The Collaborative Continuum Associated with Adverse Medical Events

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Einstein told us to widen "our circle of compassion". This article is my response to Einstein's suggestion. It explores widening our *conscious* circle of compassion through the adoption of collaborative practices associated with adverse medical events. It delineates the practices through a focus on dialogue, communication and collaboration[i], primarily in law and medicine.

Abstract: *This article describes how the practices associated with collaborative law can translate to the context of adverse medical events. Drawing on the author's experiences, the article proposes a non-adversarial, direct, respectful and open negotiation process that focuses on dialogue, communication and collaboration among physicians, patients and attorneys and focuses on the language of collaboration, compassion and healing. This process is in contrast with responses and language that escalate the situation and lead to traditional malpractice. It details and illustrates with case examples how early face-to communication among all parties shortly after the adverse medical event – including disclosure, discussion and listening – can have multiple positive effects including the reduction of the risk of litigation, opportunity for healing for all parties involved and collective learning for future patient safety improvement.*

Key Words: *Adverse medical events, collaborative law, patient/physician/attorney collaboration.*

My journey to collaboration in health care began with a tragedy. My oldest and dearest friend lost her 2l year old son to medical error in 2003 at a hospital here in the San Francisco Bay Area in California. In the days and months after Eric died, Nancy and her family were not contacted by either Eric's physicians or the hospital. No explanation was offered, no apology made, no possible compensation presented. Because the health care providers made no attempt to talk to the family, they were unaware that the family had very useful first-hand information about Eric's care in the hospital, having sat by his bedside for several days before he died.

When the family first retained a traditional medical malpractice attorney, I suggested they tell the attorney what they wanted: an explanation, their questions answered, their thoughts, suggestions, and observations about Eric's care respected, an apology, and compensation. Their attorney planned to get them compensation; that was all the litigation process could provide them. I suggested that, if their attorney wouldn't seek what was most important to the family, i.e. explanation and apology, I could act as the family's advocate with the health care system. I wrote several letters on their behalf, making it clear that I was acting as their advocate, not their attorney, which brought no substantive response. The lawsuit settled in "shuttle" mediation, a process which involved Nancy and her family in one room, the physicians and hospital in another and the mediator shuttling between the two. The mediation was only about money. No face to face meeting occurred; the opportunity for explanation, apology and healing was lost, but, as it turned out, only temporarily.

After settlement in 2006, Nancy read an article in the local newspaper, quoting one of the physicians at the health care system where Eric was treated discussing disclosure[ii] and apology after adverse medical events. I recommended one further letter, explaining that the case had settled but, for the family, it was an empty process, leaving pain, grief, unanswered questions, and unrecognized suggestions. This final letter, which referenced the provider's new disclosure and apology policy, brought responses from two health care providers within the hospital system. One started meeting with Nancy to address her questions and concerns, consider her suggestions and recommendations, provide face-to-face opportunities for her to talk with physicians about her son, and apologize to her and her family. I recall asking the health care provider if there would be just one meeting for the family, to which the health care provider responded, 'we will meet with

Nancy as often as she wants for as long as she wants'. It still brings me to tears, writing all it. Although, tragically, it could never give Nancy back her son, it may have given her some peace, with the knowledge that her observations, comments and suggestions would help another patient. One part of the process involved Nancy speaking before twenty-five physicians, telling Eric's story, which, I imagine, in whatever small way, brought forgiveness and healing to both Nancy and the physicians.

At the same time that I was writing these letters and talking to Nancy and her family, I became aware of a group of attorneys discussing the collaborative law process and its possibilities in adverse medical event situations. I realized, listening on one of the calls, that what I had been seeking as Nancy's advocate with the health care system was a coming together, a collaboration, among the health care providers and Nancy and her family to listen, learn and move forward together to help others, based on Nancy's eye-witness observations of her son's hospital care and her suggestions to improve and enhance that hospital care. Although I acted as Nancy's advocate in that process, not her attorney, I was truly advocating a collaborative process. That was, as I mentioned, in 2006.

The Advent of Collaborative Practices in the Law

Traditionally, the collaborative process had been very useful in the family law arena in cases involving divorce, custody of children and/or distribution of assets, all cases in which emotions run very high. The collaborative process affords the opportunity for healing, a natural fit in cases involving not only family law matters, but adverse medical events as well. Because this hopeful, respectful and potentially healing approach to the law is much more in line with my thinking about what the practice of law could and should be, I continue to move toward it.

Collaborative law offers a "natural fit" in the adverse medical event context, encouraging immediate participation of the parties, in consultation with their attorneys, once an adverse medical event is suspected.

Collaborative law focuses more on finding solutions than on finding fault. It recognizes concepts of fairness. This process is controlled by the parties and involves both total transparency and total respect for all involved. Collaborative law is a 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, after adverse medical events, all parties, including patients, family members, physicians, hospital representatives, and their attorneys work collaboratively toward a resolution unique to the facts of the case at issue and not limited by traditional legal remedies (damages).

Collaborative law offers a "natural fit" in the adverse medical event context, encouraging immediate participation of the parties, in consultation with their attorneys, once an adverse medical event is suspected. The process encourages early confidential discussions that can involve disclosure, apology (to the extent appropriate), proposed future patient safety solutions, 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. The collaborative law process also supports the use of non-adversarial, non-deficit language[iii], such as participation, voluntary disclosure, continuing communication, and patient- and client-centered communication.

Collaborative law is a process that brings physicians, insurers, hospitals, patients and attorneys together to work collaboratively, turning the litigation process into a tremendous learning opportunity, involving a discussion of adverse events with error risk reduction as a primary remedial goal. The process is one of unlimited flexibility, shifting the conversation from one of blaming to one of collective learning. Although blame is not part of the process, accountability is.

The process encourages early discussions that can involve listening, disclosure, apology (to the extent called for), proposed future patient safety solutions, compensation and healing. These early discussions have the advantage of encouraging and supporting face-to-face communication shortly after adverse medical events, such that, even if the

matter does not resolve and turns into litigation, a true opportunity for healing has occurred in an open forum, controlled by the parties, and patient safety improvements maybe have been agreed upon.

Although the advent of this new practice has been daunting, my spirit, determination and dedication to collaborative practices after adverse medical events were recently reinvigorated by the 2009 settlement in the medical malpractice/wrongful death case of Michael Woods, the younger brother of American actor James Woods. The case was filed in July, 2006 by James on behalf of Michael's son, Peyton. From the beginning, the case had all the traditional elements of medical malpractice litigation. James Woods was angry, bitter, and alienated, feeling disrespected and unrecognized. Although Michael and James' mother was not a party, she was devastated and an integral part of the litigation process. By the end, the case had many elements of reconciliation: apology, acknowledgement, forgiveness, and collaboration, particularly transformative in light of the term associated with the case: 'unsettlable'. This case, like Nancy's, was and continues to be about our shared humanity, and understanding and caring about each other.

Briefly, Michael Woods died on a gurney in the emergency room of Kent Hospital in Warwick, Rhode Island, complaining of throat pain and other discomfort. A heart monitor was ordered but the order was never carried out. Instead Michael Woods died of a heart attack. What James Woods sought through the litigation process was compensation for his brother's son, but, more than that, acknowledgement of responsibility and an apology. Yet, Woods' attorney, Mark Decof, explained, and Woods understood that litigation would give the Woods' family only money, nothing more. James, totally devastated, wanted Kent Hospital and the physician to be held accountable. The case proceeded to trial with a new CEO, Sandy Coletta, of Kent Hospital playing an active role. Coletta told me that, as trial unfolded, she'd been thinking that she needed to talk directly with Woods. During the third week of trial, she told her attorneys what she wanted to do, that she "absolutely" had to talk to Woods. In response to the call to Decof from the hospital's attorneys, Decof was 'gratified', while Woods, at least at first, resisted. Decof told me he had never seen or heard of a situation in which a public apology and acknowledgement, particularly when a settlement was involved, had occurred in the middle of a medical malpractice trial. Decof, referring to Woods' 'open wound', asked Woods to meet with Coletta, knowing that a meeting was the only avenue to acknowledgement of responsibility and apology. He suggested to Woods that 'Woods might be able to look at the hospital differently through Coletta'.

That is exactly what happened. Coletta approached Woods and said, 'I don't know if anyone from Kent has ever said this to you, but I am so sorry about what happened to your brother.' Coletta acknowledged that 'Mistakes were made' and 'the hospital did not follow through on the order.' According to Decof, the apology shifted Woods' frame of mind from 'search and destroy to a conciliatory attitude'. Woods said he transitioned from hurt and anger to hope.

Decof spoke of both Woods and Coletta with great admiration and respect, telling me that the case would not have resolved without Coletta. He spoke of Woods' fierce intelligence, passion, energy, and commitment to his family, saying that Woods created a 'firestorm of attention' to this case. He called Coletta a 'wonderful, sincere person'; he could see 'in her face and in her eyes that she meant it all.' Decof said at the time, quite simply, 'I can't believe this is happening.' Even more amazing, Coletta and Woods and his family began to create a mutually beneficial partnership, the Michael J. Woods Institute, established to redesign the hospital's health care system from the emergency room up.

Woods, in a conciliatory statement, said, 'The experience of my brother Michael Woods shines a light on what can occur in any institution where individuals are called upon to make life and death decisions while facing the most challenging conditions. We are pleased to take an active role in creating new, innovative approaches to hospital and emergency care. We hope that this partnership can help save other families from suffering the loss that we suffered-even one precious life would ensure that his life was not lost in vain.' Coletta told me that she and Woods could keep Michael Woods alive by doing this work together.

The Woods' case was resolved through collaboration between Woods and Coletta. The case was settled through collaborative resolution, not formal collaborative law, but certainly in the spirit of collaborative law.

Collaborative Dialogue

Inviting and involving attorneys in the collaborative process in adverse medical event situations proved something of a struggle. To be fair to attorneys, talking about new ways of doing things is threatening to most groups. After attending two conferences at which it seemed there was much nay-saying, finger-pointing, and negative assumptions about other stakeholders (i.e., insurance companies --everyone's favorite bad guy -- won't ever agree to the process, defendants' attorneys won't turn over any records without court battles, plaintiffs' attorneys won't give up contingency fees, plaintiffs just want lots of money, physicians won't admit error, hospitals won't take responsibility),[iv] I moved upstream in my thinking, designing another collaborative process: dialogue with health care stakeholders, including attorneys, in which there was no room for blame, shame or finger-pointing.

Central to the dialogue process is Appreciative Inquiry (Cooperider & Whitney, 1999; Clark, 2004). Appreciative Inquiry focuses on possibilities, not problems; it focuses on what is working so we can do more of it. This method seemed a perfect choice for this type of dialogue, bringing together as it would professionals who knew the possibilities of similar compassionate, non-adversarial processes and those who had no experiences with the collaborative process or any other non-adversarial, healing process. It brought together, in non-threatening conversation, yeah-sayers and nay-sayers who were willing to listen, share and consider, as well as propose, possible solutions to areas of conflict or misunderstanding. The hope was that the stakeholders could agree on a goal, such as improved patient safety, one they could all immediately appreciate and work toward. The professionals who had successfully used this type of process included attorneys, insurers, risk managers and patient advocates, among others. Although those processes were not formally known as collaborative law, they certainly fit within the spirit of collaborative law.

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In dialogue, I asked participants to talk about what worked for them, gray areas, doubts in their beliefs and to suspend their differences in order to work toward a goal we all supported. I sought to set aside stereotypes and misunderstandings, such as:

> Personal injury attorneys just want to line their pockets.
>
> The profile of non-error claims we observed does not square with the notion of opportunistic trial lawyers pursuing questionable lawsuits…
>
> 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.

The process was collaborative, involving the posing of questions that encouraged participants to reflect on their experiences of the adverse medical event/malpractice conflict. It promoted communication across misconceptions, misunderstanding and differences and to develop trust, such that teamwork across professions is workable. 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. These dialogues proved very informative and brought various professionals, including health care providers and attorneys, into a shared process, helping create new thinking, connections, and cultures.

Dialogues that I've convened and facilitated have included physicians, patients, patient advocates, mental health workers, attorneys, insurers, hospital administrators, and risk managers. The dialogue process provides open forums for participants to both share their successes, difficulties and struggles, as well as hear the successes and struggles of other participants. As a result, brainstorming takes place, creativity blossoms, and shared thinking and understanding arise.

The Golden Moment: Patient and Physician Collaboration

President Obama and Secretary of State Clinton noted that "studies show that the most important factor in people's decisions to file lawsuits is not negligence, but ineffective communication between patients and providers. Malpractice suits often result when an unexpected adverse outcome is met with a lack of empathy from physicians and a perceived or actual withholding of essential information."[v] I will illustrate the President's point about communication after adverse medical events with the stories of three families. There are thousands of other families with similar stories.

The story of Margaret Murphy, a mother who lost her 21 year old son, Kevin, in Ireland due to adverse medical event illustrates the heartbreak, devastation, and unanswered questions. Kevin Murphy died as a result of a series of missed diagnoses, missed communication, lost opportunities, and inappropriate medical care. Kevin was hospitalized with hypercalcaemia, a relatively common clinical problem that most often is related to hyperparathyroidism. Prognosis is normally excellent when the underlying cause is identified and treatment is initiated promptly.[vi] Unfortunately, that wasn't to be the case. One instance of missed communication was Kevin's lab results, which were placed in his chart on a post it note, which later fell out. Murphy (2008) stated: discussion and dialogue would have been so beneficial and useful after Kevin's death and would have avoided five years of trauma and uncertainty in litigation. 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. 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'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. Margaret Murphy now, literally, works for patient safety around the globe.

Although the golden moment was lost after Kevin Murphy died, it was not lost in either the Josie King or Kaelyn Sosa cases, both of which brought collaboration and healing to those involved. In both cases, the health care providers responded quickly, promptly informing the families what had occurred, maintaining and strengthening communication through openness and explanation. The families became, at once, participants in the patient safety process, helping future patients, physicians, and themselves heal.

Sorrel King lost Josie, her 18 month old daughter, at Johns Hopkins in 2001 due to medical error. According to Sorrel, lack of communication is what killed Josie. Sorrel sat by Josie's hospital bedside as a nurse administered medication. Sorrel told the nurse that the medication being administered had been discontinued, but the nurse said that the medication was appropriate and prescribed for Josie. Sorrel didn't argue, thinking that Johns Hopkins couldn't make a mistake about Josie's medication, since Johns Hopkins was one of the best medical centers in the world. Sorrel said, "Josie died because people didn't listen. They didn't listen to me and they didn't listen to each other."

According to Sorrel, "About a week and a half after Josie died, George Dover, the head of the children's center [at JH], came to our house and sat down with my husband and I and he basically said that this happened at my hospital, it shouldn't have happened, and I take full responsibility for it and I'll get to the bottom of it...he also said that his phone would be available for me and for Tony and that he would talk to us every Friday at 1 o'clock for however long we wanted."[307]

Sorrel and Dr. Dover spoke every Friday. At the same time, Josie's parents and their attorney were talking settlement with JH. Sorrel wanted to settle but didn't want to give up those conversations. Sorrel suggested giving some of the settlement monies to JH to set with a patient safety program and the Josie King Foundation, which is dedicated to reducing medical errors, was born, keeping alive the collaboration which had developed between JH and Josie's parents. Sorrel, like Margaret Murphy and James Woods, turned tragedy into advocacy to the benefit of all of us.

Disclosure supports collaboration and communication…

Sorrel now speaks around the country about Josie and medical error. Sorrel presented at grand rounds at a Pennsylvania hospital and then walked patient safety rounds with the physicians. On the rounds, when the patient safety officer asked the nurses what they wanted more than anything to keep their patients safe, the answer was always better communication. As Sorrel noted, they didn't want fancy equipment or better technology; they wanted better communication: with doctors, with patients, with nurses, with families (King, 2007).

Another golden moment that so struck me about communication after medical error is the story of Kaelyn Sosa, an 18 month old who was taken to the ER by her mother after a bumped head. She left the hospital with a severe brain injury after a breathing tube was dislodged while she was sedated for an MRI procedure. The hospital took steps to ensure that disclosure of mistakes took place quickly so that learning from mistakes could begin (Landro, 2009). Kaelyn's mother stated that the hospital's candor helped her move past the initial shock. After settling her case against the hospital, she began serving as community liaison on the hospitals' quality and patient safety committee and observed immediate changes in hospital systems as a result of her collaboration with the hospital: another shining example of turning tragedy into advocacy.

Disclosure supports collaboration and communication, as the King and Sosa stories make clear. An open, transparent, respectful disclosure[vii] process after adverse medical events presents the opportunity to address patient safety issues by examining first hand information from the patient/family and encouraging cooperation among the patient/family, the physician, and other health care providers, as necessary, to both learn from the experience and develop revised systems or practices to protect the health of future patients. Taking adverse medical events out of the realm of secrecy and obfuscation, and into an open, transparent process will (and has) created tremendous time, financial, and emotional savings. The more transparency there is in our health care system after adverse medical events, the more patient safety is improved and the less defensive medicine, to the extent it exists, will be the focus of our what's-wrong-with-medicine (or law) conversations. The disclosure process presents the opportunity to bring into the open patient safety issues, first hand information from the patient/family, and cooperation between the patient/family, the physician and other health care providers, as necessary, in developing revised systems or practices to protect the health of future patients.

Language that Supports Human Connection

I have woven the importance of the use of language throughout this article. It is significant in the medical error context in both law and medicine. As we address adverse medical events/medical errors and our responses to them as professionals, patients, and members of our communities, it is most helpful if we use the language of collaboration, compassion, and healing. Much of the language, however, is about blame, is divisive and erects walls between us, separating rather than uniting us. For instance, attorneys use the language of battle after adverse medical events: discovery battle, complaint, sanctions, pre-litigation, binding, mandatory, and order, among others. In the public debate, we hear: defensive medicine[viii], liability reform, caps on damages, and tort reform, all terms laden with blame, blame of attorneys, the courts, and our judicial process. Physicians involved in medical error are often referred to as "offenders"; patients have "complaints". We can define much of that and other language of blame out of bounds by setting rules in our conversations that blame talk is not permitted, not even disguised as questions.[ix] We can set aside blame in favor of interdependent relationships (Gergen, 1999), thereby expanding the possibilities for more efficient, less costly, more healing health care that recognizes the humanity of all of us.

How do we find new ways of to do that, new ways of relating? Perhaps, we can reframe the conversation from combat to collaboration, from acrimony to hope. Rather than: it's the lawyers who want to line their pockets, it's the insurance companies who never want to pay any claims, etcetera, the conversation could be: how do we move forward toward our common goal: patient safety/quality improvement in health care/protection of the injured patient?

We can work toward the language of collaboration, such as: we have differences of opinion between us, rather than anger or antagonism between us. Rather than: physicians practice defensive medicine because lawyers are always suing them, our conversation could be what can all of us do collaboratively to prevent medical error in the first place and, in situations in which we can't, how can we work together to bring learning, respect and healing after medical error. As former United States Senators Barack Obama and Hillary Clinton (now President and Secretary of State, respectively) said so eloquently in the MEDiC legislation article they authored in the New England Journal of Medicine (NEJM) in 2006 (and the MEDiC legislation itself): all parties, including physicians, insurers, hospitals and patients (as well as attorneys) must work together to shift our response from placing blame to a goal we can ALL agree on: patient safety (Clinton & Obama, 2006).

Restoration of dignity can only take place after true disclosure and apology.

Briefly, my own recent experiences with language in the framework of law and/or medicine are illustrative. I recently put together a symposium, which I called: *Bringing Healing to Law and Medicine*. I listed myself as the Convener on the flyer for the program. When a large bar association asked to take over sponsorship, they asked me if I would refer to myself as either the Symposium Program Chair or the Symposium Chair. I responded that Convener suggests to me someone bringing together an informal gathering for purposes of learning, while a Chair suggested more formality, not the message I intended. The bar association responded that, although other professions may be familiar with Convener, lawyers are familiar with Chair. So, we agreed on what is familiar to lawyers. Something else came up for me about the same symposium. When I was developing the project, before the bar association asked to sponsor it, I called the symposium, as noted above, *Bringing Healing to Law and Medicine*. I thought the bar association might ask if I would change the title, having been told many times in the past not to use the word, "healing", because it is not part of either our legal language or our traditional legal culture. However, I was not asked to change the title, a good sign, since this entire process is about healing. That in itself, totally aside from the symposium, is transformational.

Law and Medicine Collaborating with Families to Further a Productive Care Continuum

All these processes, dialogue, disclosure and collaborative law, allow the participants to set aside blame, expedite change, and focus on moving forward. They all focus on the future, not the past, although they help us learn from the past and take that learning into the future to help others. They bring us together in collaboration and healing. There is much, much more in health care to discuss, but I'll save that for another time.

The learning that awaits our medical communities, those that are not participating in this process already, through the disclosure process, through openness and acknowledgement of error, will, literally, change our world. Restoration of dignity can only take place after true disclosure and apology. Patients have a moral claim to disclosure. To be able to witness this process, to facilitate it and support it, is something for which I, as an attorney, will be very grateful. For all involved, the process presents the opportunity for a learning experience and the potential for healing in a non-punitive setting.

The learning that awaits our legal communities will change the legal world as well. The Woods case alone has already begun to transform our thinking. Listen to the words of Mark Decof, that the Woods case caused him to be encouraged that lengthy, harsh, adversarial litigation is preventable. He stated, 'This case can be looked at as a model for how claims can be addressed in the future. It is an example of how management at hospitals can take the bull by the horns, irrespective of advice management was getting from litigation counsel. It takes participants getting involved with genuine desire to make this type of process happen. It opens up a whole new way of communicating. The ice has been broken. I'm hoping that it will happen with other cases.' Woods said, 'This remarkable action of accountability has turned a bitter event into a landmark opportunity for hope.' Further, he noted, 'It's best to resolve differences without invoking the court system'.

Decof now has a relationship with Coletta, which he hopes will help pave the way to resolving these types of cases with a similar approach, which will include non-adversarial, direct, respectful, and open negotiations. Cole. She said no one had ever talked to Woods directly because there was no protocol for that; the system had no mechanism to do it. When I asked her how she sees herself, after the Woods case, working with attorneys for the hospital after adverse medical events, she responded that 'we need to accept our weaknesses just as we celebrate when we do well. Kent and hopefully all hospitals will be more willing to step up and address issues when they happen'. She also wants to remove

legal roadblocks, which, although intended to protect the hospital, 'only get in the way, preventing us from doing the right thing'.

The attorneys in the Woods case were playing their accepted roles - within the legal system- and didn't that contribute to the problem in this case? The Woods case illustrates that Kent, the client, was willing to take a different approach to resolving an angry situation. Could attorneys, rather than staying confined to the conventional wisdom of what litigators should do and how they should act, take the lead in facilitating non-adversarial practices in health care, ones that allow us to practice law in a healing, hopeful way, one in which future patients and our communities in general are, at least informally, parties to the process? Could we be helping health care providers to build, rebuild, and mend their relationships with patients and their communities? The Woods case affirms, 'Yes' to both, when there is an opening for shifts in thinking by all involved. Even more profoundly, can the attorneys play a role in *creating* those shifts? Those attorneys who can make this shift will lead the way. Unless and until we make these shifts, we, the attorneys, will be left behind.

The Woods case is tremendously hopeful and healing on so many levels. My hope is that we use it as a model to move forward so that attorneys can be an active part of this non-adversarial good work, giving, as it does, a voice to the patients and their families, while helping them strengthen their connection with their health care providers. Shifts in thinking need to take place all the way around, not just with the health care providers, but with hospital management, insurers, and attorneys. All of us can participate in redesigning the health care system and its juncture with the legal system, working as a team. This is a rare opportunity in which we, as attorneys, can bring our skills, expertise, experience and humanity to truly assist in healing health care.

Opportunities for Physicians and Attorneys to Collaborate

Helen Keller said: "There is just one thing worse than being blind and that is having sight but no vision" (Murphy, 2008). Can physicians[x] and attorneys create a common vision in the arena of responding to adverse events/medical errors? Do we already have one, perhaps unspoken? What if the 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" (Reid, 1992).

The American Bar Association (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.*[xi] Lawyers have a special responsibility to our communities, to build and expand a true sense of community, including working to improve the quality of justice. According to Link (2007) "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." Chief Justice of the United States Supreme Court Warren Burger (1983) has said, "The healing function ought to be the primary role of the lawyer in the highest conception of our profession…the current generation of lawyers, or at least too many of them, seem to act more like warriors eager to do battle than healers seeking peace."

Similarly, the American Medical Association's (AMA) 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 suffering and contribute to human well-being*."[xii] The first principle of the Code of Medical Ethics of the AMA reads, "A physician shall be dedicated to providing competent medical care, *with compassion and respect for human dignity and rights* (Rinpoche, 2006). Richard Horton (2007) 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…" President Obama got it right when he said to the AMA convention in Chicago: You entered this profession to be healers-and that's what our health care system should let you be.

The common threads between physicians and lawyers are many: human well-being, healing, justice, 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 adverse event/medical error situations will be a giant step forward.[xiii] Perhaps a place to start with the expansion of our collective vision is with the words of U.S. President Obama (2009) spoke about the importance of transparency in his inaugural address: we "will do our business

in the light of day". Let all of us, coming from our various professions, building upon our common vision, do our business in the light of day, particularly after adverse medical events. A culture of transparency, practicing in the light of day, particularly when the consequences for physicians can be serious, already exists in some health care facilities and is spreading to others, sometimes quickly, sometimes slowly.

There is tremendous opportunity for collaboration in health care, collaboration that breaks down barriers between and among us and leads to healing, both before and after adverse medical events. President Obama (2009) stated recently that he is "proposing that we move forward on a range of ideas about how to put patient safety first and let doctors focus on practicing medicine." All of this suggests that the thinking of at least some of the relevant stakeholders in the medical error conversation is coming into alignment.

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Endnotes

[i] Collaboration is a recursive process where two or more people or organizations work together in an intersection of common goals. http://en.wikipedia.org/wiki/Collaboration.

[ii] Disclosure conjures up 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." p. 5.

[iii] It is useful (and hopeful) to stay away from the language of deficit, in health care. In the medical error context, replace "incident report" with "patient safely learning report". Because priority is defined as "taking precedence logically" and value is defined as "intrinsically valuable.

[iv] One of these conferences involved an early morning session at an ABA Dispute Resolution conference, put together quickly, involving a small panel of practitioners of portions of the collaborative law process in medical error situations (non-adversarial), with an audience of medical malpractice attorneys, who questioned the possibilities suggested by the collaborative process.

[v] Infra at footnote 4.

[vi] http://www.familycenteredcare.org/advance/pafam-murphy.html.

[vii] "The disclosure process surrounding a medical error should be viewed simply as one aspect of the ongoing dialogue between the patient and physician regarding the patient's health and health care. Non-disclosure is disrespectful; it adds insult to the injury caused by the error. The initial provision of information can be viewed as a natural part of the ongoing patient-physician dialogue rather than as an isolated disclosure." Wu, A. *Removing Insult from Injury.* Without disclosure, there is only silence: no learning, only secrets and withholding.

[viii] "The disclosure process surrounding a medical error should be viewed simply as one aspect of the ongoing dialogue between the patient and physician regarding the patient's health and health care. Non-disclosure is disrespectful; it adds insult to the injury caused by the error. The initial provision of information can be viewed as a natural part of the ongoing patient-physician dialogue rather than as an isolated disclosure." Wu, Albert, *Removing Insult from Injury.* Without disclosure, there is only silence: no learning, only secrets and withholding.

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

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

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

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

[xiii] 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.

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