opportunistic trial lawyers pursuing questionable lawsuits…") vs the attorney ("Risk management is an effort to avoid liability, rather than an effort to avoid error. It is focused on managing risks of financial loss associated with malpractice suits, rather than on error analysis, safety principles, and corrective action associated with health delivery systems and care.") to suspend their differences and join in an effort we both/all support. That way, we can envision and work toward a future we can agree upon.

Dialogue has been shown to be transformative. One physician who took part in a dialogue that I facilitated in Florida on the subject of collaborative law and disclosure in adverse event/medical error situations stated, "Everyone came to this dialogue from the fringes, from different perspectives, having had different experiences; now, as we end this session, everyone is moving toward the center."[37] Just where we want to be: the center.

Continuing Communication With The Patient/Family After An Adverse Event: Disclosure and Disclosure Training

"To err is human, to cover up is unforgivable, and to refuse to learn is inexcusable."

-Margaret Murphy, patient safety advocate, Inspirational speaker, mother of Kevin Murphy, who, at 21 years old, lost his life because the Irish health care system failed him

Margaret Murphy stated: discussion and dialogue would have been so beneficial and useful after Kevin's death and would have avoided five years of trauma and uncertainly in

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[37] Irwin Kash, M.D., participant in dialogue in Ft. Myers, Florida, January 28, 2007.

litigation.[38] She tells us, as some of us have experienced, there is a better way; there is a window of opportunity, the "Golden Moment", as Albert Wu, M.D. calls it. That Golden Moment exists on the heels of an adverse event: the time to disclose, to communicate with the patient, or, in the case of Margaret Murphy, the family, about what went wrong, to answer questions, to listen to the patient/family's experience, to express sorrow and condolences, to take responsibility for the error, and to compensate. In addition, the Golden Moment provides an opportunity to improve patient safety, to inform the patient that anything learned directly from the patient and/or the adverse event will be used to prevent a similar event in the future to other patients, to take that learning into the future to help others. It is the best possible time to inform and respect a patient/family, generally in shock, disbelief and grief. Referring to disclosure after vision loss, John Potter wrote, "We discovered that some patients grieve over vision loss, and even loss that may not seem clinically significant can be unexpected for patients and lead to grieving. This understanding became the cornerstone of our program."[39] However, the Golden Moment is often lost due to inadequate training, defensiveness, loyalty to others, such as the hospital or other physicians, disputes with insurers, and/or fear of litigation/liability/reporting. Everyone wants to do the right thing, the physicians and other health care providers, but they may not know how.

Margaret Murphy said that, sometime after Kevin died, she met with the chairman of the World Alliance for Patient Safety, Liam Donaldson. She told him of Kevin's experience with the Irish health care system. Dr. Donaldson listened intently and noted the number of missed opportunities to save Kevin's life. He told Mrs. Murphy that any one opportunity taken would have been enough. She went home a changed woman because, at long last, someone had heard her**.** Mrs**.** Murphy stated that Dr. Donaldson validated the patient experience**.**

Margaret Murphy's story speaks to all of us. It is about our shared humanity. The fact that Kevin died in Ireland is not relevant to this conversation. She could have had the same experience in the U.S. in any one of dozens of hospitals under the care of any number of physicians. If physicians and, at least for a portion of the training, attorneys were trained in the disclosure process, each would know of the option to disclose and the healing possibilities, as well as the support and compassion available to those who chose the disclosure option. Also, as noted elsewhere herein, training together brings attorneys and physicians onto common ground, into the part that each of them can play in caring and healing the patients and each other.

The learning that awaits our medical communities through the disclosure process, through openness and acknowledgement of error, will, literally, change our world.

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[38] Margaret Murphy, keynote address, annual fundraiser, Medically Induced Trauma Support Services (MITSS), November, 2008, Boston, Massachusetts. Available at <http://www.mitss.org/7th_annualdinner_keynote_murphy.html.>, accessed February 2, 2009.

[39] John Potter, *Implementation of Dispute Resolution in Refractive Surgery,* available through john.potter@tlcvision.com.

Collaborative Law and Collaborative Law Training

In situations where a medical procedure goes awry (referred to herein as adverse events), litigation is traditionally thought to be the only road to a satisfactory remedy.[40] In theory, the tort system compensates the injured person or her/his family while punishing the health care provider(s). However, in actuality, the likelihood of a verdict or settlement in favor of a plaintiff is quite small.[41] The cases that go to trial expend tremendous time, money and emotional resources. Many cases continue for years, thereby increasing the expenditure of these resources for involved parties, their insurers, and those close to them, as well as entire communities. Remedies available in litigation are insufficient for meeting the fundamental needs of the injured party/family for information, recognition, apology, and patient safety improvements to prevent future harm and accountability.

To a great extent, medical malpractice cases often end in defense verdicts. "The legal system favors defendants, wearing down plaintiff/injured patient/family, often without compassion and consideration. It is a David and Goliath system with every effort made to settle without admission of liability."[42] In a recent dialogue, I learned that eighty five percent (85%) of medical malpractice cases that go to trial in Florida result in defense verdicts.[43] The national statistics are quite similar: eighty percent (80%) of the medical malpractice cases that go to trial result in defense verdicts.[44] The lengthy litigation process leaves all parties and the health care system depleted, having missed the opportunity to learn from each other and to improve the

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[40] Mediation often falls within the litigation process. When it does, by the time the matter gets to mediation, the parties are generally entrenched in their adversarial positions, with little hope of interest based negotiations. In addition, the parties, having moved some way through the litigation arena, are more likely to look to the attorneys and the mediator to make decisions, rather than talking openly and making their own decisions, after consultation with their attorneys. Mediation, in addition, both inside the litigation process and as a stand-alone process generally involves monetary settlements to the exclusion of other matters, such as disclosure, apology, and patient safety issues. In addition, the attorneys for the parties are looking toward continuing litigation and trial if the case doesn't settle in mediation, rather than focusing exclusively on resolution based on the interests of the parties. Although mediation can be structured in any number of ways, it is often structured like a settlement conference, i.e. the mediator going back and forth between the parties trying to agree on a number, which does not promote ANY exchanges between the parties, often frustrating the needs of the parties.

[41] Out of every one hundred medical malpractice cases filed nationally, one case results in a jury verdict in favor of plaintiff for damages; six cases result in defense verdicts; twenty two cases are settled for a payout by defendants; and seventy one cases are dismissed by courts or dropped by plaintiffs. Lewis L. Laska, Esq., Medical Malpractice Verdicts, Settlements and Experts Newsletter (www.mmvse.com) , citing Journal of Vascular Surgery(2005) Vol 43, p. 635.

[42] Margaret Murphy keynote, MITSS Annual Fundraiser, November, 2008. Although Mrs. Murphy, who lost her son in Ireland due to failures of the health care system, is referring to the Irish legal system, similar comments have been repeatedly used about our legal system.

[43] Dialogue on Collaborative Law in Medical Error, Ft. Myers, Florida, January 23, 2007.

[44] Statement of the Physician Insurers Association of America Presented by Lawrence E. Smarr, President, Physician Insurers Association of America before a joint hearing of the United States Senate Judiciary Committee and Health, Education, Labor and Pensions Committee Regarding: Patient Access Crisis: The Role of Medical Litigation, February 11, 2003 (www.thepiaa.org/pdf-files/February_11_testimony.pdf).

health care system. The purpose of this article is to explore an alternative to medical malpractice litigation--one that can benefit patients, families, health care professionals and their insurers, attorneys and communities. .

Collaborative law[45] is a structured, voluntary, non-adversarial dispute resolution process involving a series of meetings with parties and attorneys in a structured process individualized to the case. In these meetings, all parties and attorneys work collaboratively toward a resolution unique to the facts of the case at issue and not limited by legal remedies.[46] At the first meeting of the parties and attorneys, the participation agreement, explained herein, is discussed and signed. Collaborative law focuses more on finding solutions than on finding fault. It recognizes concepts of fairness. It is a process that has been used exclusively in family law matters for approximately fifteen years. [47] This process is controlled by the parties and involves both total transparency and total respect for all involved. Collaborative law 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. Compared to litigation, which involves certainty of view and takes responsibility and decision-making from the parties and give it to a judge/jury/arbitrator, collaborative law leaves resolution to the parties and their attorneys. The process encourages early discussions that can involve listening, disclosure, apology (to the extent called for), proposed future patient safety solutions, compensation and healing. Patient safety is a primary concern of collaborative law, 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.

Collaborative law in medical error has the potential to be very effective. It provides a container in which the stakeholders to any resolution of medical error can collaborate to provide a fair process to the injured party. The stakeholders include the patient, the patient's attorney, the physician, and the physician's attorney. From time to time, depending on the circumstances, others may be required, such as the physician's insurer, hospital administrators/risk managers, or counsel for the hospital. This process gives the injured party/family members the immediate

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[45] For more extensive treatment of collaborative law in medical error (adverse event) situations, see Kathleen Clark, *The Use of Collaborative Law in Medical Error Situations,* The Health Lawyer, Volume 19, Number 6, June, 2007.

[46] Even if the process does not resolve the matter, the process has the potential for some healing, such that litigation, which is likely to follow the collaborative process, has the potential to be less adversarial because the parties have had an opportunity to see each other's humanity. As David Hall points out, "When we [lawyers] are as concerned with the process we use for resolving disputes as we are with the end product, then we are striving to make our work sacred." *In Search of the Sacred,* presented at the International Association of Collaborative Professionals (IACP) Conference, Boston, 2004.

[47] In the family law context, the structured meetings are known as "Four Ways" because the two parties and their attorneys, trained in collaborative law, meet to discuss the issues in the case. It is a team approach to resolution, which may involve forensic professionals, such as financial planners, working together in a respectful way, to bring resolution to the issues. The process could take several meetings over an extended period, but, in general, can move to resolution much faster and much more compassionately than litigation.

support and advice of a collaborative attorney. It is particularly important because, unlike the traditional malpractice method, the collaborative support and advice offered by the attorneys takes place in a situation in which the injured party is less likely to be at a disadvantage. Most face-to-face meetings between an injured party and a physicians(s) and other health care providers are marked by inequality of bargaining power; lack of control over the process; difficulties insuring a full and fair opportunity to be heard, to ask questions and have them answered; and little chance for smaller claims, which wouldn't be taken on a contingency basis, to be heard and resolved.

In the collaborative law process, physicians and hospitals are not co-defendants in an adversarial process, pointing the finger at each other. In the collaborative law process, they can work together, along with patients, on solutions to patient safety issues.

Finally, 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(s) or hospitals are 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 process gives attorneys the opportunity to take part in a non-adversarial, respectful interaction; to collaborate with the parties and other attorneys; to help create potential patient safety solutions; to handle more cases; to be paid on an hourly basis, without regard to winning or losing; and to cut down on stress. Hourly fees free attorneys from focusing exclusively on monetary damages (for their client's damages and their own contingency fees) giving them the opportunity to expand the process to address patient safety concerns. (Even if a medical error claim does not resolve and moves on to litigation, changes in patient safety procedures not directly related to the medical error can still arise out of the CL process.[48] In addition, even without resolution through the collaborative process, opportunities for healing have arisen and barriers to experiencing the humanity of each other may have dissolved, such that some healing may have taken place.)

For all involved, the process presents the opportunity for a learning experience and the potential for healing in a non-punitive setting. These words are not written lightly; the author does not mean to suggest, in a case in which the family is mourning the loss of a loved one or where there has been a life-threatening injury, that all agree to the collaborative process as a mere learning experience. The collaborative process, in terms of patient safety, can provide opportunities to focus on future patient safety, from which all can learn and help future patients, whether the case resolves in total or not, as determined on a case-by-case basis.

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[48] Examples of changes in patient safety procedures not directly related to the medical error could include: changes in night security procedures at a hospital, changes in charting procedures, and changes in intern/resident/other hospital personnel's interactions with patients/families.

The collaborative law process makes the experience of loss a more compassionate process, more compassionate primarily for the patient/family, but also for the physicians, the attorneys and the community outside the room. For this process to take hold, a shift in thinking will be necessary for attorneys (as well as physicians and other health care providers). The dialogue process creates the space for just that shift in thinking to take place. In addition, both disclosure training, as noted above, and collaborative law training will be considerably more effective when both physicians and attorneys are involved. Structuring disclosure and collaborative law as overlapping sessions within disclosure and collaborative law trainings bring together lawyers and physicians, healers all, to learn the processes of each other. This kind of structure brings the very real possibility that physicians and lawyers can help each other, create community, build teams, and stand in each other's shoes for a brief time.

As previously mentioned, collaborative law can be a healing process for all. Before physicians and lawyers get to the collaborative law process after an adverse event, training in both disclosure and collaborative law will be necessary. The disclosure and collaborative law trainings could overlap. For instance, lawyers and physicians could spend one or two full days together being trained in the disclosure process and in the collaborative law process. Then, the group could split for an additional day or two to focus on the particular skills required of physicians for disclosure, on the one hand, and attorneys for the collaborative law process, on the other. The overlapping days will be fertile ground for all, creating the space for attorneys and physicians to build community and trust, to mutually understand each other, and to shift their thinking from adversarial to cooperative. That is what happens when we see each other's humanity. We listen and we find opportunities to help each other.

Physicians, attorneys, other stakeholders and interested individuals and organizations need to keep talking about the significant issues to be addressed, whether it be in dialogue or in training, as set forth above, including fair compensation, disclosure, patient safety, attorney fees, and confidentiality. As we take part in any or all of these processes, we are each healing. We are each, more and more, doing our business in the light of day.

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