Bringing Dialogue and Collaborative Law to Health Care

Kathleen Anne Clark

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PROEFSCHRIFT

ter verkrijging van de graad van doctor aan de Universiteit van Tilburg, op gezag van de rector magnificus, prof. dr. Ph. Eijlander, in het open-baar te verdedigen ten overstaan van een door het college voor promoties aan-gewezen commissie in de Ruth First zaal van de Universiteit op maandag 24 november 2008 om 10.15 uur

door

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Abstract

Background includes collaborative law, traditional only in family law; medical error situations, resulting, for various reasons, in either no action or medical malpractice litigation; separation and animosity between attorneys and physicians; and fear, mistrust and misunderstanding among physicians, insurers, attorneys, patients and others about medical malpractice.

I determined to address the question: How can we: begin to transform the cultures of law, medicine and professional liability insurance, such that collaborative law, a non-adversarial, voluntary process in which the parties make their own decisions, becomes a viable option to traditional medical malpractice litigation, and give all the stakeholders a healing voice in the process?

To begin to look at this question, I brought together, in dialogue, using an appreciative inquiry framework, a positive, compassionate, forward-looking theory, the many stakeholders/participants who need to communicate and collaborative with each other to take collaborative law or a similar compassionate process into the future. The stakeholders included injured parties and their families, physicians, insurers, risk managers, hospital personnel, other health care workers, patient advocates, therapists and other mental health workers, medical ethicists, regulators of both the medical profession and hospitals, and plaintiffs and defendants' medical malpractice attorneys, many of whom have been, invariably, at odds with each other. The issues we attempted to address, to name a few, included responsibility (is medical error individual physician failure or systemic failure or some combination of the two), deterrence, punishment, disclosure, reporting, (National Practitioners Data Bank (NPDB), various state agencies), patient safety issues, attorneys fees, confidentiality, and inconsistent requirements regarding disclosures (liability insurers, The Joint Commission (formerly known as the Joint Commission On Accreditation of Healthcare Organizations (JCAHO)), American Medical Association (AMA), and statutes).

Results of the dialogues brought forth common themes across professions, common goals, increased trust, concrete attempts to build community, ideas about other professions/groups to bring in to continuing dialogues, thinking and discussion about expansion of the collaborative law process to bring underserved communities into it, close examination of similar processes that are known to be effective, and openness to new ideas and suggestions.

De achtergrond van deze thesis wordt gevormd door zaken zoals collaboratieve wetgeving, die traditioneel alleen maar voorkomt in familiewetgeving; kwesties van medische fouten die om uiteenlopende redenen uitmonden in hetzij geen actie of procesvoering tegen dergelijke fouten; gespletenheid en vijandigheid tussen advocaten en dokters; en vrees, wantrouwen en misverstanden tussen dokters, verzekeraars, advocaten, patienten en nog andere mensen rond medische fouten.

Ik heb besloten om mij bezig te houden met de vraag: Hoe kunnen we: een begin maken met het transformeren van de verschillende culturen, in de wet, in de medicijnen, en in de professionele aansprakelijkheidsverzekering, zodanig dat een collaboratieve wet, een niet-vijandig, vrijwillig proces de traditionele procesvoering rond medische fouten kan vervangen, waarin de verschillende partijen hun eigen beslissing kunnen nemen en alle betrokkenen een genezende stem krijgen.

Als eerste stap in het zoeken naar een antwoord op deze vraag heb ik de verschillende mensen die er belang bij hebben om met elkaar te praten en samen te werken om deze collaboratieve wet of andere vergelijkbare vormen van medelevende processen te ontwikkelen, bij elkaar gebracht en met elkaar laten dialogeren, en wel volgens de methode van het waarderend onderzoek, d.w.z. een positieve, medelevende, en vooruit-ziende methode. De belanghebbenden waren getroffen mensen en hun familie, dokters, verzekeraars, risico-managers, ziekenhuispersoneel, andere mensen uit de gezondheidszorg, advokaten van patienten, therapeuten en andere mensen uit de geestelijke gezondheidszorg, ethici op het gebied van de geneeskunde, regelaars van zowel het medisch beroep als van ziekenhuizen, advokaten van zowel beschuldigden als schuldeisers rond medische fouten, die in vele gevallen het met elkaar aan de stok hebben gehad. De zaken waarover we het probeerden te hebben waren zaken zoals verantwoordelijkheid (zijn medische fouten tekortkomingen van de individuele dokters of zijn het fouten in het systeem, of beide), elkaar afschrikken, straffen, onthullen, rapporteren (de Nationale Practioners Data Bank (NPDB), verschillende staatsinstellingen), kwesties van patient-veiligheid, fees voor advokaten, vertrouwelijkheid, en inconsistente vereisten met betrekking tot openbaarheid (aansprakelijkheidsverzekeraars, The Joint Commission (vroeger bekend als The Joint Commission On Accreditation of Healthcare Organizations (JCAHO)), de American Medical Association (AMA), statuten.

Deze dialogen resulteerden in gemeenschappelijke themas over de grenzen van de beroepsgroepen heen, in gemeenschappelijke doelen, toename in vertrouwen, concrete pogingen om een gemeenschap tot stand te brengen, ideeen om andere beroepen/groepen bij de dialoog te betrekken, denken en discussieren over de verruiming van het collaboratief proces tot onderbediende groepen, nadere studie van vergelijkbare processen elders die hun nut hebben bewezen, en openheid voor nieuwe ideeen en suggesties.

Contents

Dedication

To Kevin, my son, who is wise, compassionate, smart and caring beyond his years;
and
To Eric, who left his parents and brother, along with his extended family, friends, and community, far, far too soon;
and
To Nancy, Eric's mother, a truer friend (since the third grade) I can't imagine;
and
To my dad, who said "Who cares if you're 60; just go do it";
and
To my siblings, Mary Ellen, Francie, Joan, John and Ed, all of whom are smart, interested, interesting, wise, compassionate, community-minded and caring;
and
To other friends, supporters, listeners, readers, and thinkers, including Marcia Lassiter, Mary Graves, Susan Jacob, Denise Phoenix, Sally Hedman, Janice Nicholson, Janine Ogando, Jackie Burke, Jack Weir, Carl Horn, Steve Keeva, Susan Belgard, Ruth Rickard, Karen Fasler, Sherrie Abney, Larry Maxwell, David Hoffman, Jim Heiting, Stacey Langenbahn, Kim Wright, Jeanne Fahey, Nora Bushfield, Shelly Finman, Jane Tishkoff, and, last, but certainly not least, Sheila McNamee, my adviser.
and
To all the dialogue participants and the lawyers and health care workers who work tirelessly to bring healing to the rest of us.

Prologue

My journey to this dissertation began early on in my practice of law. Each day, from the day I started practicing law, I came home discouraged and frustrated. I was a litigator, who argued in briefs and argued in court and argued at deposition and argued on the phone. At least, that is how it felt to me. I always felt like two personalities: one, the woman who wore a suit of armor as I walked out the door, an argumentative, angry, strident lawyer, and the other, the mother, sister, daughter, friend, and neighbor, a sane, loving, compassionate member of society. That all changed one day, in 2001 when I read *Transforming Practices,*[1] by Steve Keeva, an American Bar Association editor, about lawyers and their traditional role in society as healers. I felt like I'd been struck by lightning! Steve wrote these kind and caring words about lawyers even though he isn't one. From that day forward, I stopped (well, I tried to stop) complaining with other litigators about how awful it was to be a lawyer, working way too many hours, doing very little that was constructive and positive, living in the shadow of malpractice, exhausted all the time.

Another book that had a similar effect on me, written by Carl Horn III, a lawyer and U.S. Magistrate Judge[2], also addresses the traditional role of lawyers as counselors, brokers of reconciliation and peacemakers, as well as lawyers who feel that being a lawyer involves a deep moral commitment, that it is a position not only of prestige, but of honor.[3] At the very heart of

[1] Steven Keeva, *Transforming Practices, Finding Joy and Satisfaction in the Legal Life*, Contemporary Books: Chicago, 1999.
[2] Carl Horn, III, *Lawyer Life: Finding A Life and A Higher Calling In The Practice of Law,* American Bar Association: Chicago, 2003.
[3] Judge Horn tells us that "once we affirm law as a calling that transcends client or self-interest, the remaining points [lawyers striving to serve the common good to lawyers acting as counselors, officers of the court and peacemakers] fall into place." Ibid, p. 18

the legal profession is a calling[4], to public service, according to Judge Horn. Yet another book I just discovered on spirituality and lawyering is David Hall's *The Spiritual Revitalization of the Legal Profession; A Search For Sacred Rivers.*[5]

I kept reading more like-minded authors and started attending conferences and talking to creative thinkers about law as a healing profession, while, at the same time, pursuing other education and interests. The trail from a litigator to a healing lawyer took me from Keeva's book to the International Association of Holistic Lawyers (IAHL), headquartered in Vermont, referenced in Steve's book. I investigated IAHL and wound up at the IAHL Annual Conference in Vermont in September, 2001 (which put me in New York City with family on September 11, 2001). At that conference, I met an attorney from Texas, a spiritual, thoughtful, and compassionate lawyer who talked to me about collaborative family law. He told me the International Academy of Collaborative Professionals (IACP) would be meeting in Oakland, where I lived at the time, in October, 2001. I showed up at the IACP conference and found a small group, approximately thirty people, talking about collaborative family law, a process that permits lawyers to be healers and peacemakers, in terms of families split apart by divorce. Since I have never been a family law attorney, I appreciated the possibilities of collaborative law[6] in the family context but did not see much of a future for me that involved collaborative law, although I certainly saw the principles in a healing context and as central to ALL areas of the law.[7] Years later, I began to see the real possibilities in other areas of the law, such as medical error situations.

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[4] A calling links a person to her/his larger community; the calling of each contributes to the good of all.
[5] David Hall, *The Spiritual Revitalization of the Legal Profession: A Search For Sacred Rivers,* The Edwin Mellen Press, Ltd: United Kingdom, 2005.
[6] Collaborative law, as more fully described herein, is a non-adversarial, respectful process in which all parties are heard and make their own decisions, with attorneys acting as counselors.
[7] To the extent I could at that time and later, when I was practicing on my own, I practiced in a non-adversarial way, trying to resolve disputes in a collaborative fashion, coming up with solutions that worked for everyone.

My interest in the use of collaborative law in medical error arose out of a tragedy, the death, in August, 2003, as a result of medical error, of a 21-year-old smart, funny, creative, hopeful, generous young man named Eric, the son of my oldest and dearest friend. By the time the hospital realized what was happening to Eric, after his many visits to urgent care, it was too late. He died in the hospital six days after his admission.

A short time after his death, I spoke to Nancy about writing a letter to the hospital on behalf of her and her family (Eric's dad, Ron, and Eric's brother, Jeremy). I told Nancy I would write to a physician at the hospital who I knew to be kind and caring, asking him to pursue an open and honest exchange between Eric's family and the physicians who cared for Eric. The family was in the midst of working with an attorney, going through the mandatory arbitration process required under the membership contract with the HMO. The mediation process the family and the HMO took part in was totally impersonal, the family and their attorney in one room and the hospital personnel with their attorney in the other. Assuming that the mediation process would be just as it turned out to be, I suggested to Nancy that I could contact the hospital as the advocate for the family. When the family agreed, I wrote to the physician I mentioned, asking for a meeting in which the physicians/hospital would answer the family's questions, disclose all relevant information, listen to any patient safety related suggestions the family had, and apologize.

My first letter brought a short response, with the information that there would be some follow-up and/or investigation and that my letter would be passed on to those who were familiar with Eric's care. Perhaps it was, but no response was forthcoming. Over a period of about eighteen months, I wrote two more letters, one in response to an article in the local newspaper in which a physician at the hospital was quoted, talking about the hospital's new disclosure and

apology process. When Nancy told me about that article, she and I were both very angry, since the hospital proclaimed its new policy for the community to read but didn't seem to apply it in response to Eric's family's request. My letter in response to the article, my third letter, brought a response; I received two messages from the HMO and Nancy began to meet with the ombuds/mediator at the HMO[8]. Nancy and her family were provided with some answers and support, neither of which they received in the formalized, compassionless mediation process. Also, issues of patient safety were openly discussed and, as a result, changes made in the HMO's practices. Healing became a real possibility. At a memorial service for Eric over Thanksgiving weekend, 2006, Nancy showed Eric's friends and family a proposed flyer that the HMO had prepared and planned to distribute to the community; it was dedicated to Eric's memory and set forth precautionary steps before getting a tattoo. I remember listening to Nancy talk about it, as she showed it to the group; I thought: this is one small step toward healing. The health care providers who are the HMO, perhaps overwhelmed and heartbroken with the tragedy of Eric's death and their responsibility for it, took one step toward healing Eric's family, friends, and community, as well as itself. In the face of the loss of Eric, it was such a small step, but a start, sending a message of compassion. This wouldn't have happened within the litigation process.[9]

At about the time Nancy first began these conversations with the ombuds/mediator, I started meeting by phone with collaborative lawyers from around the U.S. about expanding collaborative law outside the family law arena, into other areas of practice. To the calls, I brought some of my friend's story, as well as information I'd learned at conferences about

[8] By this time, Eric's family had settled their wrongful death case against the HMO. Therefore, the HMO did not respond to our request for meeting, discussion and disclosure to save money, as some have suggested, because the HMO had already settled the case.

[9] Another dear friend was hit by a car in a crosswalk. Because the driver's insurer refuses to offer a reasonable settlement, the case is going to trial. My friend would like an apology from the driver. However, my friend's attorney said, "We can probably get one, but it will cost you." That comment shocked me. Has anyone asked the driver? It could be a very healing process all around, taking the parties from an angry, adversarial process, for however brief a time, into healing and compassion.

various healing processes, alternatives to litigation, newly introduced into health care. From there, we started a separate series of conference calls on the subject of collaborative law and its uses in medical error. Since then, we've been moving forward with our discussions. In the meantime, I've been writing about this new process, talking about it at conferences, and dialoguing with the necessary stakeholders (plaintiffs and defense attorneys, insurers, risk management professionals, physicians, patients, patient advocates, medical ethicists, and other professionals).[10], [11]

Shortly after that, I attended a workshop at the Taos Institute on the use of collaborative practices in mental health, medicine, and education. I listened and thought: this is how the law can and should work; this is what I've been trying to do, without putting any label on it. The Taos/Tilburg PhD program was not far behind. My work in this program draws on my experience with legal concepts, training and practice, organizational development and management education, social construction, principles of Appreciative Inquiry, concepts of and experiences with dialogue, and personal spiritual principles.

[10] In 2007, The American Bar Association established a Collaborative Law Committee, of which I'm a member, under the auspices of the Dispute Resolution Section.

[11] "The need to learn from errors permeates the system: individual doctors and nurses, the floors or clinics they work in, their hospitals, their professional licensing boards, hospital regulators, the states, the feds, the media-all can claim a legitimate interest in learning about medical mistakes. Add to that the individual patient who suffered from the error, and maybe the patient's lawyer." Robert M. Wachter, M.D., Kaveh G. Shojania, M.D. , *Internal Bleeding: The Truth Behind America's Terrifying Epidemic of medical Mistakes,* Rugged Land: New York City, 2004, p. 274.

Chapter One: Introduction

Question: How can we:

- Begin to transform the cultures of law and medicine, such that collaborative law, a non-adversarial, voluntary process in which the parties make their own decisions, becomes a viable option to traditional medical malpractice litigation? and
- Give all the stakeholders a healing voice in the process?

These questions are immediately overwhelming. There are so many issues and so many stakeholders to consider; it all seems so massive. Where to begin? The stakeholders include injured parties and their families, physicians, insurers, risk managers, hospital personnel, other health care workers, patient advocates, medical ethicists, regulators of both the medical profession and hospitals, and plaintiffs and defendants' medical malpractice attorneys, many of whom are, invariably, at odds with each other. The issues, to name a few, include responsibility[12] (is medical error[13] individual physician failure or systemic failure or some combination of the two), deterrence[14], punishment, disclosure, reporting[15], [16], [17] (National Practitioners Data Bank

[12] Responsibility is not about blame, shame or punishment. Rather, it is about accepting, admitting, respecting, and changing.

[13] Medical Error is defined in the Institute of Medicine (IOM) 1999 report, *To Err Is Human,* as "the failure to complete a planned action as intended (i.e., error of execution) or the use of a wrong plan to achieve an aim (i.e. error of planning)." Institute of Medicine, *To Err Is Human: Building a Safer Health System,* National Academy Press: Washington, D.C., 2000, p. 28.

[14] Past efforts at prevention of error relied exclusively on the moral restraints of medical ethics or the deterrent effect of punitive law.

[15] "There are two types of reporting systems: mandatory reporting systems and voluntary reporting systems. Mandatory reporting systems are used by state authorities or accrediting organizations as part of their safety oversight function. Voluntary reporting systems are widely used in hospitals and by a variety of professional organizations to obtain information to improve safety. To the extent mandatory reporting systems are perceived as "unfairly punitive…, compliance will be reluctant and incomplete….Systems that have been most successful in bringing about changes for safety combine mandatory reporting with some degree of confidentiality and protection of individual providers." *Statement of Lucian Leape, M.D., Adjunct professor, Harvard School of Public Health, Concerning Patient Safety and Medical Errors before the U.S. Senate Subcommittee on Labor, Health and Human Services and Education,* January 25, 2000. <http://www.apa.org/ppo/issues/sleape.html>, accessed October 2, 2008.

[16] The Patient Safety and Quality Improvement Act of 2005 (Public Law 109-41) (the "Act"), signed into law on

(NPDB[18]), various state agencies)[19], [20] patient safety issues[21], attorneys fees, confidentiality, and

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July 29, 2005, creates patient safety organizations (PSOs) to collect, aggregate, and analyze confidential information reported by health care providers. At the present time, patient safety efforts are hampered by the fear of discovery of peer deliberations, resulting in underreporting of events and an inability to aggregate sufficient patient safety event data for analysis. The Act provides federal legal privilege and confidentiality protections to information that is assembled and reported by providers to a PSO for the conduct of patient safety activities. The Act also significantly limits the use of this information in criminal, civil, and administrative proceedings. This Act came about after the Institute of Medicine recommended that "Congress should pass legislation to extend peer review protections to data related to patient safety and quality improvement that are collected… for internal use or shared with others solely for purposes of improving safety and quality…The free flow of this information to create an epidemiology of error can occur only if secrecy regarding the information is assured." *To Err Is Human,* p. 111-112. To Err Is Human (the "Report'), acknowledged the patchwork of state-enacted peer review privilege protections, which are often limited in scope and subject to waiver upon disclosure of the privileged information. The Report cautioned that, without added federal protection, the potential for data collection and analysis will not occur. The Act adds that federal protection will become operable once regulations and funding have been authorized. Although the Department of Health and Human Services released proposed regulations to implement certain aspects of the Act, with comments due by April 14, 2008, this Act cannot be implemented until it is funded.

[17] In California, the Medical Board of California (MBC), the only licensing board authorized to investigate or commence disciplinary actions relating to physicians and surgeons licensed to practice in California, has as its mission "to protect the healthcare consumers through proper licensing and regulation of physicians…and to promote access to quality medical care through the Board's licensing and regulatory functions." MBC has recently combined the two divisions, licensing and regulation, into one board and created a medical errors committee (known now as the Medical Errors Task Force) to address "how the Medical Board might best assist those in the medical community in their efforts to reduce errors. It appears that much of physicians' fears about settling cases or losing at trial involve the requirement that the exchange of money requires reporting to the MBC. See California Bus. & Prof. Code §§ 800-809.9. The Board will have, as of August 1, 2008, eight physician members and seven public members. Although California has mandatory reporting for settlements or judgments in excess of $30,000 (the physician's record is public if there are four or more in ten years in high risk specialties, including neurological surgery, obstetrics, plastic surgery, orthopedics surgery; three or more in every other medical specialty) and for judgments/arbitration awards in ANY amount, pursuant to California Bus. & Prof. Code §§ 801/801.1, the MBC has determined that insurers and employers are simply not complying with the reporting requirement. Although the number of practicing physicians grew in California by almost 12,000 between 1998 and 2005, the number of 801 reports dropped by thirty-one percent, NOT because the number of reportable events declined. The Medical Board often receives information about settlements from plaintiffs, plaintiffs' attorneys and other non-mandated reporters on events which should have been, but were not, reported by the physician's employer or insurer. An approach to skirt the reporting requirement recently prohibited under California Bus. & Prof. Code § 2220.7, was a "regulatory gag clause" in a civil malpractice settlement agreement. When a patient sued a physician for medical malpractice, the physician could decide to settle with the patient. As a condition of settlement, the physician demanded inclusion of a regulatory gag clause that prohibited the patient from contacting or cooperating with the Medical Board, and/or required the patient to withdraw a complaint pending before the Board. *Medical Board of California, Final Report of the MBC Enforcement Program Monitor, Chapter VI, Complaint Receipt and Screening: Central Complaint Unit,* November, 2005. Since the punitive approach doesn't seem to work as intended, perhaps an approach in which all stakeholders work together, rather than at cross-purposes, should be considered and set up as a pilot program. There is a seat on the Medical Errors Task Force for a public member.

[18] The establishment of the NPDB was authorized by Title IV of Public Law 99-660, The Health Care Quality Improvement Act of 1986; it is intended to improve the quality of health care by encouraging state licensing boards, hospitals, professional societies, and other health care entities to identify and discipline those who engage in unprofessional behavior and to restrict the ability of incompetent physicians and other health care workers from moving from state to state without discovery of previous malpractice payments and adverse action history. NPDB Guidelines provide that "a payment made in settlement of a medical malpractice action or claim shall not be construed as a presumption that medical malpractice has occurred." National Practitioner Data Bank Guidebook, <http://www.npdb-hipdb.hrsa.gov/pubs/gb/NPDB_guidebook.pdf>, accessed October 15, 2006.

[19] If ANY money is paid to a plaintiff/patient as a result of a WRITTEN claim or allegation against a physician, the

inconsistent requirements regarding disclosures[22] (liability insurers, The Joint Commission (formerly known as the Joint Commission On Accreditation of Healthcare Organizations (JCAHO))[23], American Medical Association (AMA), statutes).

The medical malpractice litigation process tries to deal with many of these issues, often without great success. Unknowingly, or perhaps not, the broken medical malpractice litigation process is summarized succinctly, in terms of many of the necessary stakeholder participants, by Lawrence E. Smarr, President of Physician Insurers Association of America (PIAA), which insures over sixty percent of America's physicians. PIAA is an association of 57 domestic professional liability insurance companies that are owned and or operated by physicians and other health care providers, doctors insuring doctors. PIAA encourages federal legislation

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physician is reported to the NPDB, regardless of whether the physician is to blame and even if the disputants agree the physician is not to blame. This negatively impacts a physician's ability to maintain good standing with her/his insurance carrier, may jeopardize hospital privileges and medical board status. If a settlement amount exceeds the state's reporting limit, the physician is reported to the state medical board, which could lead to censure and/or disciplinary actions, including license restrictions, and/or practice restrictions. In some states, including California, these reports are available to the public.

[20] In terms of fashioning reporting systems, the logistical problems are immense and need to involve all the stakeholders, including physicians, nurses, hospitals, licensing board, hospitals, hospital regulators, the various states, the feds and the media. There is, at the present time, a "patchwork of anonymous, confidential, and open systems-run by local hospitals, accreditors, states, the federal government and others- is a mess, not only unhelpful but wasting millions of dollars that could otherwise be improving safety if put to better use." Wachter, et al, p. 282.

[21] Improving patient safety became a movement in 1996 at a meeting of 300 experts, which was convened by professional organizations in response to several error-induced sentinel events in the mid 90s that captured the attention of the media and the public. Among the conference conveners were the American Medical Association, the Joint Commission and the Department of Veterans Affairs. William R. Hendee, *The Patient Safety Movement,* Applied Radiology Online, volume 33, Number 8, August, 2004. <http://www.enclycopedia.com/doc/1P3-738070231.html>, accessed October 2, 2008. The National Patient Safety Foundation (NPSF), founded in 1997, has one mission: improve the safety of patients. Patient safety is defined as actions taken by individuals and organizations to protect health care recipients from being harmed by the effects of health care services. <www.NPSF.org>, accessed on January 8, 2008.

[22] Regarding disclosures, the AMA ethical guidelines and the various state statutes, set forth herein, do not provide guidance on HOW to make these disclosures. Consistent with providers' fears of litigation, insurers, risk managers and others continue to advise against disclosure or apology. Another option suggested to providers is to express regret, but NOT responsibility for error. A recent survey of hospital risk managers found wide variation among hospitals on disclosure practices. Jennifer K. Robbennolt, *What We Know and Don't Know About the Role of Apologies in Resolving Health Care Disputes,* 21 Ga. St.U.L.Rev, 1009-1028 (2005), 1013.

[23] The Joint Commission (JC) is an independent, non-profit organization that evaluates and accredits more than 15,000 health care organizations and programs in the U.S. It is the predominant standards-setting and accrediting body in health care. The JC's stated mission is to improve the safety and quality of health care provided to the public.

patterned on Medical Injury Compensation Reform Act (MICRA) in California ($250,000 in non-economic damages[24]) as the only reform that has stabilized medical liability insurance rates.[25]

In his written testimony to the U.S. House of Representatives, Smarr states[26],[27]: "The current system is broken. Victims are left waiting for years to get just compensation. More than half of the damages awarded to victims of medical errors go to pay attorney fees and other legal costs rather than make these people whole.[28] Doctors are forced to practice defensive medicine[29], [30] in an effort to prevent lawsuits. They are also faced with liability insurance premiums that are

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[24] Standard medical malpractice damages include economic, noneconomic and, sometimes, punitive damages. Economic damages include lost wages, medical expenses (past and future), rehabilitation expenses and other financial costs. Noneconomic damages include past and future subjective damages, such as pain and suffering, physical impairment, disfigurement, marital losses, anguish and inconvenience. Punitive damages are damages intended to punish for intentional or willful conduct.

[25] California has a statutory cap on non economic damages ($250,000) under the Medical Injury Compensation Reform Act (MICRA), enacted in 1975. "MICRA's most important ramifications for both patients and health care professionals (and their insurers) may not be on trial awards but instead on the far greater number of matters that never went before a jury." Nicholas M. Pace, et al, *Capping Non-Economic Awards in Medical Malpractice Trials,* Rand Inst. For Civil Justice, California Jury Verdicts Under MICRA, 19-20 (2004), <http://www.rand.org/publications/MG/MG234/MG234.pdf>, accessed on July 10, 2007.

[26] Lawrence Smarr, *Submitted Statement of Lawrence E. Smarr, President Physician Insurers Association of America July 13, 2006, U.S. House of Representatives, Committee on Energy and Commerce, submcommittee on Health, "Innovative Solutions to Medical Liability", p. 1, pr*<http://www.piaa.us/pdf_files/statement_for_healthcare_subcommittee_7_13_06.pdf>, accessed March 10, 2007.

[27] Mr. Smarr states the generally accepted, although likely erroneous, arguments in support of damage caps. See infra. I'm hoping that Mr. Smarr will join a dialogue on collaborative law, which offers possible solutions to all of his concerns, soon.

[28] Mr. Smarr may overstate the case against attorneys. See infra. Mr. Smarr does not address the extent to which the "attorneys fees and other legal costs" may be associated with lengthy defense of health care providers against legitimate claims that could be resolved quickly through fair and legitimate processes.

[29] Defensive medicine traditionally involves the ordering of tests, referrals, and procedures that are not medically justified, primarily for the purpose of reducing legal risk rather than to benefit the patient. Patients are caught in the middle in these situations between the physician and the physician's liability insurer/attorney. This medical practice increases the cost of health care and may expose the patient to unnecessary risks. The strongest predictor of all types of defensive medicine is the specialists' confidence in the adequacy of their liability coverage and their perceptions of premium burdens. David M. Studdert, M.D., Michello M Mello, J.D., PhD, William M. Sage, M.D., J.D., Catherine M. DesRoches, DrPh, Jordan Peugh, M.A., Kinga Zapert, PhD, Troyen A. Brennan, M.D., J.D., MPH, et al, *Defensive Medicine Among High Risk Specialist Physicians In a Volatile Practice Environment,* 293 JAMA 2609 (2005), quoted in Michael A. Haskel's, *A Proposal For Addressing The Effects of Hindsight and Positive Outcome Biases In Medical Malpractice Cases,* Tort Trial Insur Pract Law J. 2007, Spring, 42(3): 895-940. Michael A. Haskel.

[30] California Supreme Court Justice Matthew Tobriner set forth the connection between tort liability and the practice of defensive medicine: "When every patient is viewed largely as a potential plaintiff, the method of treatment chosen by the physician may well be that which appears the easiest to justify in court rather than that which seems

so high, far too many providers are being forced to give up their practices or at least avoid 'risky' patients.[31] *Incentives exist to cover up medical mistakes rather than acknowledge them and seek out ways to avoid them in the future….The only people benefiting from the current system are the attorneys who file lawsuits against doctors and their insurers*"[32] (emphasis added). Smarr expressed concern: "The crisis we face today is a crisis of affordability and availability of insurance for health care providers[33], and more importantly, the resulting growing crisis of access to the health care system for patients across the country." He further stated that proposals discussed to address this failed system (such as caps on damages[34], [35]) should be applauded to the extent they seek to meet the needs of patients who have been injured[36],[37], "rather than line the

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best from a purely medical standpoint." Clark v. Gibbons, 66 Cal.2d 399, 418, n.9 (1967). This defensive mindset, changes clinical strategy from "What is the best for this patient?" to "How can I do what is needed without creating liability?" Wachter, et al, p.Internal Bleeding, p. 304., See infra at F/N 10.

[31] "The strongest studies have found that the malpractice environment has had small or no effects on the supply of physician services overall, although the impacts in certain specialties and in rural areas are somewhat higher." Michelle M. Mello, *Medical Malpractice: Impact of the Crisis and Effect of State Tort Reforms,* Research Synthesis Report No. 10, May, 2006, Robert Wood Johnson Foundation, p. 4.

[32] Smarr, *Statement of PIAA, presented by Lawrence E. Smarr, President of PIAA, 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. <http://www.piaa.us/publications/pdf_files/Feburary_11_testimony.pdf>, accessed October 10, 2008.

[33] According to Dr. Jerome Buckley, retired CEO of COPIC Ins. "Our profession made a grave error when we listened to defense attorneys who told us to abandon our patients after adverse events. This is the chief reason we have a medical malpractice crisis." Sorry Works Power Point Presentation available at <www.sorryworks.net>. Buckley appears to suggest that disclosure/communication about medical error would have averted what some think have been a series of medical malpractice insurance crises and would have resulted in substantial financial savings.

[34] Damage caps "help constrain growth in litigation costs and insurance premiums over time, *but disproportionately burden the most severely injured patients."* <http://www.rwjf.org/publications/synthesis/reports_and_briefs/issue10.html>, accessed on January 3, 2008.

[35] "The law is stacked against ordinary people. For instance, in my home state of California, a 1975 law caps compensation to malpractice victims. The cap has never been raised for inflation. The practical effect is that people without the wealth to pay legal fees up front are unable to get their cases before a judge or jury." Testimony of Dennis Quaid and Kimberly Quaid Before the Committee on Oversight and Government Reform of the United States House of Representatives, May 14, 2008. <http://oversight.House.gov/documents/20080514103204.pdf>, accessed on August 15, 2008.

[36] "…{T}he political mud wrestling over tort reform has centered on caps on pain-and-suffering awards, which, whatever their merits, would not fundamentally alter the dynamics of the malpractice system in terms of patient safety." Wachter, et al, p. 380.

[37] "The way we're going to successfully manage the medical malpractice crisis is through safer care, not tort reform." Timothy McDonald, M.D., J.D., University of Illinois Medical Center, in Eve Shapiro's *Disclosing Medical Errors: Best Practices From The "Leading Edge",* 2008, p. 6. <http://www.ihi.org/IHI/topics/patientsafety/safetygeneral/literature/disclosingmedicalerrorsbestpracticesleadingedge.htm>, accessed on July 1, 2008.

pockets of personal injury lawyers."[38], [39] In language scornful of our judicial system, President George W. Bush said that in "judicial hellholes,…every claim filed by a personal injury lawyer brings the chance of a huge payoff or a profitable settlement out of court."[40] These comments fail to take into consideration the injured patients and/or their families who, often as a last resort, retain personal injury lawyers to help them find answers and receive well-deserved compensation in a fair, honorable, and respectful manner.

To ensure basic fairness[41], [42] to all involved in the process of medical error, alternatives to medical malpractice litigation, such as collaborative law, have been developed. Collaborative law is a non-adversarial, structured, voluntary dispute resolution process in which the parties make their own decisions regarding disclosure and resolution, among other issues. Collaborative law starts with a cultural shift, recognizing concepts of fairness, rather than tort principles. This alternative addresses all of the major issues mentioned by Mr. Smarr in his Congressional testimony. Collaborative law gives all parties equal opportunities to speak, to listen, to learn,

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[38] As previously noted, California has a statutory cap on non economic damages ($250,000) under the Medical Injury Compensation Reform Act (MICRA), enacted in 1975. The cap, which has NEVER been raised in thirty-two years, quite clearly helps physicians and their insurers. How these caps meet the needs of injured patients, especially the neediest, is far less clear. William M Sage asked: "*Does it not seem odd that the principal malpractice legislation being debated in Congress in 2004 is basically the same as that adopted in California in 1975? (*emphasis added.) The fact that health care delivery is far more sophisticated, institutionalized, and competitive is largely ignored, as is the fact that the aggregate increase in malpractice premiums during those three decades is a ballpark equivalent to the aggregate increase in overall health care spending." (emphasis added). Sage, *Reputation,* p. 162.

[39] Smarr submitted with his statement a report by Prof Daniel P. Kessler, Stanford University, which demonstrated that the causes of rising medical liability insurance premiums are "increases in tort awards, settlement payments, and defense costs". <http://www.piaa.us/pdf_files/press_releases/Kesslier_Malpins_report.pdf>, accessed October 2, 2008.

[40] Medical Malpractice: Fiction, Facts and the Future; Part I, May 20, 2008, <http://www.healthbeatblog.org/2008/05/medical-malpr-1.html>, accessed June 1, 2008.

[41] 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.

[42] "As an end in itself, fairness incorporates notions of appropriateness, reciprocity, proportionality, and impartiality that are central to conceptions of moral behavior." Maxwell J. Mehlman, *Resolving the Medical Malpractice Crisis: Fairness Considerations,* The Project on Medical Liability in Pennsylvania, 1-96, 2003, p. 13. <www.pewtrusts.org/uploadedFiles/pewtrustsorg/reports/medical_liability/vf/medical_malpractice_fairness.pdf>, accessed October 1, 2006.

and to search for solutions. Collaborative law plays a role in creating and enhancing a culture of learning[43] from medical mistakes, rather than a culture of punishment.

This process makes the experience of loss a more compassionate process, more compassionate primarily for the patient/family, but also for the physicians and the attorneys, as well as 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). A very particular form of conversation referred to as dialogue creates the space for just that shift in thinking to take place. Dialogue can be seen as a first step in developing the collaborative relationships necessary to move the collaborative law process into general usage. It is, of course, not the only approach, but it is a start.[44] We need to keep talking about the significant issues to be addressed, including fair compensation, disclosure, patient safety, attorney fees, confidentiality, and withdrawal[45], [46] of collaborative attorneys.

Before collaborative law in medical error can take hold, the stakeholders, many of which are identified above, have to come together and see the benefits of the process. This clearly is no easy task. After attending two conferences at which it seemed there was much nay-saying, finger

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[43] "Caregivers appear to be quite willing to report errors for the purpose of learning-provided that they feel protected from being unfairly pilloried and that the system does something useful with their reports." Wachter, et al, p. 274.

[44] Another dialogue took place in October, 2007 as a workshop at the annual conference of the International Association of Collaborative Professionals (IACP), which included both U.S. and Canadian attorneys, law professors, and mediators. The scheduled physician participant had to cancel.

[45] This provision, the "withdrawal provision", is something of a controversial provision. It is sometimes referred to as the "disqualification provision". Disqualification suggests that some person or entity, external to the process, makes the decision about withdrawal of counsel. That sends the wrong message, suggesting that the decision is out of the hands of the parties and their attorneys, which it is NOT. A more positive explanation of this provision is, rather than discussion of withdrawal and/or disqualification, reference to attorneys in the collaborative process as settlement counsel, differentiated from trial counsel. Parties would agree to retain settlement counsel in the collaborative process; however, if the collaborative process did not result in settlement, settlement counsel would withdraw and trial counsel would be retained by the parties to take the case to trial.

[46] The withdrawal provision is also controversial because it may be difficult to convince the physician, hospital, and/or other health care providers, who may have a longstanding relationship with one attorney or one law firm, that that lawyer(s) must withdraw if the collaborative process does not result in settlement. The process needs to be flexible.

pointing, and 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)[47], I devised a plan to structure dialogues with all the stakeholders, or as many willing stakeholders as I could gather. The dialogue process, through the questions posed, as set forth in detail below, steered us away from finger pointing and nay saying.

The dialogues would bring together professionals who knew the possibilities of similar compassionate, non-adversarial processes and those who had no experiences with either the collaborative process or similar processes but who were willing to listen and consider, as well as propose, possible solutions. 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. Unlike typical conversational gatherings where those with conflicting views try to persuade each other of the merits of their views, the purpose of dialogue is to seek mutual understanding. It assumes that many people have pieces of the answer and that, together, they can craft solutions. Dialogue is conversation which involves an essential commitment to listen respectfully to all points of view.

The hope for the dialogue process was to build community by bringing together a group of participants/stakeholders to think together, to set aside assumptions and misconceptions about each other, and to understand each other's points of view, such that, as health care collaborators,

[47] 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.

all involved could begin to move forward together to offer a workable, legitimate, compassionate, patient safety-oriented option to medical malpractice litigation.

The dialogue process can be seen as an outgrowth of social construction, involving, as it does, the community thinking, listening and talking together. Social construction indicates that we create meaning through our activities together: our thinking, listening and conversations/dialogue. The meaning does not lie in the head of any one individual. The main premise of social construction is that meaning is not an individual phenomenon; it is created in the coordination of activities among people. Actions have no meaning in themselves; they develop meaning only in relation to the actions of others.[48] Meaning can be seen as a function of our cultural traditions, local conventions, and historical canons. Thus, meaning is always fluid. It is not determined by one person; rather, it is an achievement of people coordinating their activities together. What is most important is what people do together. Ken Gergen and Mary Gergen suggest: "In an individualist world, relationships take a back seat because they are treated as artificial contrivances, possibly time consuming, and essential only in cases where one is not self-sufficient."[49] Social construction theory maintains that we construct meaning through the conversations we have. To the constructionist, words create worlds; through our conversations, dialogues and stories, we create our world. This will be elaborated on in Chapter Two.

According to social construction, if a group comes to coordinate around certain values, they can organize as a community and continue the conversation. In order to accomplish this, we hold our own experience, our own thinking, while simultaneously leaving room for the other (others' experiences, ideas, suggestions); we come to the conversation, to the dialogue, with

[48] Kenneth J. Gergen, Mary Gergen, *Social Construction: Entering The Dialogue,* A Taos Institute Publication: Chagrin Falls, Ohio, 2004, p. 7.
[49] Gergen, et al, p. 31.

curiosity about the other people's positions.[50] If we can come together, holding our own positions, while recognizing the right of the other individuals to hold their own positions as well, with curiosity and respect, we can create a new future together. The process involves listening, hearing and speaking. According to William Isaacs, dialogue is a language of wholeness, a conversation with a center, not sides. It is a way of taking the energy of our differences and channeling it toward something that has never before been created.[51]

One elaboration of social constructionism is Appreciative Inquiry. If the way in which we coordinate our activities with others creates the world we inhabit, then designing opportunities to inquire about what we value should have the potential to construct a way of "going on together." The collaborative law in medical error dialogue needed to be grounded in a positive, compassionate, forward-looking theory, providing a way we could move forward together. Appreciative Inquiry theory seemed to be an appropriate process to construct the dialogue. 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 dialogue, bringing together as it would professionals who knew the possibilities of similar compassionate, non-adversarial processes and those who had no experiences with either the collaborative process or similar processes but who were willing to listen and consider, as well as propose, possible solutions. The professionals who had successfully used this type of collaborative 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. This will be elaborated in much more detail in Chapter 2.

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[50] John Stewart, Karen Zediker, *Dialogue as Tensional Ethical Practice,* Southern Communication Journal, 65, 224-242 (1992), p. 240.

[51] William Isaacs, *Dialogue and the Art of Thinking Together,* Random House: New York*, 1999,* p. 19.

Chapter Two: The Theoretical Orientation

Social Construction

> *"We don't accomplish anything in this world alone…and whatever happens is the result of the whole tapestry of one's life and all the weavings of individual threads from one to another that creates something."*
>
> – Justice Sandra Day O'Connor[52]

> *"Whenever we hold firm to a particular account of the real, we seal ourselves off from other possibilities…Each commitment to the real eliminates a rich sea of alternatives, and by quieting alternative discourses we limit possibilities of action…As we make declarations of the real-what is true, what really happened, what must be the case-we close off options for dialogue."*
>
> – Kenneth Gergen[53]

Social construction is a philosophical stance that asks us to look critically at our usual and accepted approaches to understanding the world and to question the conventional wisdom that claims our knowledge is based on objective, unbiased observations of the world. From the perspective of social construction, our description of reality arises from our cultural traditions and through our social interaction. It calls into question our assumption as a society that the nature of the world can be revealed by observation. Social construction suggests that knowledge is constructed between people, not through observation. All knowledge is derived from an orientation (or a perspective) and our orientation is influenced by those with whom we interact in

[52] http://www.brainyquotes.com/quotes/quotes/s/sandradayo372198.html, accessed February 15, 2008.
[53] Kenneth Gergen, *An Invitation To Social Construction,* Sage Publications Ltd: London, 1999, p. 223.

very historically and culturally specific contexts. According to social constructionism, the concept of an objective fact does not exist.[54] Facts are culturally derived. Meaning is not fixed; rather, it is an emergent process of persons in relationship.[55] Meaning is always open to new possibilities. Each construction invites different types of actions.[56] For instance, alcoholism, at the turn of the 20th Century, was thought to be blameworthy, something of a crime, punished by jail time. Alternatively, it was treated with institutionalization. At some point, perhaps about the time Alcoholics Anonymous was founded, alcoholism began to be seen as a disease, an addiction, worthy of treatment, hospitalization and the like, and not a criminal act.

Social construction is an orientation that focuses attention on the creation of meaning. The following assumptions are central to a constructionist stance:[57]

- Within a constructionist discourse, we take a critical stance toward taken-for-granted knowledge, which suggests that we take a critical stance toward our taken for granted ways of thinking. We are encouraged to challenge the view that conventional knowledge is based on objective unbiased observation of the world. The process cautions us to be suspicious of our assumptions about how the world seems to be. For instance, George W. Bush talks of exporting "freedom" around the world, convinced beyond a doubt that the world is waiting for his version of "freedom". One of the Bush White House aides noted that "Reality is what we say it is."

- A constructionist stance also emphasizes the historical and cultural specificity of our

[54] Vivien Burr, *An Introduction To Social Construction,* Routledge: New York, 1995, *p.6.*
[55] Sheila McNamee, *The Social Construction of Disorder: From Pathology to Potential, in Jonathan D. Raskin and Sara K. Bridges (eds.), Studies in Meaning: Exploring Constructivist Psychology, Pace University Press: New York 2002, p. 155.*
[56] Watching a movie, Called "Ladies in Lavender", Judi Densch, an elderly woman, says to a young Polish man (with almost no English skills, hence, a different culture) she and a friend found at seaside, washed up on the shore and almost dead, "It's not your fault." He responds: "Fault. What is fault?" Buddhists have no concept of emotion as separate from cognition and have no word for "emotion" in Tibetan. Emotion and Fault are cultural constructs.
[57] Burr, p. 2-9.

ways of acting and knowing. That is, the ways in which we commonly understand the world are historically and culturally relative, specific to particular cultures and particular time periods in history. The forms of knowledge we are aware of are cultural artifacts. For instance, our tort system in the arena of medical error, traditionally casts all blame on individuals, primarily physicians, because that is the way we've always done it, this in spite of the extensive evidence that systems play a much larger role in medical errors than do individuals. Our medical liability tort system has not kept pace with our current, complex, multilayered, technology-dependent, highly specialized health care system, a system that was unimaginable fifty, or even twenty, years ago.

- Constructionism holds that knowledge is sustained by social processes. Our shared version of knowledge arises from our everyday lives, our every day conversations. For example, the way legal and medical cultures think of medical error and what follows it are ingrained in our culture, and supported by stories, statistics and stereotypes, such that we see ourselves locked into the system as it is. The dialogue process allows us to look at our "knowledge" in this arena and reexamine it.
- Finally, constructionism posits that knowledge and social action go together: how we view things is how we react to them, assess them. Knowledge is constructed through language. Our different constructions invite different responses. For instance, the workings of our criminal law place all the blame and punishment on individuals, none on other actors, none on our communities/culture/media. To even discuss the possibility that responsibility belongs to all of us, not just to one person, brings forth accusations of "soft on crime". We allow individuals to be locked up for life, or something short of that; then we can just forget them because, as the thinking seems to go, they are just criminals.

The main premise of social construction, as previously noted, is that meaning is not an individual phenomenon; it is created in the coordination of activities among people. It is the communal creation of knowledge.[58] To think in terms of social construction, making meaning in our joint activities with others, we depart from the realm of individualism, defined as the doctrine that all actions are determined by, or take place for, the benefit of the individual, not for society as a whole, which doctrine is ingrained in western culture.[59] Relationships, under individualist theory, are artificial and unnatural. The "me-first" attitude of individualism is condemned for reducing to trivia emotional relationships, scholarly research and political discourse.[60] Joseph Jaworski writes: "People and groups think of themselves as separate. But if we could learn how to dialogue with one another at a deep level,…we would find ways to relate to one another that would dissolve the perceptions of separateness."[61] Further, Jaworski talked of fundamental shifts of mind, a "shift from seeing a world made up of things to seeing a world that's open and primarily made up of relationships."[62] Although David Hall is referring to medical school, in terms of relationships. in the following quote, it equally applies to law school: "When we structure our courses and our educational institutions in ways that isolate the inner feelings of our students from themselves and each other, then we are sowing the seeds for dispassionate professionals. When we fail to use dialogue as a means of connecting students to themselves and to the world around them, then we are draining our professional well of one of

[58] Knowledge is not viewed as something that a person has, but as something that people build together. Burr, p. 9.
[59] It can be a life-affirming force when spoken for the benefit of society: As Senator Robert Byrd said in an insert, bearing his autograph, in his book, *Losing America, Confronting a Reckless and Arrogant Presidency,* W.W. Norton Company: New York, 2004 "the individual mind remains an unassailable force. The individual voice can inspire others to act. A single act of bravery can lead an army against great odds. The strength of a single person can give hope to the hopeless, voice to the voiceless, power to the powerless."
[60] Sheila McNamee, Kenneth Gergen, *Relational Responsibility: Resources for Sustainable Dialogues*, Sage Publications, Thousand Oaks: CA, 1999, quoting Christopher Lasch, p. 8.
[61] Joseph Jaworski, *Synchronicity, The Inner Path of Leadership,* Berrett-Koehler: San Francisco, 1996, p. 57. This, to me, is brilliant: finding a way to dissolve the perception of separateness so we, physicians and attorneys, in particular, can work together**.**
[62] Ibid, at p. 10.

the most precious resources-compassion."[63]

Individualism is based on a group of assumptions which place all agency within the individual: all thinking, learning, knowledge, and action. Individualism, for instance, places attention, in our educational system, on the transmission of information, as opposed to placing attention on building communities and relationships to support and challenge us as we enter the world of business or public service. Rather than assuming, as we do in our culture, that intellect, knowledge, and values are contained within each of us as individuals, perhaps we could think about these as growing in communities.[64] Since the individual is thought to be the locus of all these activities, thinking, learning, knowledge, the individual then, based on the situation, is to be blamed, criticized, applauded, congratulated, rewarded or recognized. Our traditional medical malpractice litigation process focuses almost exclusively on the activities of individuals, creating individual liability, although "the causality of medical injuries is multifactorial and weblike."[65]

In the realm of individualism, in our culture, we are evaluated through our numerous years in school on an individual basis; we are evaluated on the job on an individual basis; we are evaluated in sports on an individual basis (Lance Armstrong, only a member of a team, is treated like a God, as if he is the ONLY member on the team); we are evaluated in public life, in government and politics, on an individual basis. Ralph White refers to our legal education, our learning through the case method as "endless case analysis according to Eighteenth and Nineteenth Century doctrine, conceived when individualism and materialism were groundbreaking concepts".[66] We even assume that our thinking is a solitary activity. Seeing our

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[63] Hall, p. 236.
[64] McNamee, *The Social Construction of Disorder*, p. 146.
[65] Mello, Michelle Mello, David, Studdert, David, *Deconstructing Negligence: The Role of Individual and System Factors in Causing Medical Injuries,* 96 Geo.L.J. :599 (2008), 603, 601.
[66] Ralph White, *From Hired Guns To Healers: The Emerging Movement to Renew Legal Culture*, Conscious Choice, December, 2002. <http://www.consciouschoice.com/2002/cc1512/healerstohiredguns/1512html>, accessed

individual selves as wellsprings of action, responsible for having the answers, having the knowledge, creates some difficulties. To paraphrase Gergen, we are isolated, never knowing each other intimately, never trusting; relations become artificial, add-ons, only of use to us when we have time and time to set aside from our individual pursuits; individualism causes us, since we are working in isolation, not together, to give away our power.

Implications of A Constructionist View for Medical Malpractice

In terms of medical malpractice litigation, we, lawyers, physicians, our entire culture, are prisoners of our own thinking. The call to change seems to be all around us, the reports and studies suggesting, on the one hand, that disclosure and apology, when appropriate, are effective, and, on the other, that traditional litigation is ineffective in terms of fairness, healing, and patient safety. From a social constructionist perspective, our culture generally takes a strictly legalistic approach to medical error. We go to court: that is how we've done it for decades, blaming the individual(s)/physician(s) when there is an injury associated with medical care. What we think of as our objective, unbiased observations include: a patient was injured in the operating room, the surgeon is responsible.

Forgive the awkwardness of this next explanation in my attempts to illustrate. Our thinking starts at the place where we have "zoomed in" as much as we can. We are in virtual time. We are looking for a certain street address in, say, Peoria, Illinois using mapquest, yahoo maps or some similar search mechanism. We type in the Peoria address and a map appears. First map on the screen is likely the State of Illinois; we zoom in to the county, zoom again into the city, where we get our first glimpse of people walking around, zoom again to the neighborhood, and zoom in, finally, to the street. For our purposes, instead of a street address in Peoria, type in,

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on November 5, 2007.

say, Peoria hospital system. A campus will likely appear with many buildings and people. From there, zoom in to the hospital building, with physicians, nurses, technicians, nurse practitioners, physician assistants, other health care workers, computers, scopes, machines, scans, x-ray machines, beds, scalpels, retractors, sponges, IVs, wheel chairs, and medications, to name a few; from there, to shift change on the second floor, people talking, milling about; from there, to the operating room, with many people and machines and equipment around the person on the gurney; from there to the patient and surgeon. Hit that "+" as many times as we can in order to view just the surgeon and the patient, no assisting physicians, no anesthesiologists, no nurses, no technicians, no equipment, no drugs, just the two parties who very likely will be the two in court four or five years from now. We, the lawyers, along with the entire legal system, operate the zoom "+" until we get to the surgeon and the patient, perhaps unknowingly. Frustrating and heartbreaking at the same time, isn't it? But, hope enters the picture as we zoom out to the broader view, questioning all the conventional wisdom, that, since something has gone wrong in the patient's care, associated with the surgery, the surgeon is to blame (or anyone is to blame). The broader view brings into focus the entire hospital system. Where are the breakdowns? What needs to be fixed before the next time? What did the patient observe that could help the entire system, going forward? What other questions should we be asking? *We can't do it differently until we see it differently. We can't see it differently until we think it differently.*

Lawyers, like physicians, have our own subculture within the larger cultural framework. Our subculture has something of a knee-jerk response when a patient is injured. As attorneys, our description of that reality comes from our training, from statutes, from cases, from rules, from legal analysis. Overall, our description comes from our legal subculture. That reality also draws on our continuing interaction with the courts, other attorneys, and the law as it is written.

Our reality also comes from our compassion. Lawyers, like physicians, live in a culture of individualism, from within our professions as well as from without. Since we, the attorneys, live in a culture of individualism, it is sometimes difficult to zoom out and take the larger view, as much for us as for society in general, for health care regulatory bodies, and for the entire health care system. "Expected to be forever self-sufficient, strong, knowing, aggressive, and confident, the lawyer is expected to be more than human. Even in situations where one would expect to find communal effort and collegiality-say in a law firm or among a group of lawyers representing the same client-we see the cult of individualism at work, transforming collegiality into competition and community into a mere collection of "I's"…Combine this objective coldness with the constant circumspection and caution with which lawyers are taught to face the world, and you have an overwhelming combination that closes the lawyer in on himself or herself. Add the unspoken but clearly conveyed sense of aristocracy that law school encourages and you have a prescription for an alienated profession made up of lonely men and women."[67]

In the context of medical error litigation, as noted, generally one person is found responsible, and, hence, liable: the physician. The litigation process, like so many other processes, arises out of the medical subculture's long-standing focus on the individual.[68] As risk communications consultant, Barry Sandman, states, "Every doc is a rugged individualist, and patients like the ideal of their doc being decisive, self-confident, their own person."[69] Certainly fifty, or even thirty, years ago, medicine was a system of solo practitioners, making decisions based on feel, asking questions, listening to responses, and generally learning more about the patient. Therefore, the traditional medical malpractice litigation model, holding one person

[67] Benjamin Sells, *The Soul Of The Law,* Vega: London, 2002, p. 51.
[68] This very likely makes sense to lawyers, arbitrators, mediators and judges, as well as physicians, all of whom are trained and likely practice in the same individualist realm.
[69] Barry Sandman, quoted by E. Scott Geller, PhD and Dave Johnson in *The Anatomy of Medical Error,* Coastal Training Technologies: Virginia, 2007, p. 111.

responsible, rather than a team or hospital, for, perhaps, misdiagnosis was fair, just and logical. Now, medicine, to a large extent, consists of interdisciplinary teams working with scans, computers, imaging, and various machines, as well as other sophisticated and complex technologies. Overwhelmingly, at present, systems failures, not individual failures, are the primary cause of medical error. "*Multiple* failures often contribute to a single adverse event[70], and early detection of the *first* such failure provides an opportunity to intervene and stop what could become a chain of failures leading up to a serious adverse event." (Emphasis added.)[71] This is the time when awareness of the failure(s) could result in an expeditious intervention, such that the next patient is saved from injury. In a traditional litigation scenario, that couldn't happen expeditiously or even slowly.

As noted above, the legal and medical processes involved in medical error, although seeking, to one extent or another, the same result, i.e. increased patient safety and quality improvement, create results that may have been fair many years ago but are no longer so, due to tremendous changes in the field of medicine, including cultural changes, conflicting cultures (i.e., individualist vs team/system) and conflicting focuses. The legal process is more expensive, more time consuming, certainly more adversarial and involves long delays. As a result, when the verdict comes in (or settlement is reached) only one or two individuals are ordered to pay damages and a huge opportunity for learning, for changes in medical care systems, is lost for two reasons: the *system* is not examined and the litigation process looks exclusively to the past. The

[70] The term "Adverse Event" is an event "that results in unintended harm to the patient by an act of commission or omission of medical management, rather than by the underlying disease or condition of the patient." Institute of Medicine, *Patient Safety: Achieving a New Standard For Care,* Quality Chasm Series, 2004, p. 201. "Medical Management includes all aspects of health care, not just actions or decisions of physicians or nurses." Massachusetts Coalition for the Prevention of Medical Errors' Study, *When Things Go Wrong, Responding to Adverse Events, A Consensus Statement of the Harvard Hospitals,* March, 2006, p. 4, http://www.ihi.org/NR/rdonlyresA4CE6C77-F65C-4F34-B323-20AA4E41CD79/0/Responding AdverseEvents.pdf. Accessed October 2, 2008. Based on my recent experience talking to health care providers at conferences, Adverse Event may be a more appropriate term than medical error.

[71] Ibid, p. 18.

Joint Commission puts it succinctly: "*Data indicating that intimidating behaviors, poor teamwork, miscommunication, verbal abuse, inappropriate hierarchies and punitive organizational cultures lead to preventable death, injury and medical errors is well supported".*[72] Every one of these processes listed by the Joint Commission that results in error are products of groups/teams/systems' actions, NOT individual action. Yet, the litigation system continues to focus on the individual. "…[I]t is precisely this exclusive focus on the individual's responsibility not to make mistakes, reinforced by punishment, that makes health care so unsafe."[73] "Approaches that focus on punishing individuals instead of changing systems provide strong incentives for people to report only those errors they cannot hide. Thus, a punitive approach shuts off the information that is needed to identify faulty systems and create safer ones. In a punitive system, no one learns from their mistakes."[74] Teams and systems are left to function as before while individuals are held accountable.

When we look around us, at our own culture, it is readily apparent why the legal system holds primarily individuals accountable. As previously mentioned, we are evaluated through our numerous years in school and on the job on an individual basis. All we need do is look at the newspaper to find articles of CEOs, given all the credit for rebuilding, growing, resuscitating, and/or doubling the stock price, who receive compensation in the realm of many millions, while managers/employees in the same organization are compensated at a much lower level and are barely recognized for their team efforts.[75] Could the CEO have effectively created these and other successes without a myriad of other managers, thinkers, R&D people, and hands-on

[72] JCAHO Sentinel Event Alert Issue #30, July 2004: http://www.jcaho.org/about+us/news+letters/sentineleventalert/sea30.htm, accessed July 8, 2008.
[73] Statement of Leape, January 25, 2000, p. 1.
[74] Ibid, p. 1.
[75] I recently overheard a conversation about Richard Grasso, former head of the New York Stock Exchange, suggesting that Grasso "deserved" the $140 *million* package he walked away with when he left the Exchange because, after all, he "ran" the Exchange and was deserving of all that cash.

workers? Not likely. Even when the organization does not perform well, the CEO gets millions in severance, walking away from her/his wreckage. The message is clear: the individual CEO gets the credit; the individual CEO gets the blame, such as it is (losing her/his job, but walking away with millions).

Both physicians and attorneys are educated and practice in an individualist culture, as previously noted. Attorneys are taught to "think like lawyers", write like lawyers, prepare for and make air tight arguments, and take the credit (or the blame) for verdicts, motions, hearings and settlements. Physicians have similar experiences through, for one, the Morbidity and Mortality (M&M) Conferences, held weekly at academic hospitals, at which physicians "gather behind closed doors to review the mistakes, untoward events, and deaths that occurred on their watch, determine responsibility, and figure out what to do differently next time."[76] This seems somewhat arrogant in that the people most affected by the "mistakes" and "untoward events" are not allowed to be present, almost as if the injured parties (and/or their families) experiences, insights, observations, contributions and wisdom don't matter. As Nancy Berlinger points out on the subject of M&M conferences, "This is *not* to say that injured patients should be included in M&M conferences. Rather, it is to say that the ritual of confession, repentance, and forgiveness, enacted within a culturally appropriate context and with reference to the needs and expectations of the injured party, may be as important to patients as it is already understood to be among physicians, and should be available to them."[77]

We have been trained well for competition, not collaboration, in both law and medical schools, after years of test taking, paper writing, reciting, and practicing. Mark Lebed, a physician and head of Medical Dispute Professionals, describes a cultural norm among

[76] Atul Gawande, *Complications: A Surgeon's Notes on an Imperfect Science,* Picador: New York, 2002. p. 58.
[77] Nancy Berlinger, *Missing the Mark: Medical Error, Forgiveness, and Justice,* in Virginia Sharpe (ed.), *Accountability: Patient Safety and Policy Reform,* Georgetown University Press: Washington, D.C. 2004, p. 125.

physicians that resists delegating responsibility. Physicians are expected to solve their own problems, not to hand them off to outsiders- a sense that leads them to believe, "If I can't fix it, it can't be fixed."[78] We started (and ended) professional schools competing and trying to outdo each other. That was (and is) the culture of both types of professional schools. My experience in law school and in practice involved very little teamwork.[79] In practice, the culture involved mostly isolation. Of course, it never occurred to me that it should (or could) be otherwise.

The meaning we give to "the facts" arises out of our traditions and culture. In our legal system, cases are determined "on the facts". "The facts" are the material facts which are the basis of the case, as set forth in statutes and case law. For instance, the tort of negligence in a medical malpractice context requires proof of certain elements: duty, breach of duty, causation and damages. Often, duty is defined statutorily; breach of duty and causation are determined after discovery[80] of "the facts". The facts the litigation system examines and evaluates are not necessarily "the facts" we work with in a collaborative process. If we're looking for someone to blame and a theory to blame her/him, we are looking for one set of "facts"; if we are looking to heal, we are looking at an entirely different set of "facts". They could be the same facts but we examine them from a different perspective, a different frame of mind. Attempts are made in a collaborative process to examine "the facts" without judgment. The facts in a litigation process are highlighted to establish error beneath a certain standard and blame. We language the two processes from polar opposites. For instance, in litigation we talk about negligence, fault, breach of duty, below the standard of care; in litigation, we make every effort to discredit experts' education, experience and opinions. If we represent plaintiffs, we discredit physicians, hospitals,

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[78] Edward Dauer, *Postscript on Health Care Dispute Resolution: Conflict Management and the Role of Culture* , 21 Ga. St.U.L.Rev 1029-1054 (2005), p. 1029, 1047.

[79] Of course, this is also due to my own thinking throughout law school and much of practice.

[80] *"Discovery" presupposes the existence of a stable reality that can be revealed by observation and analysis.* Burr, *p. 12.*

and health care workers. If we represent defendants, we discredit patients and/or their families, accusing them of malingering and the like. A social constructionist approach, a collaborative law approach, to medical error would be to talk, listen, think together and propose solutions. In addition, a collaborative law approach provides the opportunity to define blame, NOT responsibility, out of bounds. "The facts" become whatever the parties want to focus on, what the parties think are important.

In the realm of psychology, our culture's labeling and approach to "learning disabilities" is instructive. Although a "learning disability" is a label often put on a child, social construction would question this, suggesting that the term arose from the frustration of parents, teachers, coaches, and others. A social constructionist, looking at a traditional learning disability, ADD/ADHD, suggests that attention deficit in the classroom is not a learning disability, but rather a normal response of children being forced to sit still and listen for hours on end. When the children can't (or won't) sit still, they are labeled and blamed.

Vivien Burr, in *An Invitation to Social Construction*[81], discusses Foucault, who argues that the way we talk about and think about mental illness affects how we treat others. For instance, we think of people who hear voices as mentally ill, in need of therapy, psychiatric hospitals, and medication. Institutions are required to keep us in check because we are mentally ill, have personality disorders, are disabled. These categories require us to be watched, kept in check by therapists, police, teachers, nondisabled. Individuals cause problems and need to be fixed.

The concept of personality, including various diagnoses, while based in individualism, is more of a social construct. As Burr points out, words used to describe personality types include friendly, warm, caring, shy, outgoing, self-conscious, self-absorbed, charming, compassionate,

[81] Burr, p. 32.

angry, etc. "Most personality words would completely lose their meaning if the person described were living alone on a desert island."[82] These words are only meaningful in terms of relationships. When I see accusations in print that a particular person has a "personality disorder", my thoughts go to "Says who?[83] Based on what? By whose standards?" If personality traits are universal, why are they different in different parts of the world, in different cultures?

The social constructionist position is that what we take to be our personal qualities is a function of the particular cultural, historical and relational circumstances within which we live. When we talk about mental illness, disabilities, personality disorders, who is excluded? Who gains by these categories? Who loses? Knowledge is created through conversation.

Dialogue

"Dialogue is a conversation with a center, not sides."

– William Isaacs[84]

"Problems are not solved, but dissolved, in language."

– Anderson & Goolishian[85]

"No problem can be solved at the same level of awareness that created it."

– Albert Einstein

"One of the best ways to persuade others is with your ears

– by listening to them."

– Dean Rusk[86]

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[82] Burr, p. 32.
[83] Self-reflexive inquiry invites us to question these concepts.
[84] Isaacs, William, *Dialogue and the Art of Thinking Together, 1999,* Doubleday, p. 18.
[85] Harlene Anderson, Power Point handout, Harlene Anderson presentation on Collaborative Practices, Taos Institute, October, 2005

"When individuals in their communities of work learn together, those individuals change. And when those communities of work organize their voices, society will change."

– Carol Bayley[87]

"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."

– Irwin Kash, M.D., participant in dialogue[88]

"The primary human reality is persons in conversation."

– Ron Harre[89]

"You can't do it differently until you see it differently."

– Unknown

"[w]hat you 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[90]

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

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[8686] http://www.wow4u.com/communication/index.html., accessed January 7, 2008.
[87] *Accountability, Medical Mistakes and Institutional Culture, Chapter 6, p. 110,* Georgetown University Press: Washington, D.C., 2004.
[88] Dialogue in Ft Myers, Florida, January 28, 2007.
[89] Harre (1983:58), quoted in Stewart, John and Zediker, Karen, *Dialogue As Tensional, Ethical Practice, Southern Communication Journal, Volume 65, Numbers 2&3, Winter-Spring 2000, p. 225.*
[90] Quoted in *The Heart is the Key to All of This, Conversation with Joseph Jaworski*, October 29, 1999**,** http://www.dialogonleadership.org/Jaworski-1000.html**,** accessed on March 23, 2008**. .**

from our new reactions new socially intelligible ways forward, in which the old problems become irrelevant."[91] According to Bohm, 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."[92] 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, it 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 use about each other:

- The only people benefiting from the current system are the attorneys who file lawsuits against doctors and their insurers. (insurer)[93]
- Rather than meeting the needs of patients, medical malpractice litigation just lines the pockets of personal injury lawyers. (insurer)[94]
- Very often, lawyers aren't looking after the best interests of society, the medical

[91] John Shotter, John, quoted in Power PointPowerpoint handout, Taos Institute, Collaborative Practices, October, 2005.
[92] Stewart, et al., p. 227.
[93] Smarr, *Statement of July 13.2006, p. 2.*
[94] Ibid.

profession or the health care system. (non-litigation attorney)[95]

- Except for lawyers, this system [med mal litigation] does no one any good. (insurer)[96]
- Lawyers are modern-day mercenaries. (non med mal attorney)[97]
- If there is a barrier to the adoption of a humanistic risk management policy by 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)[98]

Risk management is an effort to avoid liability, rather than an effort to avoid error." (author/scholar/editor)[99]

- "Risk management…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." (professor of law)[100]
- "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/expert witness in medical malpractice, discussing litigation and physicians'

[95] Randolph W. Pate, *How Should Malpractice Policy Put Patients First,* AARP Bulletin, posted: 4/6/2006, pp. 1-2, <http://www.AARP.org/health/doctors/articles/medical_malpractice.html>, accessed November 15, 2006.
[96] Ibid, p. 2.
[97] Ibid, p. 1.
[98] Gawande, *p. 57.*
[99] Virginia Sharpe, *Introduction, Accountability,*p. 17.
[100] Bryan A. Liang, *Error Disclosure for Quality Improvement: Authenticating a Team of Patients and Providers to Promote Patient Safety,* in *Accountability,* p. 63.

insurance rates.)[101]

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)[102]

- 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)[103]

- "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).[104]

- Claimants are often simply attempting to ensure that the error is not repeated. (academic study report)[105]

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[101] Marc R. Lebed and John J. McCauley, *Mediation Within The Health Care Industry: Hurdles and Opportunities,* 21 Ga.St.U.L.Rev 911-930 (2005), quoting Dr. Barry Schifrin, p. 923.
[102] David Studdert, Michelle Mello, Atul Gawande, Tejal Gandhi, Allen Kachalia, Catherine Yoon, Ann Louise Puopolo, Troyen Brennan, *Claims, Errors, and Compensation Payments In Medical Malpractice Litigation,* 354 NEJM 2024-2033 (2006), p. 2033 <http://www.nejm.org/cgi/content/short/354/19/2024>, accessed Jun 3, 2007.
[103] Ibid, pp 2029-2030.
[104] Harvard School of Public Health, *Study Casts Doubt on Claims That the Medical Malpractice System Is Plagued by Frivolous Lawsuits,* May 10, 2006 Press Releases, <http://www.hsph.harvard.edu/news/press-releases/2006-releases/05102006.html>, accessed May 13, 2007.
[105] Edward Dauer, Leonard Marcus, *Adapting Mediation To Find Resolution of Medical Malpractice Disputes With Health Care Quality Improvement,* 60 Law & Contemp. Probs. 185 (Winter 1997), pp 185-186.

- At some point we must all bring medical mistakes out of the closet. (physician)[106]
- A transformation in how the medical profession communicates with patients about harmful medical errors has begun. (academic journal)[107]

We can't reconcile these statements. How can we stop the finger pointing? 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. We can't do it differently until we see it differently. 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 in dialogue. The questions we propose create the space for shifts in thinking, for building community.[108]

Thinking about questions for dialogue, I came across eight very thoughtful ones, proposed by Diana Chapman Walsh, former President of Wellesley College[109]: "How do we… create spaces for the silences, without which we will not be able to hear ourselves in dialogue with others? What are the essential structures that can support difficult dialogues-get them started and keep them going deeper and deeper? Where will we find the resources…to sustain

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[106] David Hilfiker, *Facing Our Mistakes*. 310 NEJM 118-122 (1984), <http://www/davidhilfiker.com/docs/miscellaneous/mistakes.htm>, accessed January 7, 2008.
[107] Thomas H. Gallagher, M.D., DavidThomas H, Studdert, LL.B., WendyDavid, Levinson, M.D, .Wendy, *Disclosing Harmful Medical Errors to Patients,* N Engl J 356 NEJM 2713-9 (:26, June 28, 2007), p. 2718.
[108] For instance, pose questions using the quote "A transformation in how the medical profession communicates with patients about harmful medical errors has begun." Gallagher, et al., 356 NEJM2713-9. 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?
[109] Diana Chapman Walsh, *Difficult Dialogues,* <www.clarku.edu/dd/docs/DD-keynote.pdf>, accessed October 10, 2008.

our own commitments, and that of others, to this work? How do power relations affect the narrative that is allowed to unfold and what can be done to insure that the buried wisdom in the voices from the margins is brought forward into the dialogue and truly heard? How does large scale change occur? Are there creative alliances that could accelerate this process? What would have to happen to produce new networks/alliances that would take the work to a higher level of intensity and effectiveness? What constitutes success in a difficult dialogue, how do we know it when we see it, and might our conventional notions of success be utterly wrong?"[110] Dr. Walsh then reformulated them all as one question: "*What am I called to do now, what is mine to bring to the relentless violence in the world?"*[111], [112]

Dialogue is a discipline for developing coordinated meaning among disparate groups of people. Dialogue is a conversation in which people "think together" in relationship. It involves relaxing our grip on certainty, which, for a lawyer, is very disconcerting. According to David Bohm, a creative and innovative thinker on dialogue, humans have an innate capacity for collective intelligence. We "can learn and think together, and this collaborative thought can lead to coordinated action."[113] "When people join together and go beyond their habitual way of being as a group, even more possibilities open up."**[114]** "Dialogue does not require people to agree with each other. Instead, it encourages people to participate in a pool of shared meaning that leads to aligned action. As Isaacs and his research group at MIT confirmed, out of this new shared meaning, people can and will take coordinated and effective action without necessarily agreeing about the reasons for the action." [115] It takes in all viewpoints and rejects none. Multiple points

[110] Ibid.
[111] Ibid, p. 17.
[112] Litigation can be and often is verbal violence.
[113] Jaworski, *Synchronicity, p. 109.*
[114] Ibid, p. 82.
[115] Ibid, p 111.

of view come together and each retains its integrity. It takes us to new ways of being in the world. Dialogue "implicate[s] a kind of in-the-moment interactive multivocality, in which multiple points of view retain their integrity as they play off each other".[116] It is an approach that seeks diverse ideas and embraces ambiguity-actively, seeking information or beliefs that conflict with our own- so that we can stretch our comfort levels with contradictions and figure out how to make connections between seemingly dissimilar ideas in order to create new frames.[117] Part of the dialogue will likely bring forth ideas on taking the conversation back to our communities, expanding the ideas through these further exchanges. It involves risk for all of us, causing us to step out of our preconceived notions and comfort zones.

Dialogue is about deep listening as much as it is about speaking. It is listening with only one purpose in mind: to understand.[118] We must listen without agenda, without the need to "reframe", without judgment. Listening as the student, rather than the teacher, communicates our respect for the speaker.[119] We need to listen with full engagement, without interruption and without editorial comment, whether manifested by facial expression, body language, comment or question.[120] It is about genuine inquiry into ways of thinking so to explore, reflect, listen and examine our own thinking as well as another person's thinking. Real communication can only take place where there is silence. There is no dialogue without listening. It is the ability to engage or synchronize one person to another person, to be present for another. Somehow, we hope to come to this process with a clear head, without preconceived notions, without assumptions. It permits us to replace individualistic conceptions of humanity with conceptions of

[116] Stewart, et al., quoting B.W. Montgomery, L.A. Baxter, p. 231.
[117] Tojo Thatchenkery, Carol Metzker, *Developing Your Appreciative Intelligence: Seeing the Mighty Oak In The Acorn – Part 3*, World Business Academy Transformation, Volume 20, Issue 214, August 4, 2006.
[118] Wayne Brazil, Wayne, *Hosting Mediations as a Representative of the System of Civil Justice,* Ohio State Journal on Dispute Resolution, Volume 22 2007 Number 2, p. 260.
[119] Ibid, p. 260.
[120] Brazil, Wayne, Ibid, p. 261

personality as interpersonal, knowledge as socially constructed, behaviors as fundamentally responsive, and social life as inherently indeterminate and "messy".[121]

Dialogue is not about advocacy, not about competition. It is the possibility of two or more people making something new together. It is a "dynamic generative kind of conversation in which there is room for all voices, in which each person is wholly present, and in which there is a two-way exchange and crisscrossing of ideas, thoughts, opinions, and feelings."[122] According to Bill Isaacs, dialogue enables the emergence of genuine collective leadership, the highest aim of which is to make a contribution, to give, not to take. It explores underlying causes, rules, and assumptions to get to deeper questions and alternative ways of framing problems. It invents unprecedented possibilities and new insights. Generative dialogue emerges as people shift and expand on their positions and views. It is a progression from defending to suspending and on to dialogue and involves listening, respect, and voice. It involves a shared commitment to the community. Further, as William Isaacs has noted, it involves listening, rather than reloading for the next round. Images of the future we hold are created through the use of language[123]; through inquiry and dialogue, we can shift our attention and action away from problem analysis to lift up worthy ideals and productive possibilities for the future.

Dialogue seeks to form the foundation of community across the divide that may exist among various stakeholders and professionals. It explores common ground, in this case, the

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[121] Stewart, et al.,John & Karen Rediker, *Dialogue as Tensional, Ethical Practice,* Southern Communication Journal, Volume 65, Winter-Spring, 2000 p. 226.
[122] Harlene Anderson, *Collaborative Learning Communities, in Relational Responsibility, p. 66.*
[123] One way of addressing the use of language is to think of it as "semiotic" shading, the substitution of a word or phrase with a near equivalent, but not threatening, intimidating, or conflict oriented, such as "tension between us", rather than "Anger between us" or "antagonism between us"; rather than "we are adversaries", "we are collaborative professionals". "We are here to discover how we can work together", rather than "We are here to try to set aside our differences". Kenneth Gergen, Sheila McNamee, Frank Barrett, *Toward a Vocabulary of Transformative Dialogue,* Preliminary Draft for International Journal of Public Administration, 24, 697-707 (2001), 704. *http://www.swarthmore.edu/socsci/kgergen1/web/page.phtml?id=manu23&st=manufascripts&hf=1, accessed September 25, 2008.*

values, processes and procedures of various organizations and individuals who work in the areas of medical error/malpractice and patient safety. Dialogue involves suspension of judgment, release of the need for specific outcomes, an inquiry into and an examination of underlying assumptions, authenticity, a slower pace with silence between speakers, and listening deeply to self, others, and for collective meaning.

Dialogue can transform our thinking and our actions**.** "Transformative Dialogue may be viewed as any form of interchange that succeeds in transforming a relationship between those committed to otherwise separate and antagonistic realities (and their related practices) to one in which common and solidifying realities are under construction"[124] Transformative dialogue aims at facilitating the collaborative construction of new realities.[125] It is capable of transforming relationships, *shifting the thinking of the participants from adversarial to cooperative.* It involves creating a conversational space to integrate multiple perspectives, create community, examine assumptions and imagine a new future.[126] The hope is to foster a vocabulary of relevant action along with a way of deliberating on its function and translation into other practices.[127] The vocabulary we use, the questions we ask can leave blame behind. Mutual blame, any blame, impedes forward movement and relational responsibility.

Discourse that involves individual blame is divisive and erects a wall between us and sabotages the process of transformative dialogue. Can we move conversation to focus on group differences? If so, individual blame recedes in importance.[128] We can define blame out of bounds

[124] Ibid, p. 698.
[125] It is a perfect descriptive term for the process I envisioned regarding medical error.
[126] McNamee, *Moving To Relational Realities in Organizations,* handout.
[127] Medical error/medical malpractice litigation is exactly the type of situation/condition in which transformative dialogue can occur. The various professionals who are participants in medical error situations and their aftermath come to dialogue "from multiple and conflicting realities". Gergen, et al, *Toward a Vocabulary,* p. 699. Through the conditions and conversational framework, i.e. questions posed, participants chosen, transformation in thinking, leading to transformation in action, is possible.
[128] Ibid, p. 702.

by setting rules in our conversations that blame talk is not permitted, not even disguised as questions.[129] We can set aside blame in favor of interdependent relationships.[130] 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 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.

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.

Participants in dialogues, in the best of circumstances, have the opportunity to focus on shared meaning and learning, release the need for specific outcomes, listen without resistance, respect differences, suspend role and status, share responsibility and leadership, speak to the

[129] This is particularly difficult for an attorney; after all, we either wear the white hat or the black hat! Much of the litigation process is about blame.
[130] Gergen, *An Invitation,* pp. 156-157.

group, speak when the spirit moves us, and balance inquiry and advocacy. Dialogue involves authenticity and a slower pace with silence between speakers, listening deeply to self, others and for collective meaning.[131] The dialogue process flows from the questions posed to the group. Once a group has had the opportunity to break down barriers through dialogue, the next step in the process can be transformative, moving beyond the initial stages of getting to know each other, getting beyond our assumptions about each other and our alienation from each other, and into new ways of moving forward together.

Trust is central to the dialogue process. We can encourage trust by our genuineness, honesty, transparency about ourselves and the process. Genuineness is about listening, caring and commitment. Because distrust is so ubiquitous in litigation, it will take time, lots of talking, lots of listening, and lots of patience to convince clients that this process may work, that we are ethical, that we are genuine and have their best interests in mind. We can use our own transparency to attack the cynicism about the legal system that seems so widespread. Our best task for the process is being ourselves, making it clear we want to help and that we are ethical. Our success depends on how much of ourselves we give to the process and by the integrity the process reflects when it is in our hands.[132]

The Use of Dialogue To Build Community Around Responses to Medical Error

I came to the dialogue process with an extreme case of frustration. I attended the ABA Dispute Resolution Section Conference in Atlanta in 2005, where a few forward-thinking attorneys from around the U.S. held an early Saturday morning session on collaborative law in medical error. The overwhelming audience response was skeptical at best, negative at worst. The

[131] Linda Ellinor, Glenna Gerard, *Dialogue, Creating and Sustaining Dialogues*, John Wiley and Sons: New York, 1998, pp. 143-144.
[132] Brazil, p., 262.

few attorneys who chose to show up at 7AM on Saturday morning shook their heads repeatedly and said: where are the cases, where are the numbers,[133] the statistics, there is no track record, it will never work, how would we ever "sell" it. There was, generally, much nay-saying, finger pointing, and assumption-making about other stakeholders (i.e., as above, 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). I thought about structuring a dialogue about the process with all these, and other, stakeholders.[134] How could I create the space for all these perspectives to be heard, for a conversation that left finger-pointing behind? Each person needed the opportunity to speak from her/his unique perspective. How could something akin to a community of cooperation arise among these stakeholders? How could a collaborative intelligence be created? I thought of using Appreciative Inquiry, which focuses on possibilities, not problems and arises out of concepts of social construction. Social construction indicates that we create meaning through our activities together: our thinking, listening and conversations/dialogue and that meaning does not lie in the head of any one individual.

The dialogue process brought together several participants already using portions of the collaborative process to great success in their organizations. The hope was to expand the conversation from their experiences, i.e. how it works, how it was developed, how much money has been saved, how respectful it is, and both build on that and expand the dialogue to other stakeholders and other health care issues. Although not formally known as collaborative

[133] Numbers are just another language; they don't give us information, experiences, stories. They distance us from each other. Gergen, *An Invitation*, p. 92.
[134] This brought to mind the words of Jon Filer, Chairman of the Aetna Insurance Company, at the opening of a community dialogue, calling the group assembled "a magnificent coalition of the unalike", *Synchronocity*, at p. 112.

law/practice, these processes come from the same kind of compassionate thinking.

For attorneys, the process of dialogue is foreign. However, it is laden with possibilities. Attorneys wanted to know how to prepare, what questions they'd be asked, who was going to make the "other side" of the argument. They had trouble grasping that it wouldn't be oral argument, wouldn't be a debate, wasn't about winning and losing, right and wrong. What it was about is, as noted above, listening, silence, and sharing our stories and wisdom. Looking back on the stakeholder participants in the dialogues, having recently done a third one in Toronto, I'm thankful that the right people showed up for them. When I say the "right people", I mean individuals who believed in what they were doing, while having the willingness to listen to others' points of view and new ideas.

Appreciative Inquiry

> ***"****We each harbor the voice of possibility and yet it is the voice of deficit, of assessment, of diagnosis, that gains our attention. It is time to consider forms of practice and relational communities where multiple participants, personal stories, self-reflexive inquiry, and images of the future are given voice."*
>
> – Sheila McNamee[135]

> *"Whatever you can do or dream you can, begin it."*
>
> – Goethe[136]

We can construct the future together through dialogue, through proposing questions that call forth our own individual stories. One of the approaches to do this is the process of appreciative inquiry (AI). As noted above, the process focuses on what is working, not what

[135] McNamee, *The Social Construction of Disorder*, p 166.
[136] Goethe, quoted in *Synchronicity*, *Preparing To Journey, Part One.*.

isn't. AI focuses on possibilities, not problems; it builds on past successes. That sounds easy, but it requires an important shift from our usual, problem-centered approach to bringing about change. Appreciative Inquiry is the brainchild of Dr. David Cooperrider, Professor of Organizational Behavior at Case Western Reserve University's Weatherhead School of Management and cofounder of Appreciative Inquiry Consulting. AI helps us discover what works, so that we can do more of it. It is inquiry, based on positive questions. In AI, a clear, concise topic is chosen, positive questions are developed, and the consultant (or whoever is asking the questions) sits down with the team/group/individual and asks the questions. Stories start to develop; patterns begin to emerge. Individuals recall and tap into positive achievements and stories that strengthen and inspire. The process, which is more fully described below, doesn't ignore problems—it just approaches them from the other side, the other side being what IS working, rather than what is NOT working. It can be used informally, such as in a conversation, or in a formal context, such as at a strategic planning conference or retreat. It can be used with two people or two thousand. People, organizations, communities do not need to be fixed; they need constant reaffirmation, which this process can bring them.

Appreciative Inquiry takes the theoretical framework of social construction, the idea that a social system creates or determines its own reality, and applies it in a positive context.[137] There is overlap between AI and social construction theory, including:[138]

- Patterns of social/organizational action are not fixed by nature;
- All social action is subject to multiple interpretations;
- Our observations are filtered through our belief systems;

[137] David L. Cooperrider, Diana Whitney, Jacqueline M. Stavros, *Appreciative Inquiry Handbook, the First In A Series of AI Workbooks For Leaders of Change,* Lakeshore Communications, Inc.: Bedford Heights, OH, 2003, p. 13.
[138] Ibid, p. 13.

- We are our stories;
- Dialogue is a vehicle for change through language;
- Social knowledge is not "out there" to be discovered through objective practice;
- Dialogue is necessary to determine the "nature of things";
- Social knowledge resides in our stories.

Could all that we construct as problems in our culture be reconstructed as opportunities? That is where dialogue based on appreciative inquiry comes in. From a constructionist perspective, problem talk is optional. Cooperrider says: "The single most prolific thing a group can do, if it aims to consciously construct a better future, is to discover what the 'positive core' of any system is, and then make it the common and explicit property of all." (Positive core of medical error situation/medical malpractice litigation is healing.)

AI builds on several assumptions, including:[139]

- In every society, organization, or group, something works.
- Every human system already has strengths and assets.
- Any system has factors and forces that lead to successful outcomes.
- What we focus on becomes our reality.
- Reality is created in the moment, and there are multiple realities.
- People have more confidence and comfort to journey to the future (the unknown) when they carry forward parts of the past (the known);
- The act of asking questions of an organization or group influences the group in some

[139] Ibid, p. 1-18; Diana Whitney, Amanda Trosten-Bloom, *The Power of Appreciative Inquiry: A Practical Guide to Positive Change*, Berrett-Koehler Publishers, Inc: San Francisco, 2003, p. 2.

way;

- What we want already exists in ourselves, our firms, our organizations and our communities.

AI is collaborative, generative, and inclusive. It brings all voices into the conversation. The inquiry becomes a self-fulfilling prophesy: what we think about and tell stories about focus on the direction in which we want to go. True change can't take place until all voices, all points of view have been heard, until people can think out loud together and listen to each other's ideas and stories. It discovers capacity and builds towards and through it into even greater cooperation and capacity. It encourages organizations to draw on and expand on their existing strengths, hopes and dreams. AI is built on relationships, on conversations and connections. It gives all of us an opportunity to be heard. It encourages us to be positive. It gives us discretion and support to act. It allows us to decide how we will contribute.

The intent of the AI process is the constructive discovery and narration of the organization's/community's life-giving story: focusing on the organization's most positive qualities, what the organization is has done well in the past and is doing well now (what facts give life to this organization when it is most successful and effective). The process then leverages those qualities to enhance the organization, dreaming and designing a better future.

Some core values and beliefs of the AI process include: people individually and collectively have unique gifts, skills, and contributions to bring to life; images we hold of the future are socially created; images of the future we hold are created through the use of language[140]; through inquiry and dialogue we can shift our attention and action away from

[140] It is helpful in the AI process to keep in mind that language shapes culture. Therefore, it is useful (and hopeful) to stay away from the language of deficit, in organizations: executive burnout, job dissatisfaction, low morale; in individuals: depressed, dysfunctional, midlife crisis. In the medical error context, replace "incident report" with

problem analysis to lift up worthy ideals and productive possibilities for the future. Efforts to "discover and theorize about the life-giving properties of organizations-what is happening when they are operating at their best-is more likely than problem-solving to lead to innovation and capacity building."[141] The process seeks to recognize the best in all of us and to affirm our strengths and potential, to ask questions, and to search and explore, as well as locate, highlight, and illuminate what are the life-giving forces of the organization's existence.

AI posits that people/organizations change in the direction of what they study. It focuses attention on the positive core of the organization, on the organization's collective wisdom and strengths. If the problem in the organization can be stated in the affirmative, and studied, organizational performance will improve. AI, through dialogue, allows us to decide how we will contribute. Ideally, it gives us support to take action.

The Eight Core Principles of Appreciative Inquiry include[142]:

- *Constructionist Principle*: Our organizations evolve in the direction of the images we create, based on the questions we ask. Constructionism, as explained above, is an approach to human science and practice which replaces the individual with the relationship as the locus of knowledge. As a result, it is built upon an appreciation of knowledge and discourse. Constructionism, based as it is on communal knowledge, invites us to find new ways of generating knowledge. It challenges the traditional

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"patient safety learning report". Because priority is defined as "taking precedence logically" and value is defined as "intrinsically valuable or desirable", we might want to refer to patient safety as a value, not a priority. Value indicates permanence, while priority indicates order of importance, which could change. Other examples of the language of deficit: "meeting JCAHO requirements" vs "fulfilling an organizational mission"; "patient safety compliance task force" vs "patient safety achievement task force"; "disclosure" vs "recognition", perhaps, because 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.

[141] Frank Barrett, Ronald Fry, *Appreciative Inquiry*: *A Positive Approach to Building Cooperative Capacity,* Taos Institute Publications: Chagrin Falls, OH, 2005, p. 37.

[142] Whitney, Trosten-Bloom, pp 51-79.

individualistic, historic, objective ways of knowing. It challenges absolutist ways of thinking, bringing collaboration, conversation and dialogue forth as real options to help us create new opportunities for living.

- *Simultaneity Principle*: Change begins the minute we ask questions; inquiry and change take place simultaneously. Inquiry is intervention. The source of our ideas and our research is the question. The questions we ask truly set the stage for what we find, what we expand on. One question leads to another, constantly expanding our conversation on a specific topic. Think of the impact of questions: they can cause a shift in thinking, a new awareness, or a generative conversation.
- *Anticipatory Principle*: Our behavior in the present is influenced by the future we anticipate. Our images of the future guide our current behavior. Our collective imagination about the future creates our anticipatory view of the future.
- *Poetic Principle*: Just as poets have no constraints on what they can write about, we have no boundaries on what we can inquire and learn from. Poetry has endless opportunities for interpretation and learning. If we think of our organizations and communities as open books, rather than machines, destined to work in one way, we see the endless possibilities for new learning and change.
- *Positive Principle*: The more positive the questions we use to guide a change process, the more long-lasting and effective that process will be. We can make a tremendous difference by crafting and seeding the unconditionally positive question. Building and sustaining momentum also requires social bonding in terms of hope, community, purpose and inspiration.

- *Wholeness Principle*: bringing all stakeholders to the process encourages greater understanding of each other's positions, greater understanding of the whole story. The word "health" is based on an Anglo-Saxon word "hale" meaning "whole". To be healthy is to be whole.[143]

- *Enactment Principle*: positive change comes about by enacting today our visions and desires of what we hope for for our desired future. As Gandhi told us: "Be the change you wish to see in the world."[144] Another leader of our times, Martin Luther King, Jr., said: "Darkness cannot drive out darkness; only light can do that. Hate cannot drive out hate; only love can do that."[145]

- *The Free Choice Principle*: people and organizations thrive when she/he/they can determine the extent of her/his/their participation and contribution. People support the processes they have helped create.

The first step in the AI process is choosing a topic. This is crucial because the AI process builds out from the topic choice. Change starts to happen with the first questions we ask. Because change begins to take place at the same time as inquiry, we want our inquiry to focus on what is working so that we can build on that. The topic should be one in which the team, group, or person is really interested and wants to learn more. The topic should be stated with positive wording, i.e. "What is the most satisfying…etc." It should (and will) generate possibilities. Start with the topic that is most relevant or urgent to the organization - growth, client services, marketing, diversity, etc. If this seems too daunting, start with a small topic or a small group, even one person. Inquire about what has worked best for that person in her/his profession, what

[143] Whitney, Trosten-Bloom, quoting David Bohm, p. 69.
[144] <http://www.quotationspage.com/quotes/Mahatma_Gandhi> accessed July 15, 2007.
[145] King, Martin Luther, Jr. "The Most Durable Power", in Whitney, et al., *The Power Of Appreciative Inquiry*, sermon delivered November, 6, 1956 in Montgomery Alabama, p. 72.

work s/he is most proud of, or something similar. Once we learn how to do this, we can share the concepts of AI and our success stories with our firms, clients and communities.

To choose a topic, start with peak experiences, things valued most about yourself, nature of your work, what gives life to the organization/team, three wishes that heighten vitality and health. Involve those that have an important stake in the future of the process/envisioned change, build a steering committee or start with a senior executive-level team, involve the whole system to the extent possible. People commit to topics they have helped develop; topics are phrased in affirmative terms. Inquiry may include questions that are affirmative, expansive, enhance possibilities of storytelling, value what is, evoke essential values, aspirations and inspirations; assumptions of health and vitality, commitment, caring. Interview about when interviewees have seen things at their best at work. Some possibilities include: What is the most outstanding or successful achievement interviewees have been involved in pulling off? What was it about interviewee's unique qualities that made it possible to achieve the result? What was it about the organization that fostered interviewee's determination to excel or achieve? What individual qualities are most valued in this organization? How do people develop these qualities? What does the organization do to heighten a sense of understanding and alignment among its members? When new members enter the organization, what does the organization do particularly well in educating them about both the mission and values of the organization? How does the organization empower its employees? What does the organization do to create common goals and beliefs that allow diverse people to work effectively together? What does the organization do to encourage reflective thinking? What two or three things about the culture of this organization are you most proud? How does your leadership contribute to morale? What have been the highlights of this process? What would you like to see come out of this process?

Whichever topic is chosen, whatever groups or individuals the facilitator talks with, look for patterns in their responses. Pay attention to the attitudes of the responders, both at the time they respond and at later times. Take a step back; take some time to absorb the responses. Notice the changes that start to take place, the shift in thinking based on the inquiry and the responses, the conversation. The changes are likely to be subtle at first, so keep paying attention. This will allow you not only to see and experience the changes, but to more easily move into the next steps in the process. From the topic, we move on to inquire about the positive moments we have experienced in terms of the topic. We share our stories of what is working and how it is working; from there, we move onto how we can carry these images forward into the future and expand on them; we talk of innovation, talking and listening together. In this situation, the topic is collaborative law in medical error/non-adversarial alternatives to traditional medical malpractice litigation.

The process used to apply AI is a 4D Cycle, plus Delivery, which includes:[146]

- *Definition*: choose overall focus of inquiry; choose the positive as the focus of the inquiry.
- *Discovery:* Inquire into exceptionally positive moments so that everyone takes the opportunity to realize how much their world is comprised of the stories they are telling themselves and one another. Changing our stories changes our world. When we change the questions, we change our stories. When we change our stories, we change our lives. We examine the positive core; we share our stories of best practices. Our organization's history becomes a positive possibility, rather than problem-centered, static, etc. Through the discovery process, we identify stakeholders, decide who will be interviewed, develop

[146] Cooperrider, et al, pp 4-7.

interview protocol and distribute to team members, decide on a method/format for organizing data. Conduct interviews; create method for capturing the best stories, visions. Conduct interviews (Discovery, Part 1), share stories, identify topics/themes, life giving forces. (Discovery, Part 2)

- *Dream*: What world do we want to create? What best possible dream can we share together? Focus on Positive and Anticipatory Principles. Create shared image of a preferred future. Take time to envision the best possible future. Create visible image; write macro provocative proposals/propositions; create shared images of a preferred future. Brainstorm all the key relationships within your group/team/organization that can be impacted by the accomplishment of the dream. Brainstorm all the formal organization/team design elements that will influence or be influenced by the accomplishment of the dream. Envision possibilities; practical and generative; discuss unique contribution we can make in the legal world; possibility conversations. How will AI contribute to the changing world in this organization over the next ten years? What in your opinion are the most exciting strategic opportunities on the horizon for your organization?
- *Design*: How shall we live? Innovate and improvise ways to create that future. Design the structure/dynamics of relationships that support our dream. How do we make dream happen? Innovate and improvise ways to create that future. Create a design statement/provocative proposition that: is a real possibility, bold, challenges and stretches you, articulates your highest hopes and vision, supports your goal(s), and supports appreciative action. Craft a set of provocative propositions/statements that list the organ qualities they most desire; expand the organization's image of itself by presenting clear,

compelling pictures of how things will be when the organization's positive core is boldly alive in all of its strategies, systems, decisions and collaborations. Envision a collectively desired future, carry forth that vision in ways which successfully translate intention into realty, and beliefs into practices. When has cooperation been at its best in this organization? What makes cooperation possible? What are possibilities which enhance or maximize the potential cooperation? Provocative: grounded, desired, affirmative.

- *Destiny/Delivery*: Live the principles: practice, be open, stay awake, be flexible, pay attention. Live into and toward our dreams and goals. Focus on personal and organizational commitments and paths forward.

AI has been applied in a variety of processes, including: Whole system 5-D dialogue (all organizational members); AI summit (large group in 2 to four day workshop, includes all stakeholders); mass-mobilized inquiry (large number of inquiries on socially responsible topic; Imagine Chicago: transform a community's image of itself, build relationships among diverse groups); core group inquiry (small group selects topics, crafts questions, and conducts interview); positive change network (train a group and give them resources to initiate projects, share stories and best practices); positive change consortium (multiple organizations engage in 4-D to explore and develop common area of interest); AI learning team (small group conducts an AI 5-D process; progressive AI meetings (meetings to work through process, like 2 hour meetings, weekly).

AI is collaborative, generative, and inclusive. It brings all voices into the conversation. The process opens up space for possibilities. The inquiry becomes a self-fulfilling prophesy: what we think about and tell stories about focus on the direction in which we want to go. True change can't take place until all voices, all points of view have been heard, until people can think

out loud together and listen to each other's ideas and stories. It discovers capacity and builds toward and through it into even greater cooperation and capacity.

If you want to create change, Appreciative Inquiry is a great way to begin the process. It is an affirmative approach to human and organizational development. AI springs from possibilities and from hope. Again, it works with two people or with two thousand. If structured correctly, all involved have the opportunity to co-create change and transform their organization. Everyone gets to be heard! It brings out the best in us. If you're skeptical, try suspending judgment; experiment with it. Keep in mind the words of Gandhi, an attorney himself: "You must be the change you wish to see in the world." Remember--even the most innocent affirmative question evokes change. Often, the change is not what we expected, but welcome, just the same. For instance, asking subject matter questions may not bring forth a new organizational plan but, instead, may bring a rededication to the core values of the organization or individual.

The use of affirmative language changes the way we think; changing the way we think will change the way we work. The shift in thinking begins with the questioner. The process allows us to move beyond the ineffective problem-solving approach; we need to focus on what WORKS, so we can do more of it. The problems won't disappear (wouldn't that be nice?) but they will be smaller as what works gets larger and greater in stature.

Affirmative Dialogue focuses on participants' past interactions and interdependencies, the potential for new meaning to arise out of open discussion, new connections, respect and dignity of all participants, and the stories and experiences they tell. It focuses on a continuing conversation. The dialogues I've facilitated at this point have been one-time-only sessions. I will convene and facilitate one in the S.F. Bay Are in the spring, 2008 that could become a continuing

dialogue, if I can gather a number of local professionals and stakeholders as participants and expand the circle as I become aware of other interested parties. I hope this session will lead to others, building trust and community as we go. The interactions between and among the various professionals in the medical error process have not always been positive, as explained herein; however, this process is intended to overcome misconceptions and assumptions, and has been successful in the past.

Chapter Three:
Law as a Healing Profession

"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."

– Chief Justice Warren Burger[147]

"The path forward is about becoming more human, not just more clever. It is about transcending our fears of vulnerability, not finding new ways of protecting ourselves. It is about learning how to act in service of the whole, not just in our own interests."

– Peter Senge[148]

"How can professionals [lawyers] invite the kinds of relationships and conversations with their clients that allow all participants to access their creativities and develop possibilities where none seemed to exist before?"

– Harlene Anderson[149]

"Who, then, will speak for the common good?"

– Barbara Jordan[150]

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[147] Chief Justice Warren E. Burger, *The Role of the Lawyer Today,* 59 Notre Dame L. Rev.1 (1983).
[148] Peter Senge, *Solving Tough Problems,* Excerpts from the Forward, <http://www.collectivewisdominitiative.org/papers/kahane_solving_fwd.htm>, accessed May 15, 2007.
[149] Harlene Anderson, *Becoming a Postmodern Collaborative Therapist: A Clinical and Theoretical Therapy: Part II,* <http://www.taosinstitute.net/manuscripts/becomingapostmodther.doc>, accessed October 1, 2008.

"Among the public services provided by law professionals, beginning the healing process may be the most important."

– Dean David T. Link[151]

"Where there is discord, may we bring harmony."

– St. Francis of Assisi

Healing

There is a southern Africa tradition called Ubuntu, the notion that my humanity is inherently connected to your humanity and that we are people because of other people. Archbishop Desmund Tutu defines it as "A person with Ubuntu is open and available to others, affirming of others, does not feel threatened that others are able and good for he or she has a proper assurance that comes from knowing that he or she belongs in a greater whole and is diminished when others are humiliated or diminished, when others are tortured or oppressed."[152] Our own dignity can only be measured in the way we treat others.

As lawyers, we can choose to treat others differently. We can choose to see the law differently.[153] Alan Reid challenges lawyers to seek a transformed vision of law to bring about healing. Reid suggests seven guidelines for lawyers: let go of grievances towards the other person, whether lawyer or client; never use the law to reinforce a judgment made about the other person; never use legal rights or skills to attack another or seek vengeance; make all decisions that have legal implications while in a state of peace, not fear or anger; trust that the process will

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[150] Keynote Address, 1976 Democratic National Convention.
[151] David Link, *Shifting The Field Of Law and Justice: A Collection Of Essays Reshaping The Lawyer's Identity,* Volume 1, Center For Law and Renewal: Kalamazoo, MI, 2007, p. 20.
[152] Archbishop Desmund Tutu, <http://en.wikipedia/org/wiki/ubuntu_(philosophy)>, accessed October 2, 2008. [152] Tutu, Desmund, Archbishop, *Truth and Reconciliation,* Greater Good, fall, 2004, Volume 1, Issue 2.
[153] Alan Reid, *Seeing Law Differently: Views From the Spiritual Path*, Borderland Publishing: Ontario, Canada, 1992, reviewed by Anu Osborne in Collaborative Review, Summer 2007, Volume 9, Issue 2, p. 13.

open up opportunities for healing if choices are made from a loving, not fearful state of mind; seek only the gift of healing for all involved in the legal proceeding; be aware of resistance to the foregoing principles in daily events and commitments. Reid encourages lawyers to look for healing in every situation, to always use the law, even when litigation is involved, for healing.[154],[155]

To be ethical, lawyers must be "doing good", one step beyond the physician's code of "do no harm."[156] However, many of us, as lawyers, have moved a long way from doing good. An anonymous lawyer once said: "The problem with our profession is that we have gone from the people who broke up street fights to the surrogate street fighters." "…[T]he lawyer as zealous advocate[157] has eclipsed all the other possible roles, and what was once thought of as legal ethics is now almost entirely adversarial ethics."[158], [159] Judge Horn stated that "we may need to engage in some hard, clear thinking about whether new boundaries to 'zealous advocacy'[160],[161] should

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[154] Ibid, p. 13.
[155] This concept, to me, is nothing short of revolutionary; it is brilliant. It gives me peace of mind, just thinking about it. I am a plaintiff in litigation involving my homeowners association, which gives me an opportunity to "try" this new way of thinking, to see if healing can actually arise in this litigation.
[156] Link, p. 19.
[157] Sells, p. 86.
[158] Horn, p. 41; Keeva, p. 101.
[159] "What if litigators were to turn a more aggressive eye toward the rigid and atrophied ideas that dominate litigation itself? Why not explore settlement first, instead of putting it off until later when the other side has weakened, or the meter has been allowed to run a little longer? And what about the knee-jerk reaction that if the other side wants it then we must be against it? Or the essentially barbaric idea that justice emerges only through adversity? Or, God forbid, litigation's first commandment that litigators must "zealously represent" their clients? "*Is that what we want? A profession of zealots?"* (emphasis added.) Sills, p. 86.
[160] "zealous advocacy" is traditionally defined as arguing for the best results for your client, regardless of how it affects or damages anyone else. Sometimes, it is a take-no-prisoners approach.
[161] One of the nine principal canons in the ABA's Model Code, first passed in 1970, was "A lawyer should represent a client zealously within the bounds of the law." The word "zeal" or "zealous" was mentioned nine times in the code, usually exhorting a lawyer to act zealously. In 1983, when the ABA passed the Model Rules of Professional Conduct; the word "zeal" appears three times, twice to admonish lawyers to balance zeal with other duties. These rules replace the duty to act "zealously" with the duty of "diligence" ("A lawyer should act with commitment and dedication to the interests of the client and with zeal in advocacy upon the client's behalf. However, a lawyer is not bound to press for every advantage that might be realized for a client." Richard Zitrin and Carol Langford, *The Moral Compass Of The American Lawyer,* Ballantine Books: New York, 1999, p. 65-66. Zitrin and Langford tell us that "zealous representation" has stretched the adversary theorem "beyond its reasonable limits", that it should be laid to rest and courts should be encouraged to remove the phrase from their opinions". Lawyers can still maintain all fiduciary duty to their clients, which includes competence, loyalty, advocacy and communication, but they can do

be fashioned and constructed."[162] In his review of *The Myth of Moral Justice*, Samuel Freedman tells us that the book "contends that from law school on through their careers, lawyers are so imbued with the concepts of servicing a client in an adversarial arena ("zealous advocacy", in legal parlance) and unemotionally evaluating facts and rules ("thinking like a lawyer", as the phrase goes) that they fail to answer to any overarching sense of right and wrong."[163] Charles Halpern explains: "Like many lawyers, I did work that I basically didn't believe in, taking satisfaction in the skillful and responsible way that I executed my assignments. The legal system is set up for zealous advocates who need not think too much about the value or merit of any particular position they take...[A]t law school, they had promised to teach us to 'think like a lawyer.' It was the only way I knew how to think…logical, unemotional, doubtful of intuition and passion."[164]

Setting aside "zealous advocacy" for the moment, "good lawyers are healers and problems solvers. They know how to listen to a client, understand the client's problem or opportunity, and serve as a counselor rather in society than a gladiator. Sometimes the best lawyers practice psychiatry without a license."[165] "Because of the inherent conflicts that exist, lawyers are called onto the stage of human existence to be one of the society's most previous healers".[166] 'A well-known Texas attorney, John McShane, asks himself two questions before meeting with a client: what was this person sent to teach me? How can I serve this person?[167] In terms of serving the client, Rule 2.1 of the Model Rules of Professional Conduct states: "[i]n

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that without being zealots. Zitrin, et al., p. 242.
[162] Horn, p. 50,
[163] Samuel Freedman, *On Education: Challenging Ethical Training of Lawyers,* New York Times, August 11, 2004.
[164] Charles Halpern**,** *Escape From Arnold & Porter,* ABA Journal, February 2008, Volume 94**.** <http://ABAJournal.com/magazine/escape_from_arnold_porter/>, accessed October 3, 2008.
[165] Newton Minow, Former Chair, Federal Communication Commission, cited in *Transforming Practices, "Praise for Transforming Practices".*
[166] Hall, *p. 153.*
[167] Ibid, *p. 134.*

rendering advice, a lawyer may refer not only to law but to other considerations such as moral, economic, social and political factors, that may be relevant to the client's situation." [168] We do our clients a service when we bring our entire selves, including our wisdom and experience to our roles as counselors, advocates and advisers, while respecting them and their autonomy.

In terms of McShane's other question, we need to keep in mind that wisdom, experience, and knowledge flow both ways in the attorney-client relationship. If we, the attorneys, see ourselves as the experts, we likely will not hear what our clients have to teach us. "There are always numerous lessons in the universe for all of us, if we open ourselves to them and are ready for the teacher to arrive…If we make ourselves available in a complete and authentic way, then we are creating the possibility for this person to add something"[169] to our lives. Always keeping the question- what was this person sent to teach me- in mind has the potential to keep us in a listening, learning stance when we talk to our clients. In the attorney-client relationship, the client is the learner *and* the teacher, as is the attorney.

Applying portions of social constructionist theory to this analysis of lawyers as healers, knowledge between attorney and client can be co-constructed, meaning that the relationship is not one of an expert controlling the relationship with her/his knowledge, telling the client what facts are important, what next steps need to take place, and how the case should be handled. Rather, the attorney can enter the relationship from a stance of "not knowing", "that is of relinquishing the grasp of professional realities, and remaining curious and open to the client's vocabularies of meaning."[170] It is not the professional's task to "lead the way to knowledge" but to "collaborative with the individual in generative conversations. The… relationship is thus one

[168] <http://www.abanet.org/cpr/mrpc/rule_2_1.html>, accessed on July 3, 2008.
[169] Hall, p. 137.
[170] Gergen, *An Invitation*, p. 170.

of conjoint meaning making."[171] The attorney, of course, enters the relationship with specialized knowledge and training, including verbal, writing and analytical skills, as well as knowledge of the law. However, the attorney doesn't have all the answers The attorney needs to continually focus on the needs and desires of the client. The greatest skill the attorney can bring to bear is her listening ability, for the client has many of her own answers, which often just need to be drawn out and discussed.

"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." [172] I want to see lawyers be able to contribute fully to our communities, to bring our communities together, not tear them apart or assist others in tearing them apart. I see lawyers as stewards of the legal system, having a moral contract with society. Collaborative law is one of the faces of legal stewardship[173]. For me, that involves trying to create a healing process associated with medical error, a process that allows silence, listening, empathy and communication, such that all voices can be heard, take part in all decisions, and have a say in change in health care practices to protect future patients and other members of our communities.

Dean Emeritus David Link of Notre Dame Law School has done extensive research on the historical role of lawyers as healers and is convinced that the earliest lawyers routinely performed this kinder and gentler function.[174] Based on his research, Dean Link believes that

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[171] Ibid, p. 170.
[172] Link, *p. 18.*
[173] "Stewardship begins with the willingness to be accountable for some larger body than ourselves-an organization, a community. Stewardship springs from a set of beliefs about reforming organizations that affirms our choice for service over the pursuit of self-interest…Stewardship is the choice for service. We serve best through partnership, rather than patriarchy. Dependency is the antithesis of stewardship and so empowerment becomes essential." Peter Block, *Stewardship: Choosing Service Over Self-Interest*, Berrett-Koehler Publishers, Inc.: San Francisco, 1993, p. 6.
[174] Keeva, p. 102.

hunters and gatherers moved into villages and had three categories of "experts" in their communities: medical, spiritual and conflict resolution. These three categories all involved healing. The healers of conflict, these antecedents of lawyers, rather than being adversaries, were concerned with keeping the communities together and maintaining peace among the villagers.[175] They brought their skills and education to bear to bring people together.[176] Dean Link also stated that "Judges, lawyers, and others in the legal profession have not only the opportunity, but also the responsibility to assist their clients in healing…[they] can and should inspire the healing process-bring about the healing potential. Law professionals can motivate the call for healing…[L]aw practitioners must recognize, however, that beginning the healing process may be the service most meaningful to many people involved in social conflict or social planning."[177] Finally, Professor Link informs us, "[H]ealing and peacemaking ethics are not inconsistent with zealous advocacy and adversarial ethics. The former are ends, while the latter are means."[178]

Chief Justice of the United States Warren Burger, expressed similar sentiments, "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."[179] Larry E. Riley, a Missoula, Montana attorney who represents physicians in medical malpractice suits, states: "I think that lawyers, when we're at our best, are problem-solvers and healers. Money has its place in the compensation system, but it is not the be-all and end-all. There are often times that other things

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[175] Link, p. 12.
[176] "Some scholars say that before the late eleventh century, the peoples of Western Europe did not distinguish between legal institutions and other indigenous forms of community. For them, the law was not a separate body of rules and regulations but an inherent part of everyday life interwoven through the social fabric. With the advent of modern written law, a different notion of society emerged. When once it was impossible for a person to think of himself or herself in isolation from the community, this now became the accepted view. Society began to focus more on individuals and their inalienable rights." Sells, pp. 171-2.
[177] Link, p. 13.
[178] Link, p. 21.
[179] Chief Justice Warren E. Burger, The *Role of the Lawyer Today,* Volume 59, Notre Dame Law Review, 1983, p.1.

must take place, such as being heard, finding out that someone truly does care and, in the appropriate case, a sincere and heartfelt apology."[180] Healing, from a lawyer's perspective, involves many relationships, some of which include: client with attorney; client and attorney and opposing party/attorney; judge with plaintiff, defendant, attorney; lawyer with community.[181] Dean Link believes it is time for lawyers to reclaim their role as healers. One approach to reclaiming our role as healers is to reach back into the legal education process. In that regard, David Hall states: "A fundamental pedagogical belief for me is that the more the study of law feels like the study of life and values, the greater the possibility that we can produce more humane, sensitive and respectful professionals".[182]

We don't often hear the words "lawyer" and "healer" mentioned in the same sentence. Lawyers are not only healers, but counselors, advisers, and advocates. In place of these roles, we know all too well the pervasive stereotypes about attorneys: sharks, thieves, ambulance chasers. Adjectives used to describe lawyers include greedy, self-absorbed, overzealous, dishonest, arrogant, mercurial, angry, compassionless, pugnacious, aggressive, and pushy, to name a few. Lawyers are often at the center of controversy; they are at the center of peacemaking as well, although not as often. But, think of lawyers healing conflict around the world. Gandhi was a lawyer. Nelson Mandela is a lawyer. Mandela, rather than being bitter, angry, and vengeful, came out of Robben Island with this to say (regarding sketches he did of the prison), a tremendous expression of his healing spirit:

"Today, when I look at Robben Island, I see it as a celebration of the struggle and a

[180] Riley spoke these words in response to the comment of Philip Corboy, a plaintiff's attorney, "We're in the redress business, the business of seeking justice under the justice system. The role of the tort system is compensation, not apology." Steve Keeva, *Law and Sympathy: Apology Reforms Cost Little But Contribute Much to Clients' Healing,* ABA Journal, August, 2004.
[181] As we act as agents of healing for our clients, we begin to heal ourselves.
[182] Hall, p. 205.

symbol of the finest qualities of the human spirit, rather than as a monument to the brutal tyranny and oppression of apartheid. Robben Island is a place where courage endured in the face of endless hardship, a place where people kept on believing when it seemed their dreams were hopeless and a place where wisdom and determination overcame fear and human frailty. It is true that Robben Island was once a place of darkness, but out of the darkness has come a wonderful brightness, a light so powerful that it could not be hidden behind prison walls, held back by prison bars, or hemmed in by the surrounding sea. In these sketches entitled: My Robben Island, I have attempted to colour the island sketches in ways that reflect the positive light in which I view it. This is what I would like to share with people around the world and, hopefully, also project the idea that *even the most fantastic dreams can be achieved if we are prepared to endure life's challenges"*[183] (emphasis added).

Barbara Jordan[184], who, as a member of Congress, spoke so eloquently about the Constitution during the Watergate hearings, was a lawyer and a true defender of the Constitution. She always spoke in a calm, reasoned, thoughtful way. She never exaggerated, she never yelled, she never name-called. She always spoke as a healer during a horrific time in our country. Thurgood Marshall, long before he became a Supreme Court justice, was the attorney for the plaintiffs, the children who sought a good education, one equal to the education the white children received, in *Brown v. Board of Education*[185]. Marshall was another healer, healing the wounds of segregation through his courtroom skills, words and values. George Mitchell, as an attorney and private citizen, worked day and night for peace in Ireland; he was also majority

[183] Print of words handwritten by Nelson Mandela, sold at the Nelson Mandela museum, Cape Town, South Africa.
[184] See her question to all of us, above, "Who, then, will speak for the common good?" Wish she were still here to ask us again.
[185] 347 U.S. 483 (1954).

leader of the U.S. Senate during Iran-Contra[186] and was a healer for the country when he questioned Oliver North in a respectful way. He was also a federal judge. Mitchell during the Iran-Contra hearings admonished North not to impugn the patriotism of those who disagreed with him.

All of these individuals, from Gandhi to Mitchell and beyond, are (were) all peacemakers and healers. As I write this, the most vocal professionals demonstrating against Musharoff and marshal law in Pakistan are the lawyers.[187] One of the early repressions in Nazi Germany was against the lawyers. The Bush Administration strongly criticizes lawyers and the courts. In opposition and to offset his comments, to some extent, is Senator Robert Byrd, another lawyer, who, sometimes standing alone, speaks about civil liberties and the true meaning of our freedoms, including our responsibilities as citizens, always trying to educate, inform and heal.

I have a story of my own about healing. Once, I represented a couple, let's call them Bill and Betty, with two small children. All they had in terms of assets were their insurance policy and their house. Bill had a friend, let's call him Joe, who helped with a project on Bill's house. There was a horrible accident. Joe fell, maybe due in part by Bill accidentally bumping into him, hit his head and died. I was appointed by the insurance company to represent Bill and Betty. Joe was a single parent, leaving two small children. The children were the plaintiffs in the wrongful death case. I made it clear from the outset with the attorney for the children, Harry, that my clients were so sorry and wanted to resolve this as quickly as possible so that Joe's children would be taken care of. Harry and I treated each other with respect and came to trust each other.

[186] Even as Senator Mitchell pressed Oliver North about his many illegal activities in relation to Iran-Contra, Mitchell was always the peacemaker because he was always respectful and always spoke with reverence about our Constitution.

[187] The ABA held a Lawyers' Solidaritylawyers' solidarity with Pakistan MarchPakistani march in Washington, D.C. on November 14, 2007, at which 600 to 700 lawyers, dressed mostly in black, took part. One lawyer who took part said: When was the last time the legal profession was galvanized by anything?

Bill and Betty were devastated, stricken, and terrified of losing everything. After much discussion, Harry agreed that he was willing to take the insurance policy limits as full settlement of the case. The tricky part was getting the insurance company on board. If the insurance company wouldn't agree, Betty and Bill, very likely, would lose their home. The insurance company said NO several times; they would not pay the policy limits. I kept at it, going higher up the chain in the insurance company, while trying to comfort Betty and Bill and keep them hopeful that the insurance company would eventually agree. The insurance company finally agreed and the case was resolved. Betty and Bill sent me a hand-written note that I have to this day. They expressed their heartfelt appreciation beautifully. That was a transforming experience for me, a true healing all the way around, with Betty and Bill, with Joe's children, with Harry, and with me.[188] This could never have happened without the substantial and collaborative efforts of Harry. It was truly a collaborative law case, with both attorneys acting as healers, while zealously representing our clients.

Oliver Wendell Holmes believed that the law should be seen as separate and apart from our communities, should be on a scientific footing, that it was a science consisting of principles and doctrines applied "to the very-tangled skein of human affairs." The tool Holmes recommended to students was "cynical acid", used to burn away the language of right and wrong and thereby reveal the law as it really is. Holmes wanted the law to be seen as a legitimate discipline, a self-contained one, separate from the larger context of human activity. Holmes said, "I often wonder if it would not be a gain if every word of moral significance could be banished

[188] This was a rare situation in that I didn't have many opportunities to work with my clients directly. Often, defense counsel works with the insurance company almost exclusively, not with the client, the defendant who has been sued. It is difficult to make a connection, really be of assistance to a client, when the attorney gets very, very little opportunity to speak directly to that person. Opportunities for healing are very, very limited. I see this as analogous to physicians who see their patients for 5 to 10 minutes once a year: opportunities for healing are generally as limited.

from the law altogether". Keeva comments, "The problem with that notion, relative to the dilemma facing so many lawyers today, is this: while Holmes, his colleagues, and their progeny may have produced a system unexcelled in its ability to train the mind to produce airtight, unassailable legal arguments, *they also managed to marginalize most of human experience."* "In the law today, first in law school, then in practice, you run the risk of overlooking the central fact of human life that makes laws necessary in the first place: *That we are formed by and exist in a web of relationships.* Our laws are about our relationships, they affirm them by clarifying and enforcing the rights and responsibilities that we, as a society, believe they should entail; and they help us deal with them when they founder or fall apart. However, it is only in relationship to the *relational* nature of human beings that the law makes any sense. Yet we sometimes make the law *about* relationships more important than the relationships themselves, allowing doctrine to eclipse humanity" (emphasis in original.)[189], [190]

I know one person who is teaching the law by attempting to make the relationships themselves more important than the law about relationships: Peter Gabel, dean of the New College School of Law in San Francisco and director of the Project on Integrating Spirituality, Law and Politics (SLP). Peter, several years ago, gave a talk to SLP about learning the law through what I'll call the case method plus: his students read one case and prepared to recite the facts and the holding (the decision of the court). The "Plus" was the addition of an investigation of the case, the community, the individuals involved, their financial circumstances, their decision

[189] Keeva, p. 8.

[190] Recall the National Socialists Party (NSP), a division of the American Nazi Party, which applied for a permit to march in Skokie, Illinois. The town refused, in part because the town contained a large number of Jewish citizens who were outraged about the Nazis marching in their town. When the town refused the permit, a Cook County Circuit Court Judge issued an injunction, authorizing the march to go forward. An Illinois Appeals Court lifted the injunction, stating that the swastika could incite violence, and refused to allow the march to go forward. The ACLU stepped in to represent the NSP, arguing that the NSP was denied its free speech rights under the First Amendment. The ACLU supports the First Amendment, often regardless of the parties and situations involved, "allowing doctrine to eclipse humanity". The march eventually took place in Chicago.

making process, and the culture of the times, i.e. why did the plaintiff decide to sue, what was the culture of the community, and what was the subject of the case, what happened "off camera". That was such a revelation to me: rather than a very few relevant facts, the students brought forth the parties as individuals and the culture of the community. It became, rather than two parties in isolation, two parties in society, in community. The case method expanded and morphed into the story of two people in a cultural and community setting. The parties became real, their interactions with each other, their circumstances and their community connections and relationships became real.

Ralph White refers to the case method of legal analysis as "endless case analysis according to Eighteenth and Nineteenth Century doctrine, conceived when individualism and materialism were groundbreaking concepts".[191] White tells us that we need to move beyond a legal culture "characterized by brutality and rudeness."[192] White is hopeful that students will be asked: "How is your work going to create a more loving and caring society?" "How would you bring healing to the legal problem presented in the case?"[193] Thane Rosenbaum wants to "remake the very essence of the profession and its education system. Lawyers would seek reconciliation rather than conquest, and courtrooms would serve as forums for aggrieved parties cathartically to tell their stories rather than pursue monetary settlements."[194] David Hall tells us that, as lawyers, we need to "reposition the law as a service profession in the best sense of that word."[195] Hall, in turn, cites Joseph Allegreti, in terms of law students, "law school is the means and end-it is the

[191] White, p. 1. In this article White discusses a California conference on Spirituality, Law and Politics, which I attended. A recurring question at the conference was "How can we make the practice of law sacred?"
[192] Ibid.
[193] Roland Johnson, Cynthia T. Johnson, Patti Gearhart Turner, *Integrating Life and Law: An Ethical Lawyering Practicum,* in *Shifting the Field of Law and Justice*, p. *65.*
[194] Samuel, Freedman, *On Education: Challenging Ethical Training of Lawyers*. N.Y. Times, August 11, 2004, discussing Thane Rosenbaum's book: *The Myth of Moral Justice.* Harper Collins Publishers Inc: New York, 2004, http://query/nytimes/gst/fullpage.html?res+9B0CEFDD1F3CF932A2575BC0A9629C8B63>, accessed October 5, 2008.
[195] Hall, p. 215.

instrument by which we develop the competencies to implement our inner call to service. It is the place where our inner call takes on flesh. Without the public calling of the law school, our private calling would remain ineffectual. Those who serve must learn to serve."[196]

Peter Gabel, noting that our legal culture is based on the adversary system, states, "But legal culture is very important to putting forward, to a society, what is a just world. We need a legal process that can foster a sense of empathy and compassion and mutual understanding."[197] Mindful Meditation, also known as Zen meditation, is an approach increasingly used by lawyers to get to that thinking, leading to action. Mindfulness is traditionally defined as living in the moment, without judgment. This process is thought to improve lawyers' (and many others) work satisfaction and their relationships with their clients.

I just attended an author interview in San Francisco, one in a series, called City Arts & Lectures. Jeffrey Toobin, author, commentator and attorney, was interviewed by Christopher Edley, the Dean of Boalt Hall School of Law at U.C. Berkeley, CA. Jeffrey Toobin, appearing to discuss his new book, *The Nine: Inside The Secret World of the Supreme Court*[198], mentioned the difference in the culture of the court between 1986 and the present day. He referenced two cases brought to determine the constitutionality of a Texas anti-sodomy law, one brought in 1986, one in the last year. He talked about the world the justices live in today compared to the world they lived in twenty years ago, in terms of gays in our culture. The subtle and not-so-subtle shifts in our culture affected the justices' decisions in that the 1986 decision upheld the constitutionality of the anti-sodomy statute and the 2006 decision did not. The dean promptly responded with horror that Toobin would suggest that the justices would consider their community and culture in

[196] Hall, p 215.
[197] Heidi Benson, *Zen and the Art of Lawyering: Legal Eagles Find Meditation a Stress Solution,* San Francisco Chronicle, July 30, 2007,<http://www.sfgate.com/cgi-bin/article.cgi?file=/c/a/2007/07/30/MNGHOR9DPM1.DTL> accessed October 5, 2008.
[198] Toobin, Jeffrey, *The Nine: Inside the Secret World of the Supreme Court,* Doubleday: New York, 2007.

addition to the statutes and case law. Toobin said something like: We'll, they're human beings and live in society, so the world around them is, of course, a consideration. As Keeva said above, it is only in relationship to the relational nature of human beings that the law makes any sense.

A Calling

Is law a calling? At the heart of a calling is the desire to serve, to make a contribution to our communities. It links one individual to the larger community. Ensuring equality for all, facilitating open and honest communication, apologizing, when appropriate, listening to others' experiences, helping with healing: the opportunity to do these things, and more, is a true calling. Doing these things is the essence of collaborative law. Joseph Allegretti writes, "Those who practice law with the intent to bring justice to a broken world, vindicate the rights of the weak and vulnerable, heal broken relationships, ensure equality for all persons-these lawyers have a true calling."[199]

I never thought of law as a calling; however**,** reading about the concept, I immediately had a shift in thinking and can see it now so clearly. I understand that striving to think and act in ways described by Allegretti above is about service, about a calling. I so appreciate the idea of work beyond winning, to heal. How do I do that? It feels at least possible now, since I don't see myself any longer as one person practicing law and another person being and doing everything else in my life. Seeing the law as a calling gives it a whole new sense of meaning, a meaning that was there all the time, just waiting to be discovered.

One of the pieces of a calling is forging relationships with clients that are collaborative, based not on the lawyers having all the answers, but on the clients having all the answers. I've so often heard lawyers talking about "client control", a phrase which always made me wince.

[199] Joseph Allegretti, *Clients, Courts, and Calling: Rethinking the Practice of Law, in Shifting The Field,* p. 30.

Certainly, we talk about the law to our clients, we advise them on what is legal. Do we tell our clients, ask our clients what is ethical, what is moral? Or do we just do what we are asked, without question? Do we give clients the space to think before they act? Do we take time to remind them of their values? Help your client get centered, get to the place where she can take a step back and keep the big picture, the long term picture, in mind. By acting as healers with our clients, we can begin to heal ourselves, a bit at a time.

Respect, honor, forgiveness, reconciliation: all pieces of healing, all pieces of a calling. Healing also requires trust, which grows with purposeful and consistent action. Behaviors associated with trust include: integrity, consistency, emotional and physical accessibility, communication through listening; demonstrated understanding; openness and candor; clear expectations; clear explanation of decisions; concern for others; and respect.[200] In medicine, as in law, the promise of trust to patients/clients is at the root of professionals' institutional ethics. Medical error, regardless of blameworthiness, however caused, is a violation of trust. Restoration of dignity can only take place after true disclosure and apology. Plaintiffs have a moral claim to disclosure.[201] To be able to witness this process, to facilitate it and support it is something that, as an attorney, I will be very grateful for.

While I'm thinking about, writing about and trying to practice healing, I'm involved in litigation as a plaintiff. Several members of my homeowners association, including me, have sued the Board of Directors for conflict of interest, breach of fiduciary duty and the tort of cloud on title. We've tried to resolve these issues without litigation; I've written letters, as the only

[200] John Settle, Susan Gunn, *A Perfect Storm: A Confluence of Problems In Organizational Team Building,* ACResolution, Fall/Winter, 2007, p. 10.
[201] Disclosure is defined as "The process by which an adverse event (an event which results in unintended harm to the patient, and is related to the care and/or services provided to the patient rather than to the patient's underlying medical condition) is communicated to the patient by healthcare providers." Canadian Disclosure Guidelines, Edmonton, AB: Canadian Patient Safety Institute, 2008, <www.patientsafetyinstitute.ca>, accessed on October 15, 2007.

attorney in the association, and hired attorneys who asked the board to remember and respect the community, to recall that we are neighbors, to recall their ethical (and legal) objections to ALL the homeowners, and to meet with a mediator to resolve these issues, all to no avail. We were told by an honest and ethical board member that the other four members of the board would not respond to anything but legal action, and that our appeal to their ethics and honor was "just words". The cost of the legal action fell on some of the homeowners, including me, paying on both ends: for our attorneys and for the attorneys for the board, who are paid out of homeowners dues. Although this litigation cannot be compared, even for a second, with a case involving injury or death due to medical error, I get something of a sense of what being a party to litigation is like. The other homeowners and I have been involved with this for almost one year. The battle is always lurking in the shadows, always a presence in my life, always a stress. Involvement in this entire process has at least one healing benefit for me: knowing that some situations will resolve only through litigation. Having had this personal experience, I can pass this learning-sometimes you have to go to court-on to clients of my own when faced with similar situations.

The collaborative law movement focuses on healing. Listening[202] to each other in the collaborative law process, as well as in dialogue, is a healing process. Listening honors the speaker and others present. "The collaborative law movement contains the seeds for the revitalization and transformation of the legal profession. Collaborative law permits us to strive to create wholeness within our clients as we strive to resolve legal disputes. *It gives us the license to be instruments of healing, and not just gladiators in legal coliseums.* Collaborative professionals

[202] "Listening is a rare happening among human beings. You cannot listen to the word another is speaking if you are preoccupied with your appearance, or with impressing the other, or are trying to decide what you are going to say when the other stop talking, or are debating about whether what is being said is true or relevant or agreeable. Such matters have their place, but only after listening to the word as the word is being uttered. Listening is a primitive act of love in which a person gives himself to another's word, making himself accessible and vulnerable to that word". William Stringfellow, <www.urbanstone.blogspot.com/2007/11/from-depth-of-last-rush-essays.html>, accessed on June 15, 2008.

search for a deeper meaning to the practice, and this search makes for a more meaningful relationship to your clients' problems, which makes what you do so much more important than even you may realize. The profession's strong adherence to the adversarial model has provided many benefits, but it has also cost us our soul. The culture of individualism, emotional distance, atomistic analysis, has stripped the profession of so much of its sacredness. The exclusive focus on legal disputes and issues, at the expense of the underlying human, emotional and spiritual conflicts, has turned healers into technocrats"[203] (emphasis added.)

"When we strive as lawyers to live according to the highest values that we can articulate and understand, then we are in search of the sacred. When we give over our lives to the calling of healing, justice and love, then we bring sacredness to the lives of others and to the world. The sacred does not necessarily represent a religious tradition, but it does serve as a reminder to all of us that there is a purpose to our lives and thus to our practice that transcends the license we hold or the shingle we hang. *When we 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"*[204] (emphasis added.)

Collaborative law, described in detail below, is a healing process, involving listening, forgiveness[205], reconciliation and compensation, when appropriate, and treating the parties with dignity and respect.[206] In the last couple of years, small groups of like-minded attorneys around

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[203] David Hall, *In Search of the Sacred,* presented at the IACP Conference, Boston, 2004.
[204] Ibid.
[205] Linda Biehl, mother of Amy Biehl, who was murdered in South Africa while there as a college student on a Fulbright, states: "I do think forgiveness can be a fairly selfish thing. You do it for your own benefit because you don't want to harbor the pain, you don't want this cancer in your body. So, you work through it. The reconciliation part is the hard work. It is about change." The young men who murdered Amy were granted amnesty in 1998 by the Truth and Reconciliation Commission. This decision was supported by Linda Biehl, who now employs two of the four young men who were granted amnesty for Amy's murder at the Amy Biehl Foundation in Cape Town, SA. Linda Biehl, *Making Change,* Greater Good, Fall, 2004, Volume 1, Issue 2, p. 12.
[206] Dignity and respect are, in the litigation process, often hard to come by. Attorney behavior in depositions and cross-examination can be hostile, insulting and even abusive. Judges can be distant, demeaning, and appear

the country have started talking about expanding this process beyond the family law arena, into areas such as medical malpractice litigation and employment law. It came into my line of sight, as I noted above, at a time when I was acting as an advocate for a friend who was litigating a medical malpractice wrongful death case. Her son had died in a situation that clearly involved medical malpractice, as described briefly above. Nancy worked with the Kaiser ombuds/mediator, a nurse and a lawyer. She and Nancy met many times, helping Nancy and her family through their grief, and helping Nancy help the physicians and health care workers get through their grief about losing Eric. This process, dealing as it did with apology, disclosure, and new procedures, appears to have helped everyone heal. However, this process did not involve compensation issues, which were dealt with in the medical malpractice litigation context.

A personal medical error situation, one that involved my son and his neurologist, allowed me to experience the anger and resentment I've read about and talked about of dealing with a physician who was arrogant and unwavering in his refusal to admit ANY mistake or error. I could see, as a result of this situation, why people sue when they get no satisfaction or respect when asking for an explanation; instead, they get stonewalling. The situation had great potential for compassion, as well as the opportunity for healing and learning. My son was diagnosed with epilepsy at age 23. He had his first seizure when he lived in Chico; about two years later he moved back to the San Francisco Bay Area and found a new neurologist, a medical school department head, well known and respected in this area. About a year into my son's treatment with this neurologist, my son shifted to a generic medication (because of cost); my son called the neurologist, told his staff that he was beginning a generic and asked if he should increase the dosage; the neurologist's office staff checked with the doctor and called my son back and said

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uninterested. Patients often feel they are forced to give up too much of their privacy. The process, in itself, can be viewed as disrespectful, often taking five or more years for any type of resolution.

there was no need to increase the dosage. My son, soon after, had a seizure and was treated in the emergency room. When my son next went to the neurologist, he allowed me to go with him. The neurologist looked at his file, asked him about generics, and said: when you take a generic, you always need to take a higher dosage. Due to various circumstances, I later met with the neurologist as my son's advocate. He never admitted error, he never admitted his staff made an error, he never apologized to Kevin; instead, he informed me several times that it didn't do any good to talk about the past, that we needed to look to the future. He seemed annoyed and condescending throughout our conversation. Although this happened at least two years ago, I still hold out hope that he will someday call Kevin and admit he (or his office staff) made a mistake and apologize. I must admit that the chances of that are slim, almost nonexistent, but there is always room for a miracle.[207] I think that would be such a tremendous healing for my son, for me *and* for the doctor).[208]

Collaborative law is a group process, wide open as to options; all participants are members of the decision-making process. Litigation is an individualist process, involving certainty of view; it takes responsibility from the parties and gives it to a judge/jury/arbitrator. Collaborative law is not right versus wrong; winning versus losing. It is not persuasive ability trying to have *the* most persuasive voice, one argument wins. Collaborative law requires trust; requires a set of assumptions far removed from the assumptions most litigators bring to any

[207] The best I could do, in terms of healing in this situation, was to send that neurologist an article about disclosure, apology and healing and a note that said: "How would you feel if it were your child?" Clearly, I was still holding on to that resentment.

[208] My son recently discovered that he needs some surgery. He had a name of a surgeon and said he would like to get a second opinion. I thought of the neurologist, since he knows everyone in the local medical community. I called his office and asked for a recommendation. The doctor called me back, opening the conversation with, "What can I do for you?" I told him Kevin has a malignancy and I'd like the name of a surgeon. The doctor gave me the name of a surgeon without a moment's hesitation. I thanked him and that was the end of the conversation. He never said he was sorry to hear that or to pass on his regards or hope Kevin is well soon.

process[209], such as the attorneys are honorable, responsible, have the best interests of their clients as their top priority, and make only promises they intend to keep.

The peace of mind that comes from taking a case out of the win-or-lose litigation process into a non-adversarial, compassionate process is empowering to all participants. In the collaborative law process, participants have the opportunity to share information and seek workable solutions, to come together in a healing process. I hope to play some role in that healing process. Diana Chapman Walsh, as noted above, posed the following question, "What am I called to do now, what is mine to bring to the relentless violence in the world?"[210] I think of much of the litigation process as verbal violence "Litigation is a substitute for violence. It lets the parties 'fight it out' in the (relatively) safe confines of a courtroom."[211] But, it is still violence, just violence of a different sort.

Servant Lawyership

I use this term as a variation on Robert Greenleaf's concept of "Servant Leadership". Greenleaf explains the concept with a story: "Hermann Hesse's Story, Journey To The East, tells of a band of men, each having his own goal, on a mythical journey to the East. With them is the servant Leo, who does their menial chores, sustains them with his spirit and his song, and, by the quality of his presence, lifts them above what they otherwise would be. All goes well until Leo disappears. Then the group falls into disarray and the journey finally is abandoned. They cannot make it without the servant Leo. The narrator, one of the party, after some years of wandering

[209] Leonard Riskin tells us that litigators "impose the taxonomy of the law on peoples' problems and insist on solving them in the only ways allowed by that classification. If we can avoid the legal preconceptions, avoid the litigation-type conceptual map, we may be able to create change. Dauer, *Postscript,* p. 1049.
[210] Walsh, p.17
[211] Allegretti, *p. 41*

finds Leo and is taken into the Order that had sponsored the journey to the East. He discovers that Leo is the titular head of the Order, its guiding spirit, a great and noble leader. Leo portrays at once two roles that are often seen as antithetical in our culture: the servant who, by acting with integrity and spirit, builds trust and lifts people and helps them grow, and the leader who is trusted and who shapes others' destinies by going out ahead to show the way."[212]

The servant leader is trusted because she is one of us, has worked with and for us. She has proven herself and continues to do so. She chances losing the support of portions of the community/organization by working for the common good by making the hard choices and leading the community by example, by doing the next right thing, by speaking and acting in an ethical way. Trust is *the* central issue for leadership through service to take hold. Greenleaf quotes Hillary Rodham, speaking at her commencement as president of the Wellesley student body in 1969, "Trust. This is the word that, when I asked our class what it was they wanted me to say for them, everyone came up to me and said "talk about trust, talk about the lack of trust both for us and the way they feel about others, talk about the TRUST BUST."[213], [214]

In addition to developing trust, listening is of primary importance in developing as a servant leader. Greenleaf tells the story of a very able leader who is appointed to head a large public institution. He quickly becomes aware that things are not as he hoped in the organization. His approach: for three months, he stopped reading newspapers and watching the news. Instead, he relied exclusively on the people he met at work to tell him what was going on. This approach, just listening, led him to new insights which led to resolution of his administrative problems. Greenleaf believes that a strong servant leader reacts to a problem first by listening. Greenleaf

[212] Robert Greenleaf, *The Servant Leader Within, A Transformative Path,* Paulist Press: New Jersey, 2003 p. 32.
[213] Ibid, p. 36.
[214] This speech was delivered in 1969, during the first year of the Nixon Administration and the continuation and escalation of the Vietnam War. Enough said.

reminds us of the line in the St. Francis prayer: "Lord, grant that I may not seek so much to be understood, but to understand" and tells us not to be afraid of a little silence.[215] He discusses persuasion, one person at a time, action, one at a time, and empathy (the imaginative projection of one's own consciousness into another being) and acceptance (receiving what is offered, with approbation, satisfaction, or acquiescence).

"As lawyers, we can create the type of practice we desire and the type of profession we know the public deserves if we are willing to use our will to bring this new reality into existence. This will not occur just by passing new bar rules and regulations. It will occur when we intentionally pursue a different understanding of our work and purpose in life, and when we structure our lives and practices in ways that are consistent with our declarations.[216] The qualities and values that we declare, like love, humility, forgiveness, service, faith, and integrity, exist within each of us now."[217]

Greenleaf also discusses two theories of leadership, one of which is the lone person in charge, atop a pyramid-type structure. The other, from Roman times, involves a principal leader as primus inter pares-first among equals. S/he is the leader, but not the chief. The primus constantly tests and proves her/his leadership among a group of able peers. The single chief, once she takes on that role, has no colleagues, only subordinates.[218]

I think of Greenleaf's theory from a slightly different place: I have long envisioned "Servant Lawyership"©. I see Servant Lawyership as akin, in part, to Timothy Tosta's description of practice in spiritual terms, "set noble intentions for how you conduct yourself.

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[215] <http://en.wikipedia.org/Wiki/prayer_of_St._Francis>, accessed on May 15, 2008.
[216] "By declaring to ourselves that we will try to serve the whole client, we go into the experience looking for ways to achieve this goal, and being available for those opportunities when they present themselves." Hall, p. 147.
[217] Ibid, p. 147.
[218] Robert Greenleaf, *Servant Leadership; A Journey Into The Nature of Legitimate Power & Greatness*, Paulist Press: Mahwah, New Jersey, 1977, p. 74.

Each morning,..take some small aspect of that noble intention and try to fulfill it. At the end of the day, see if you have even gotten close….Most people intuitively grasp your intentions; if you include among these honoring others, they will know it. And you will be offered a greater opportunity to build real relationships…[l]earn to listen deeply and patiently. Begin by presuming the essential goodness of those with whom you are dealing."[219] In the same vein, as previously mentioned, John McShane, a well-known Texas attorney, asks himself before meeting with a client, "How can I serve this person?"[220] A response to that question is provided by Alan Reid, who writes of healing in the litigation process. He describes seeing the legal process differently, replacing attack thoughts with forgiveness and finding peace. If we, as attorneys, and our clients approach the other attorneys/parties without blame and anger, we can provide the space for healing. Reid provides us with a series of supposes, including

- "Suppose law could be seen not as a means of control exerted by winners over losers, not as a weapon of attack and vengeance, not as a basis of judgment, but rather as a process that can really draw the community and its members together, to help the community function more smoothly and to reduce the fear and animosity that are expressed in anti-social behavior.
- Suppose we could begin to appreciate that law need not be a divisive influence, splitting communities and families into factions, and promoting labeling, stigmatization and a view of the world as separated into victims and victimizers.
- Suppose law and legal process could be seen differently, as an opportunity for forgiveness, for healing and for coming into touch with a true sense of community."[221]

[219] Tosta, Timothy, *Agent of Change, California Lawyer, March, 2008.*
[220] Hall, *p. 134.*
[221] Reid, *p. 31.*

I hope this writing is one small step in taking these dreams a bit closer to fruition.

I've long held a URL for "Servant Lawyership"©, knowing that a website will unfold that will help lawyers develop community, through the sharing of articles, new forms of practice and other ideas. I think lawyers are starved for this or something similar. Witness the awareness and popularity of Steve Keeva's column in the ABA journal, which always had a spiritual component, and his book, previously mentioned, about lawyers and spiritual practices. While his column appeared monthly, Keeva had a huge following. Unfortunately for attorneys, Keeva no longer writes this column. I see Keeva's work and that of like-minded attorneys as cultural shifts, shifts to healling ourselves, as lawyers, as well as encouraging the process of healing for our clients.[222] Servant Lawyership©, in my vision, manifests itself in collaborative practices/collaborative law/dialogue, in that they are all based on listening, trusting and not having all the answers. It is co-creating possible solutions; it involves coming to the process from the stance of "not-knowing", not having all the answers. A useful mindset is that our clients have their own answers, they just need help in accessing them. So much of that process, working with our clients, involves listening. As I discuss elsewhere in this dissertation, a study indicated that physicians listen to their patients for an average of twenty-two seconds before interrupting with a diagnosis. Lawyers have the same tendencies, interrupting to inform our clients with: that isn't important or relevant or material.

[222] Greenleaf tells us of a seminar in which ministers, theologians and psychiatrists took part and answered the question: "We are all healers, whether we are ministers or doctors. Why are we in this business? What is our motivation?" After ten minutes of discussion, the answer came, "For our own healing." <http://servantleadershipblog.com/servant-leadership/blog/2007_03_01/servantleadershipblog_archive.html>, accessed June 15, 2008.

Chapter Four: Medical Error, Litigation, The In Between, and Collaborative Law

"Care and healing… must be center stage in any system that seeks to remedy medical errors."[223]

Pieces of the Puzzle

As I've noted previously, there are many organizations, agencies and individuals who need to come together, develop trust, acknowledge differences, set aside assumptions, and work together in order for a collaborative process to be effective in medical error situations, including physicians, nurses, other health care providers, attorneys for plaintiffs/injured parties and/or their families, attorneys for defendants/physicians and/or other health care providers, patients, patient advocates, risk managers, insurers, hospital administrators, medical boards, and patient safety foundations, among others. These and other decision-makers need to come to an understanding and agreement for a collaborative, non-adversarial process to be useful and effective. If we continue to bring many of these stakeholders, while enlarging the circle, together in dialogue, creating the space for shifts in thinking about our reactions and responses to medical error, these stakeholders, in turn, can (and have) take new ideas/proposals/solutions out into their particular communities.

It is instructive to look at the various stakeholders, as well as the cultures and practices in which they live and work.

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

Medical Error and Medical Malpractice Litigation

The tort system, ideally, compensates the injured person or his/her family while punishing the health care provider(s). However, since we don't live (or practice law) in an ideal world, the likelihood of a verdict or settlement in favor of a plaintiff is quite small. In fact, taking a huge step backward from the likelihood of a verdict or settlement, the likelihood that a patient injured through compensable error will sue is also quite small.

"While error prevention requires analyses of the systems within which individuals work and err, tort law focuses on individuals alone…tort law attaches blame[224] to and focuses on rare and singular events, while error prevention requires that physicians become active participants in the search for quality improvement. The public and punitive attributes of tort law dissuade useful involvements and while error prevention requires comprehensive information about errors and their causes, the risk of additional tort liability tends to cause cover ups and reduce the incentives, if not the willingness, to examine errors root causes."[225] As Lucian Leape expressed it in summarizing the Institute of Medicine's report, To Err Is Human, "Errors are caused by faulty systems, not by faulty people" [226]

The medical malpractice litigation process does not meet society's social goals of promoting patient safety and compensating those injured in our health care system. "A survey of the field yields a picture of a system that has internal logic but falls far short of its social goals of promoting safer medicine and compensating wrongful injured patients." Social goals of malpractice litigation are to deter unsafe practices, compensate persons injured through negligence, and exact corrective justice. Patients' decisions to bring malpractice claims are

[224] "Assigning blame, according to systems theory, is not helpful in reducing error, since it discourages admission of error and a frank scrutiny of the conditions that lead to it." Bayley, *Accountability,* p. 101.
[225] Dauer, *Accountability,* p. 189.
[226] E. Haavi Morreim, *Medical Errors: Pinning the Blame versus Blaming the System*, in *Accountability* p. 227.

driven by patient dissatisfaction and physicians' poor communication and interpersonal skills. The Report of Harvard University's Medical Practice Study indicated that, in New York hospitals in 1984, *there were 7.6 times as many negligent injuries as there were claims.* the Harvard Medical Practice Study to the State of New York concluded that only twenty-seven percent of adverse events that occurred during hospitalization were due to actual negligence on the part of a healthcare provider.[227] The study reported the incidence of adverse events for hospitalizations was 3.7% and, of these, l.1% were due to negligence. The Study indicated that only one in fifteen actual cases of medical negligence resulting in serious injury or death in New York State in 1984 was eventually litigated. Further, the Study showed that there were about as many suits as there were real injuries, only the overlap between the truly injured and those who sued was shockingly low.[228]

The findings of the Harvard Study were corroborated by a study of adverse events in Colorado and Utah that took place in 1992, based on a random sample of 15,000 discharges. As previously mentioned, two percent of negligent injuries resulted in claims and only seventeen percent of claims appeared to involve a negligent injury. Ten year follow up on the New York study showed that the *key predictor of payment was the plaintiff's degree of disability, not the presence of negligence.* Sixty cents on the dollar is administrative costs, predominantly legal fees. Studies yield mixed findings and are vulnerable to methodologic criticism; considered as a whole, the evidence that the system deters medical negligence can be characterized as *limited at best"* (emphasis added).[229]

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[227] Barry R. Furrow, Thomas I. Greeney, Sandra JH Johnson, Timothy C. Jost and Robert L. Schwartz, *Health Law Cases, Materials and Problems,* 3rd Edition, West Publishing: Eagan, MN (1997) in *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York – the Report of the Harvard Medical Practice Study to the State of New York* (1990), p. 32. <http://www.nysl.nysed.gov/scandoclinks/OCM2133.1963.htm> , accessed October 5, 2008.

[228] Ibid.

[229] David Studdert, Michelle Mello, Troyen A. Brennan, *Medical Malpractice, 350* NEJM 283-292 (2004), p. 286.

For those who do sue, there is evidence that the severity of the injury, rather than the fact of negligence, is a more powerful predictor of compensation, with the older, poor, and very young disproportionately excluded from access.[230] This may be, in part, because, in many states, there are caps on non-economic damages. This also may be, as discussed extensively below, because many injured parties cannot find an attorney and/or, for whatever reason, they don't have the wherewithal to know they should have their records reviewed by an attorney, or they have been lied to or not told the entire truth by health care providers, among other reasons.

Medical malpractice suits are a remarkably ineffective remedy. Troyen Brennan, a Harvard professor of law and public health, points out that research "has consistently failed to find evidence that litigation reduces medical error rates."[231] As noted herein, the great majority of patients who had suffered medical error for which compensation was appropriate never file a lawsuit. An even deeper problem with the litigation system is "that by demonizing errors[232], they prevent doctors from acknowledging and discussing them publicly. The tort system makes adversaries of patient and physician and pushes each to offer a heavily slanted version of events."[233], [234]

"The current tort system does not promote open communication to improve patient safety. On the contrary, it jeopardizes patient safety by recreating an intimidating liability

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<http://www.content.nejm.org/cgi/reprint/350/3/283.pdf >, accessed October 6, 2008..

[230] Sharpe, p. 18. Also, Troy Brennan and his group found that the magnitude of the patient's disability was by far a better predictor of victory and the size of the award than was mere proof that there was breach of some ephemeral 'standard of care.' Wachter, et al, p 308.

[231] Gawande, p. 57.

[232] Rather than demonize errors, we need to learn from them.

[233] Ibid, p. 57.

[234] Dr. Gawande, far from alone in his analysis, blames the "tort system", as if the system works on its own, like a runaway train, without the help of attorneys, physicians, insurers, hospitals, patients, judges and juries. Don't we need to take a step back from this analysis and look at the big picture? Isn't the place to start with all of us, all of us who bear responsibility for the system by giving it life and allowing it to thrive?

environment."[235],[236] Money is *not* what motivates most medical malpractice plaintiffs, but ineffective communication between patients and providers.[237] Structures and incentives of the tort system are inconsistent with accountability for truth-telling and safety improvement. The tort system fails to compensate the majority of patients injured by their medical care.[238] Of all the people severely injured by medical error, only about ten to twelve percent actually file a claim.[239]

The negligence standard, because it is embedded in an adversarial process, is inconsistent with attempts to learn from errors and improve quality. Remedies available in litigation are insufficient for meeting the fundamental needs for information, apology, and practice changes to prevent future harm and accountability. Mediation, traditionally a subset of litigation, rather than using the interest-based[240] or transformative style[241], is generally fundamentally evaluative and focuses on a monetary outcome, failing to give patients who have been injured during their treatment what they come into the process seeking, face-to-face discussion and explanation, while, at the same time, failing to improve the broken systems that caused the harm to begin with. Neutrals and counsel discourage face-to-face sharing and exploration that can lead to the resolution of difficult issues underlying the event at hand, and in so doing, they also undermine

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[235] Hillary Clinton, Barack Obama, *Making Patient Safety the Centerpiece of Medical Liability Reform,* 354 NEJM 2205-2208 (2006), p. 2205.

[236] When it comes to public discourse about changing our tort system, "[S]trikingly absent from debates over who should be able to sue whom, when and for how much is any discussion of the fairest and most effective way to make sure that true victims are appropriated compensation for injuries and that people without authentic injury are not compensated." Jonathan Glater, *To The Trenches: The Tort War Is Raging On,* New York Times, June 21, 2008.

[237] Dauer, *Accountability,* p. 187.

[238] Harvard Medical Practice Study, *Report to the State of New York: Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York* (Cambridge MA: President and Fellows of Harvard College, 1990), p. 145-152, p. 145 <http://www.oshmanlaw.com/Harvard-Medical-Pracitce-Study.pdf>, accessed October 10, 2008.

[239] Dauer, et al, *Adapting Mediation,* p. 187.

[240] Interest based mediation is a process in which the mediator assists the parties to examine the issues in dispute and to look at what is most important to the parties: their needs, expectations, hopes, fears, and desires.

[241] Transformative mediation does not seek to resolve the issues at hand but, rather, seeks the empowerment and mutual recognition of the parties involved. Recognition involves seeing and recognizing the other's point of view; empowerment means allowing the parties to determine their own issues and seek their own solutions. <www.colorado.edu/conflict/transform/tmall/htm>, accessed June 3, 2008.

the ability of the patient/family and the clinical care provider to learn from each other, to see what the events looked like from the patient's unique point of view, and to hear the physician's explanation. The mediation process, in this model, is similar to litigation in that the injured patient/family has no voice in the resolution process. This type of traditional mediation, often called "shuttle mediation" does nothing to reestablish trust between and among patients, families, physicians and hospitals.

Structures and incentives of the tort system are inconsistent with accountability for truth-telling and safety improvement. "The legal system becomes a sparring match between injured and ignored patients and faceless insurance companies. But the doctor in whom all the trust was initially place is nowhere to be found."[242] The physician, if not "nowhere to be found", is on the sidelines, doing what her/his attorney tells her/him to do and say, in terms of the litigation.

According to Robert Wachter, M.D., health care needs **a** blame-free environment, period**.**[243] This does not suggest no accountability, for without accountability, there is no learning. The assumption that forms the fabric of medicine and law is individual accountability. In order to shift to accountability under a systems approach[244] (which permits patient safety to be the focus of conflict resolution), "we have to reinvent not only our understanding of accountability but the structures of accountability institutionalized in our legal and cultural approaches to medical error. *We have to knit the sweater at the same time that we are wearing it"*[245] (Emphasis added). So, we need to shift from blaming individuals or hospitals to developing systems for improving the quality of our patient-safety practices. To do that, the tort

[242] Rosenbaum, p. 198.
[243] Wachter, et al, quoting Professor Ian Kennedy, chair of an inquiry into error-related infant deaths in an English hospital, "We need a system which recognizes that accountability is not the same as blame. Blame is a serendipitous weapon used to pillory someone who happens to be caught in the sights" , p. 314.
[244] "The basic premise of the systems approach is that humans are fallible and errors are to be expected….Errors are seen as consequences rather than causes, having their origins not so much in the perversity of human nature as in 'upstream' systemic factors." James Reason, *Human Error: Models and Management,* 320 BM J 768 (2000), p. 768.
[245] Sharpe, p. 9.

system must: reduce rates of preventable patient injuries; promote prompt open communication between physician and patients; and ensure patients' access to fair compensation for legitimate medical injuries. The tort system now jeopardizes patient safety by creating an intimidating liability environment. While there is a need for both transparency and accountability in health care, the fear of malpractice litigation impedes the expansion of these practices.

As noted herein, the Institute of Medicine (IOM) 1999 report found that as many as 98,000 deaths in the US each year result from medical errors; the IOM also found that more than 90% of these deaths are the result of failed systems and procedures, NOT the negligence of individual physicians. Because of its public policy focus, the IOM report focused on accountability of *organizations*, not of *individuals*.[246] We need a new definition of accountability that stops blaming individuals.[247]

However, we don't have one that is universally accepted (or accepted at all in much of our health care and/or legal cultures). We still work overwhelmingly within the traditional process: in situations in which a medical procedure goes awry (referred to herein as medical error), litigation is thought to be the only road to a satisfactory remedy.

Although a complaint commonly heard is that there is far too much medical malpractice litigation, as pointed out above, the Harvard study found that *two percent* of negligent injuries resulted in claims. The Kaiser Family Foundation President, Drew Altman, stated in November, 2004: "Maybe the question instead of 'Why do we have so many lawsuits?' is 'Why do we have so few?'"[248] These comments/questions arose after Kaiser Foundation took part in a national survey on consumers' experiences with patient safety and quality information and found: one in

[246] Institute of Medicine Report, pp. 166-8.
[247] "We need a system which recognizes that accountability is not the same as blame. Blame is a serendipitous weapon used to pillory someone who happens to be caught in its sights." Wachter, et al, p 314.
[248] At set forth at various places in this dissertation, many people can't find attorneys to take their cases, no matter how worthy, especially in states like California with damage caps.

three said that they or a family member has experienced a medical error, *eleven* percent of those who said they or a family member had experienced a medical error reported pursing a malpractice lawsuit, and, in instances of serious health consequences, only *fourteen* percent reported bringing a suit.[249] Further, among the one third who had experienced medical errors, *seventy* percent reported that their doctor did not tell them that a medical error had been made. *Eighty-eight* percent of those surveyed believe doctors should be required to tell patients if a preventable medical error resulting in serious harm is made in their own care.[250]

The Harvard Medical Practice Study found that "most physicians perceive their suits as arising from circumstances beyond their control…Physicians perceive that they will be sued for a bad outcome approximately forty five percent of the time, irrespective of negligence. They perceive that the chance of being sued increased to only sixty percent if they act negligently. It would be better if the tort system were viewed by physicians as rational, for their responses and the deterrent effect then could be more rational than they are today."[251] Evidence is almost nonexistent that the tort liability system deters medical negligence. *"The tort system's narratives are historical. Its focus is on identifying the individuals who are to "blame" for having caused a plaintiff's loss. Quality improvement's narratives are the future. Its focus is on identifying the things that can be changed to alter the future. Tort and quality improvement systems have different objectives, the conventional tort system is not only ineffective at deterrence, but it may also be positively interfering with the proper working of medical quality improvement, the sole purpose of which is the error prevention that the tort system apparently does not itself*

[249] "…evidence indicates that very few negligent adverse events lead to the filing of a tort claim, whereas, reciprocally, few claims filed are actually associated with a negligent injury". Morreim, *Accountability, p. 217.*
[250] *Most Americans Do Not Believe Patient Safety Has Improved; Want Mandatory Public Reporting of Serious Medical Errors,* Protecting Your Rights, Factsheets and Resources: Medical Malpractice News, November, 2004, p. 1
[251] Dauer, et al, *Adapting Mediation*, p. 192-193.

achieve"[252] *(*emphasis added). *Torts asks the questions "who", "what", and sometimes "how." Quality improvement initiatives ask the question "why?"*[253] *Quality improvement is …a "backwards march of whys", inquiring about the underlying causes of errors to determine where changes can be made in the future."*[254]

The tort system versus error prevention, individual versus systems approach[255], win or lose versus examination of errors that illuminate opportunities for improvement; blame for failures versus opportunities to understand and improve every part of the system; *departure from punitive framework to that of errors-are-inevitable-and-manageable,* possesses no intrinsic organizational follow-up versus involvement of physicians in quality assurance. Letter to JAMA: *wasteful loss of information that could otherwise be derived from systemic study of adverse outcomes is the most pernicious effect of malpractice litigation.* TQM requires: a culture in which errors and deviations are regarded not as individual failures but as opportunities to improve the system, a grassroots participation in identifying errors and their sources and the ways to systems modification and a commitment to TQM from organizational leadership.

Traditional remedies for medical error under the medical malpractice litigation system "are not viewed as part of the continuum of care…answers to the recurrent medical malpractice crises may lie in health care's core values."[256] Medical malpractice litigation "pays little attention to suffering. The highly contentious nature of medical malpractice lawsuits frequently does nothing to address patient suffering. In addition, as cases can languish in the courts for years, the suffering can be prolonged. Too often in a medical malpractice action, all parties-the injured

[252] Dauer, et al, *Adapting Mediation*, p. 194.
[253] Ibid, p. 194.
[254] Ibid, p. 195, citing Rebecca Voelker, *"Treat Systems, Not Errors", Experts Say,* 276 JAMA 1537, 1538 (1996)
[255] Sharpe, "Most errors cannot be attributed solely to the proximate activities of an individual actor." *Accountability,* p. 12.
[256] Porter, *Circles,* p. 1.

patient, doctors and other health care professionals who provided care, and the community-suffer much more than they ought to. Care and healing, therefore, must be center stage in any system that seeks to remedy medical errors."[257],[258]

[257] Todres pps. 675-676.
[258] Robin Youngson, M.D. states: "So I know in my heart that the answer to the problems of healthcare lies in healing healthcare, not fixing it". <Robin.youngson@waitematadhb.govt.nz>, accessed October 3, 2008.

Legal and Medical Cultures:

Parallel and Similar, but Mistrustful

In many ways, physicians and attorneys play similar roles. For instance, physicians and attorneys have a common duty to their patients/clients: a fiduciary duty, the highest duty of trust and loyalty. In addition, both lawyers and physicians are healers and advocates. Warren Burger, former Chief Justice of the United States, as noted herein, stated: "The entire profession-lawyers, judges, law teachers-have become so mesmerized with the stimulation of the courtroom contest that we tend to forget that we ought to be healers-healers of conflict. Doctors, in spite of astronomical medical costs, still retain a high degree of public confidence because they are perceived as healers. Should lawyers not be healers: healers, not warriors? Healers, not procurers? Healers, not hired guns?"[259] (emphasis added.) The healing role of physicians is evident to all of us every day, has been written about extensively, and is ingrained in our culture. The healing role of physicians/health care providers certainly includes voluntary disclosure of errors, although often health care cultures don't support and/or encourage this. Some of the non-supportive health care cultures are beginning to shift, reducing the disincentives to voluntary disclosure of errors. Reducing the disincentives, to be sure, is an uphill battle, since physicians often associate medical error/adverse events with malpractice.

I now turn to the clashes, misunderstandings and mistrust between the traditional medical culture and the traditional legal culture. In 2005, The New Yorker published a cartoon in which Hippocrates, addressing a group of medical students, says "First, treat no lawyers".[260] Undoubtedly, this mistrust and antagonism arises, to a great extent, out of the threat of or the fact

[259] Burger, *The Role of the Lawyer Today,* 59 Notre Dame L. Rev.1 (1983).
[260] New Yorker, March 7, 2005, ID 120655.

of malpractice suits. Also, I daresay, the animosity often arises out of misunderstanding and misinformation. Attorneys, when asked what their most difficult challenge is, when working with physicians, cite "[e]go, arrogance, and an elite attitude" and state that physicians behave "as if they could do the attorney's job better than the attorney."[261] In terms of what has been called the medical malpractice insurance "crisis", it has been said that "[w]hile the GAO (General Accounting Office) has painted a complicated, nuanced picture of the crisis in which no single factor accounts for the controversy, *doctors and plaintiffs' lawyers have steadfastly blamed each other*."[262] (emphasis added.) As a recent Kaiser Permanente study puts it, illustrating the finger-pointing that goes on between these cultures (with physicians' insurers included), "Trial lawyers say doctors and insurers have only themselves to blame-medical negligence hurts far too many people that only lawyers can help, and insurers' bad investments and business plans jeopardize insurance availability and price stability. Tort reformers say that lawyers and juries are out of control and must be reined in to keep premiums affordable and prevent insurers and doctors from withdrawing."[263]

Attorneys and physicians have many of the same difficulties. Part of the healing process requires good listening. Listening to patients is a function of time, which is limited, more and more each day, as explained below. It seems many, many attorneys as well as physicians have difficulty with this piece of the patient/client relationship. Both attorneys and physicians are trained to listen and ask questions, to focus on the "complaint"[264], whatever that may be. Both

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[261] Randye Retkin, Ellen Lawton, Barry Zuckerman, Deanna DeFrancesco, *Lawyers and Doctors Working Together: A Formidable Team,* The Health Lawyer, Volume 20, Number 1, October, 2007, p. 33.
[262] Jim Edwards, *GAO Study Finds Damage Caps and Lower Premiums Loosely Linked,* New Jersey Law Journal, Sept 8, 2003.
[263] Randall Bovbjerg, Bryan Raymond, *Kaiser Permanente Patient Safety, Just Compensation and Medical Liability Reform* (2003), <http://www.kpihp.org/publications/briefs/patient_safety.pdf>, accessed October 15, 2007.
[264] Another unfortunate choice of words, "complaint", used as a catch-all phrase by physicians, refers to patient's explanation of problem/concern but is traditionally defined as a statement of displeasure. Why use it? Doesn't this use of language tend to separate patient and physician at the outset?

can get impatient with extraneous details; all that is important are the material "facts".[265] Both attorneys and physicians are often trained to listen only until they think they know the answer or can interrupt. One study demonstrated that physicians give to their patients an average of twenty two seconds to answer a question before cutting them off.[266], [267]

Both attorneys and physicians are placed in the position of not listening, of impatience, because their time is, to some extent, controlled by insurance companies or other market forces. The time pressures both attorneys and physicians are under invite impatience. Physicians, under the HMO system, are often required to see a certain number of patients every day, often in twenty minute increments; therefore, extended discussion and/or listening to the patient and developing a relationship are not options. Alternatively, physicians' time may be limited by fees for services reimbursed by insurance companies that don't keep up with costs/overhead. Do these or other pressures or time restraints permit enough human contact to establish and maintain a healing relationship between the physician and the patient? Perhaps not. This question feeds into the issue of individual liability versus systemic responsibility, which is discussed below. Is the physician the only person responsible for some miscommunication and/or misunderstanding when time with each patient (including time thinking about the patient's concerns and time charting/making notes about the patient) is so limited by outside pressures?

Physicians believe that the legal system attacks their professional judgment and integrity.

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[265] I recall, before I became an attorney, going to an attorney for advice about a personal situation. The attorney was very impatient with anything I had to offer that had to do with emotions and/or "unimportant" facts. At the end, she said to me: the judge doesn't care about most of what you've told me. It didn't occur to me at the time to be offended or to choose another lawyer.

[266] Michael S. Woods, *Healing Words: The Power of Apology in Medicine,* Doctors In Touch: Oak Park, Il, 2004, *p. 68*.

[267] After all, as lawyers like to say, time is of the essence. One lawyer, recently interviewed in the ABA Journal, said that getting married and having children is "vastly time-consuming." Jill Schachner Chanen, *Should I Stay or Should I Go,* ABA Journal, January, 2008.

They believe, according to the result of the Fitzgerald study[268], that lawyers are not deserving of trust. Lawyers, when asked what physicians can do to improve their relationship with lawyers, state: trust us.[269] The hopeful news: both sides believe the physician-attorney relationship can be salvaged. A possible step toward salvaging the relationship, a step in the healing process, has been suggested by Fitzgerald, "Although time is precious for physicians, they must find the time to have an ongoing dialogue with lawyers and other key business and professional people. This dialogue can lead to wiser decisions and a strategy to reduce both [physicians'] legal and business risk. Also, when a pressing matter is at hand, it is imperative to make the time right away to deal with it. Putting it off can lead to serious consequences."[270] This is an incredibly affirming idea for me, since this, bringing together physicians, insurers, lawyers and others, is what I'm trying to do already.

Cultural Influences

The cultural influences in the legal field have already been discussed. The core values of healing and commitment to human well-being in the medical field go without saying and are verbalized simply by many organizations and individuals. For instance, the AMA, in its *Declaration of Professional Responsibility: Medicine's Social Contract with Humanity,* declares that physicians commit themselves to "[W]ork freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being…They additionally commit themselves to advocate for social, economic, educational and political changes that ameliorate suffering and contribute to human well-

[268] Paul E. Fitzgerald, *Lawyers Evaluate Each Other in New Study: Building Trust, Opening Communication Lines Could Improve Doctor/Lawyer Relationships,* <http://www.thefreelibrary.com/doctors%+lawyers+evaluate+each_other+in+new+study>, *accessed May 1, 2008*
[269] Ibid, p. 2.
[270] Ibid.

being."[271] A committee of The Institute of Medicine (IOM) states: "In the 21st century health care system, care should be organized and paid for so that all types of health care interactions that improve information transfer and strengthen the healing relationship are encouraged….[S]ome direct human contact is critical to establish and maintain a strong healing relationship."[272] 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 and not merely practitioners working with single patients…they should be willing to concede that they are part of a multidisciplinary health team…In the US, for example, nine out of ten doctors rate community activity, politics, and patient advocacy as important aspects of their work."[273],[274]

Other physicians' insurers, as well as leading organizations in health care, support this view. For example, the National Quality Forum (NQF), which develops standards for health care delivery through consensus among stakeholders and experts, called the Consensus Development Process, has added standards for disclosure of unanticipated outcomes to its list of safe practices, as follows: "Following serious unanticipated outcomes, the patient, and, as appropriate, family, should receive communication about the event."[275]

We have options, such as dialogue, discussed extensively herein, to break down barriers and eliminate, one person at a time, the clashing cultures between physician and lawyer. Both cultures need, both within their individual cultures and across cultures, to "learn humanity and

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[271] <http://www.ama-assn.org/ama/upload/369/decofprofessional.pdf>, accessed June 3, 2007.
[272] Institute of Medicine, *Crossing The Quality Chasm: A New Health System for the 21st Century,* National Academy Press; Washington, D.C., 2001. This is the second and final report of the committee on the Quality of health care in America.. The first report, *To Err Is Human,* referenced herein, was released in 1999.
[273] 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.
[274] Russell L. Gruen and Colleagues, *Public Roles of US Physicians*, 296 JAMA 1467-2475 (2006), <http://www.jama.ama-assn.org/cgi/content/296/20/2467>, accessed October 10, 2008.
[275] National Quality Forum Updates Endorsement of Safe Practices For Better Healthcare, <http://www.qualityforum.org/pdf/projects/safe-practices>, accessed on June 15, 2008.

compassion as individuals, as teams, as departments and as whole organizations. When individual practitioners become more humane, then so do teams, departments, and the whole system. If the system is humane, individuals within the system quickly adopt a different set of behaviors. Changes at any level resonate up and down". [276]

Communication, Including Disclosure and Apology, When Appropriate

"Executives at ProMutual Group and CRICO/RMF, Massachusetts' largest malpractice insurer, which encourages doctors to be honest with patients, said they have never seen a plaintiff's lawyer use [disclosure, apology] statements as evidence. Some patient safety leaders believe this is because patients don't sue doctors who are honest with them about what went wrong."[277] The Massachusetts Medical Society recently stated, "*One of the most recent breakthroughs in the area of reducing professional liability litigation lies in the encouragement of apologies for medical errors.* Often, patients don't want litigation, but are frustrated by the health care provider's seeming unwillingness to acknowledge that an error had occurred and to express remorse. The health care provider, on the other hand, is advised by counsel to avoid any statement, since remarks of apology or remorse could be seen as evidence of an admission of liability in subsequent litigation. Thus, an apology is not made and an avoidable lawsuit is filed by the aggrieved patient while the frustrated physician is forced to remain silent"[278] (emphasis added).

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[276] Robin Youngson, *Humanity and Compassion in the Practice of Medicine*, p. 255, <http://www.aimi.net.au/documents/HHC_book_sample.pdf>, accessed on October 3, 2008.
[277] Liz Kowalczyk, *Doctors Say They Need Protection To Apologize,* Boston Globe, October 31, 2007.
[278] Massachusetts Medical Society, *Massachusetts Medical Society Urges Support, Adoption of Medical Liability Reform,* October 24, 2007, <http://www.massmed.org/AM/template.cfm?section=news_Releases&CONTENTID=20013&TEMPLATE=/CM/CONTENT DISPLAY.cfm>, accessed October 3, 2008.

The Full Disclosure Working Group of the Harvard Hospitals released a consensus statement emphasizing the importance of disclosing, taking responsibility, apologizing, and discussing the prevention of recurrences. Disclosure is part of the continuing conversation between patient and physician, the communication we've been examining. The statement, in part, sets forth, "Prompt, compassionate, and honest communication with the patient and family following an incident [any adverse event or serious error] is essential….[T]he occurrence of an incident should be communicated to the patient as soon as it is recognized and the patient is ready physically and psychologically to receive this information. Typically, this should occur within 24 hours after the event is discovered. *Early acknowledgement is essential to maintaining trust"*[279] (emphasis added.) Lucian Leape, who chaired the working group behind the Harvard statement, stated: "*Silence is lying without words. It confirms suspicion*"[280] (emphasis added).

In that regard, Edward Dauer expresses it so clearly, "The legal plank [silence, litigation] of the medical culture is thus transformed by the process [disclosure] to more accurately reflect the medical component of the medical culture-namely healing, nurturing, and respect."[281],[282] Critics of medical malpractice litigation may also seek to persuade providers that honest disclosure of errors actually decreases the probability of expensive litigation. "Despite anecdotal reports of such positive experiences, the notion that disclosure reduces litigation is largely

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[279] Massachusetts Coalition for the Prevention of Medical Errors' Study, p. 6.
[280] Kevin O'Reilly, *Harvard Adopts a Disclosure and Apology Policy,* AMedNews.com, June 12, 2006, <http://www.ama-assn.org/amednews/2006/06/12/prse/0612.htm>, accessed June 3 2008.
[281] Dauer, *Postscript, p. 1052*.
[282] Todres, p. 667. Todres sees the concept of restorative justice as a healing-centered framework after medical error. Restorative justice is traditionally a criminal justice mechanism, involving all parties, the victim, the offender and the community. Restorative justice is defined as "justice that focuses…on harm and addressing the harm, first to victims, then to the community as a whole, and finally to the offender as well. This justice involves…accountability, real accountability, where the person who created the harm is…involved with the victims and the community in determining how to address the harm and make things right." Tom Porter, *Circles of Conversation: One Trial Lawyer's Journey into Sacred Spaces,* Disp. Resol. Mag, April, 2004, p. 1. <http://www.acrnet.org/pdfs/spirituality_sideofadrarticle.pdf>, accessed on October 3, 2008.

unproven and somewhat implausible."[283] At first blush, it does seem implausible. However, the evidence, growing all the time, as discussed herein, is that disclosure, in conjunction with offers of compensation, when appropriate, reduce litigation and reduce the time, energy and expense of settlement.[284]

In situations involving litigation, there is substantial evidence, anecdotal and otherwise, that a physician who apologizes is a much more sympathetic defendant. Dr. Lucian Leape encourages disclosure: "*The long, painful, shameful spectacle of the plaintiff lawyer trying to prove in public that the physician is negligent, a bad person, will not take place. The court's role will be limited to establishing just compensation. What is the jury likely to do with a physician who has been honest and also apologized? Judgments will most likely be far less costly"*[285] (emphasis added).

Research shows that when physicians fully disclose and apologize, when appropriate, patients are more satisfied, more trusting, and less likely to change physicians than when the patient received evasive and/or incomplete information.[286] Patients have a moral claim to disclosure. The promise of trust to patients is at the root of healthcare providers' institutional ethics. Disclosure is part of the continuum of care. Medical error, regardless of blameworthiness, however caused, is a violation of trust. In many circumstances, as noted above, physicians are prohibited by their liability insurance carriers from speaking with patients after an adverse event. This prohibition seems to make litigation almost inevitable, when the intent of the carrier is just

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[283] Studdert, et al, *Medical Malpractice,* p. 287.
[284] It will be instructive to watch the tragedy of newborn twins, born to a Hollywood celebrity, who were given one thousand times the dose of an anti-coagulant prescribed. The Chief Medical Officer at Cedars Sinai called it "preventable error", involving failure to follow standard practices and procedures, extended an apology and said the hospital is conducting a comprehensive investigation and will take all necessary steps to make sure it never happens again. Los Angeles Times, November 21, 2007. (Cedars has been identified in many of the articles about this overdose as one of the leading hospitals in the United States.)
[285] Lucian L. Leape, *Understanding the Power of Apology: How Saying "I'm Sorry" Helps Heal Patients and Caregivers,* 8 Nat'l Patient Safety Foundation Newsl. 3 (2005).
[286] Liebman, et al., *Medical Error Disclosure,* pp. 22-23.

the opposite. David Erickson stated, "It's about empathy and compassion. It has nothing to do with admitting fault…The thing to do is express your concern and empathy, then let the patient participate in what would make things right for him and her. If you refuse to acknowledge the suffering, you don't allow people to heal." [287]

Erickson is right: people don't get to heal. That includes physicians. As noted author and physician said more than twenty years ago, "Unable to admit our mistakes, *we physicians are cut off from healing*. We cannot ask for forgiveness, and we get none. We are thwarted, stunted; we do not grow."

Richard Horton, in his book review, entitled *What's Wrong With Doctors,* states, "The corollary of admitting uncertainty is that doctors should be more aware of their errors and should more freely and openly disclose them. Only then will they be able to evaluate and learn from their mistakes." This statement sounds too obvious even to deserve mention. Yet the prevailing medical culture is still heavily weighted against revealing even the possibility of error. "Disclosure of uncertainty and error will demand a deep change in medicine's attitude toward emotion. Most physicians fail to recognize, let alone analyze, their own emotional states in clinical encounters. This repression of feeling misses an important variable in the assessment of a patient's experiences and outcome. The emotional temperature of the doctor plays a substantial part in diagnostic failure and success."[288] Far upstream from disclosure is the ongoing physician/patient communication. Horton quotes the author, Jerome Groopman, *"For three decades, practicing as a physician, I looked to traditional sources to assist me in my thinking about my patients: textbooks and medical journals; mentors and colleagues with deeper or more varied clinical experience; students and residents who posed challenging questions. But, after*

[287] Rosenbaum, p. 197.
[288] Richard Horton, *What's Wrong With Doctors,* New York Review of Books, May 31, 2007, reviewing *How Doctors Think* by Jerome Groopman.

writing this book, I realized that I can have another vital partner who helps improve my thinking, a partner who may, with a few pertinent and focused questions, protect me from the cascade of cognitive pitfalls that cause misguided care…That partner is my patient or her family member or friend who seeks to know what is in my mind, how I am thinking" [289], [290],[291] (emphasis added). Interesting, isn't it: a physician who is smart, committed to his patients, and caring, talking honestly about looking, for thirty years, to all the traditional sources to help (heal) his patients and never seeing the patient as the most vital resource, the vital partner. What might that say about the culture of medicine? Groopman is discussing the essence of collaboration between patient and physician, where the relationship between patient and physician should start, grow and flourish.[292] That collaboration enables the patient-physician relationship to survive and thrive when difficulties, like medical error, arise.[293]

From the legal education sector, Jonathan B. Cohen, a law professor at the University of Florida who has written extensively about apology, estimates that thirty percent of all malpractice cases would never require litigation if doctors apologized for mistakes/errors.[294] That

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[289] Ibid.

[290] Groopman's statement is in line with what I discuss herein about patients (and clients) having many of their own answers.

[291] The old rule: "professionals control care"; the new rule: "the patient is the source of control". "The new rules give patients more community, control and information." The new rules, called "ten simple rules for the 21st century health care system", were developed by the Institute of Medicine (IOM) as part of its landmark report, "Crossing the Quality Chasm", as discussed in the Institute For Healthcare Improvement's Quality Rules, 2008 Progress Report, http://www.IHI.org.

[292] "Each patient carries his own doctor inside him. They come to us not knowing that truth. We are at our best when we give the doctor who resides within each patient a chance to go to work." Albert Schweitzer, quoted in Wachter, et al, p. 233.

[293] Robin Youngson, M.D. states, "Before Jessie [a patient from whom Youngson learned many lessons about **his** humanity], I conceived of the doctor-patient relationship as a one-way street. I was the highly trained doctor, the expert, the person with authority and control. Caring was a one-way process. I cared for the patients and I determined the process and the agenda." Those patients who didn't do what they were told were 'difficult patients' or 'non-compliant' or 'manipulative'. "But somehow, Jessie turned the tables on me. She was the one caring for me and supporting me in my difficulties. The relationship had become a two-way process." p. 249, available at <robin.youngson@waiternatadhb.govt.nz.>

[294] Rosenbaum goes on to tell us that "most standard medical malpractice insurance contracts specifically instruct the doctor not to apologize, and, even more egregiously, to stay completely away from the injured party once it is clear that the procedure did not achieve a favorable result." Rosenbaum, p. 196. I'm left wondering if that statement

percentage would probably be a LOT higher if doctors continued the conversation with patients, not only before medical error, but after it as well. As Keeva notes, it is not whether an apology will prevent all legal recourse, but "how it will influence the character of that recourse-whether compensation will be determined by a relatively cooperative and speedy settlement process or through more lengthy, costly and often unpredictable litigation."[295]

In terms of what triggers litigation, Edward Dauer, in discussing various alternative dispute resolution programs, described it thus, "These programs build on, and in return validate, what has been known for some time about the origin of medical malpractice claims-namely, that the impetus for suit lies more often in the emotional consequences of what the medical facility personnel do in the aftermath of an error than it does in the degree of legal risk or to a lesser extent in the degree of physical injury."[296]

In terms of the likelihood of impending litigation, again, t*he factor with the greatest value in predicting lawsuits is how well the provider (physician or hospital) responds to the initial post-injury confrontation by the claimant.* In a study of all the variables involved in making the decision whether or not to file a medical malpractice case, Penchansky and MacNee found the quality of the relationship and the quality of the communication to be the largest in reducing willingness to sue, exceeding every other variable relating to the doctor, the patient, or the injury.[297] In their report, entitled *The Project on Medical Liability in Pennsylvania, Medical Error Disclosure, Mediation Skills, and Malpractice Litigation: A Demonstration Project in Pennsylvania,* Carol B. Liebman and Chris Sterns Hyman report: "research findings demonstrate that ineffective communication between physicians and patients is the single most significant

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is still accurate, in 2008, since it appears that many insurance companies are rethinking those policies.

[295] Keeva, *Law and Sympathy: Apology Reforms Cost Little But Contribute Much to Clients' Healing,* ABA Journal, August, 2004, <http://www.abajournal.com/magazine/law_and_sympathy>, accessed October 6, 2008.

[296] Dauer*, Postscript, p.* 1044.

[297] Roy Penchansky, & Carol MacNee, *Initiation of Medical Malpractice Suits,* 32 Med Care 823, 838 (1994).

factor in explaining why physicians are sued.[298] Significant other research support this proposition, that poor physician communication with patients often leads to litigation.[299] In addition, research also demonstrates that silence (nondisclosure) contributes to medical errors and adverse events and impedes improvement of patient safety.[300]

One much-quoted study indicates that injured persons and/or their families sue physicians because of the following reasons: they are advised to by third parties, often a health care provider, but rarely a lawyer (33%), *they believe physicians are not honest or even lie* (24%), they need money to care for their injured child (24%), *they can't get answers to their questions* about what happened (20%), or they decide to seek revenge or to protect others from harm (19%).[301] Another often-cited reason for suing a physician is that the patient feels the physician does not listen to her/his experience, suggestions and questions, which often creates mistrust.[302]

It goes without saying that the medical malpractice cases that go to trial expend tremendous time, money and emotional resources. Many cases continue for years, increasing the

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[298] Carol B. Liebman and Chris Sterns Hyman, *Medical Error Disclosure, Mediation Skills, and Malpractice Litigation: The Project on Medical Liability in Pennsylvania, p. 9-10.* < www.medliabilitypa.org>, accessed June 15, 2007, citing Levinson. Another Levinson study concluded that lawsuits had little to do with physical harm and much to do with doctor-patient relationship. Of even greater import are survey results that show increased patient good health when doctor-patient communication is good. Meredith Levine, *Tell The Doctor All Your Problems, But Keep It to Less Than One Minute, New York Times,* June 1, 2004.

[299] "Candid disclosure of a mistake may decrease the likelihood of legal liability. Some have suggested that a strong doctor-patient relationship makes a patient less likely to bring suit. Furthermore, if the patient learns about a mistake and brings a lawsuit, failure to disclosure may place the physician in greater jeopardy." Albert Wu, Thomas Cavanaugh, Stephen McPhee, Bernard Lo, Guy Micco, *To Tell The Truth: Ethical and Practical Issues in Disclosing Medical Mistakes to Patients,* Journal of General Internal Medicine (JGIM), Volume 12, December, 1997, p. 772.

[300] Liebman, et al. p. 9-10. "[w]hat has been known for some time [is] about the origin of medical malpractice claims—namely, that the impetus for suit lies more often in the emotional consequences of what the medical facility personnel do in the aftermath of an error than it does in the degree of legal risk or, to a lesser extent, in the degree of physical injury."
Dauer, Postscript, p 1044.

[301] G.B. Hickson, E.W. Clayton, P.B. Githerns, F.A. Sloan, *Factors That Prompted Families To File Medical Malpractice Claims Following Perinatal Injuries,* JAMA, 1992, 257:1359.

[302] Michael Woods, M.D., tells of being sued by a female patient for malpractice. After a defense verdict at trial (no liability), Dr. Woods discovered that the plaintiff, his former patient, sued him because she felt that he was arrogant and didn't listen to her, that he didn't care about her. That led him to reevaluate his patient skills/bedside manner. Woods, p. 9.

time, money and emotions of the parties and those close to them as well as entire communities. These cases, to a great extent, end in defense verdicts, as noted herein.

Some practical suggestions made to physicians include keep good, thorough records: "The plaintiff attorney is putting her or his own money into the case expenses, which he or she will get back only if the case is won. Thus, it is important for you [the physician] to know that the early stages of review are done with utmost care to avoid accepting a case that has little chance of recovering damages."[303] Others comments and suggestions include, "Talk with your patients. Do not avoid the patient or hide the facts. In the majority of cases, an open and honest explanation will keep the patient from seeking an answer from an attorney."[304] Further, "Do not feel that your openness will be held against you in a courtroom. Plaintiff attorneys are not going to win cases against doctors who are kind to their patients, try to help them, and take responsibility when an adverse outcome occurs…. From a plaintiff attorney's perspective, nothing lowers your risk of being sued successfully as much as your documented frank explanation to the patient regarding what happened. The patient gets an explanation and knows you care. That is the best form of risk management…. Openness with a patient is a very effective deterrent to a plaintiff lawyer."[305]

Once the case is in litigation, it is the "job" of the plaintiff/patient's attorney to make the physician look bad in front of the jury, so it is unlikely that that attorney would introduce a physician's apology. An attorney who represents both physicians and patients said, **"**In over twenty years of representing both physicians and patients, it became apparent that a large percentage of patient dissatisfaction was generated by physician attitude and denial, *rather than*

[303] David Wm Horan, MD, JD, *Risk Reduction From A Plaintiff Attorney's Perspective,* in Richard E. Anderson, MD, FACP (ed), *Medical Malpractice: A Physician's Sourcebook,* Humana Press: New Jersey (2005), p. 37.
[304] Ibid, p. 37.
[305] Ibid, p. 37.

the negligence itself. In fact, my experience has been that close to half of malpractice cases could have been avoided through disclosure or apology but instead were relegated to litigation. What the majority of patients really wanted was simply an honest explanation of what happened, and, if appropriate, an apology"[306] (emphasis added).

Briefly, a portion of the Josie King story, set forth in detail above, bears repeating here. This is how disclosure should work. Because of the way the disclosure was handled, a continuing, healing relationship exists to this day among Josie King's family, Johns Hopkins and health care in general. Josie King died at Johns Hopkins Children's Center due to medical error. According to Sorrel King, Josie's mother, "About a week and a half after Josie died, George Dover, the head of the children's center, 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]

In terms of disclosure and apology, the Josie/Sorrel King story is the best possible result that could arise from a horrific tragedy. As discussed in detail below, Sorrel King and Johns Hopkins, to this day, are working together to promote patient safety around the country. The Johns Hopkins Hospital Disclosure Policy, developed as a direct result of the tragedy of Josie King, reads, in part, "All health care professionals have an obligation to report medical errors as a means to improve patient care delivery and to help promote safety and quality in patient care. Since the majority of medical errors can be linked to environmental and system-related issues

[306] Albert Wu, *Handling Hospital Errors: Is Disclosure the Best Defense?* Annals of Internal Medicine, Volume 131, Number 12, 970-973, December 21, 1999, p. 970.
[307] Albert Wu and Samantha L. Stokes, MPH, *Removing Insult From Injury: Disclosing Adverse Events,* Sorrel King Video Text, John Hopkins University, 2004, Johns Hopkins Bloomberg School of Public Health, p. 7.

that may affect the actions of health professionals, a systems improvement focus will be used in all error analysis."[308] "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."[309] "The initial provision of information can be viewed as a natural part of the ongoing patient-physician dialogue rather than as an isolated disclosure."[310] Disclosure is respectful; at an even deeper level, disclosure so clearly shows that the physician SEES the patient/family.

These new, very visible approaches to disclosure are very hopeful. These articles, studies and comments are creating a shift in the culture of health care, albeit very slowly. "A transformation in how the medical profession communicates with patients about harmful medical errors has begun. Within a decade, full and frank disclosure of these events to patients is likely to be the norm rather than the exception. Making disclosure of harmful errors to patients an expectation in medicine and giving providers the tools to turn this principle into practice may prove to be critical steps in restoring the public's trust in the honesty and integrity of the health care system."[311] (emphasis added).

Resistance to Disclosure

In spite of the foregoing and how hopeful it seems, based on my research, it seems that the culture of health care does not, in general, agree with the attorney quoted above who represents both patients and physicians that open and honest communication with patients re medical error acts to LOWER risk of being sued successfully by patients. Rather, it seems that

[308] Wu, *Removing Insult,* p. 8.
[309] Ibid, p. 8.
[310] Ibid, p. 9.
[311] Gallagher, et al, *Disclosing Harmful Medical Errors, p. 2718*.

fear or perhaps something darker may rule the day.[312] I have read extensively, as documented herein, that physicians fear the medical malpractice litigation system[313], [314] so don't speak openly about medical error to their patients.[315], [316] Fear of the medical boards' investigation/enforcement[317] divisions in the various states, along with lack of training in disclosure/communication, fear of angry patients and fear of damage to reputation, all prevent physicians from speaking openly to patients. Large portions of the culture of health still deny the usefulness and healing possibilities of disclosure. In some situations, physicians also have their hands tied by their insurers and/or hospitals at which they practice, hospitals that don't permit disclosure and transparency about medical error.

Other impediments to disclosure exist as well. "It is no accident that physicians often resist acknowledging offenses in the medical setting or fail to adequately apologize for them. An obvious and understandable reason is the fear of consequences, such as an angry patient, a complaint sent to the state Board of Registration or a malpractice suit. [318] *Initial evidence now*

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[312]Marlynn Wei, *Doctors, Apologies and the Law: An Analysis and Critique of Apology Laws,* Yale Law School Student Scholarship Series, Year 2006, Paper 30. <http://lsr.nellco.org/yale/student/papers/30>, accessed February 10, 2008. Wei argues that physicians' unwillingness to disclose medical error is often associated with physicians' (and our culture in general) belief that they are (or should be) infallible. P. 48

[313] Physicians overestimate the certainty and severity of legal sanctions and the actual risk of getting sued by threefold. Studies suggest that physicians believe erroneously that most negligent adverse events lead to lawsuits, estimating that sixty percent of cases involving negligence result in litigation, which is thirty times higher than most estimates when, in fact, as set forth herein, just the opposite is true. Wei, p. 6.

[314] "[L]awyers who tell clients to deny and defend find a willing audience because doctors' emotions rather than logic are guiding them." Shapiro, p. 12.

[315] Between 25 and 30 percent of physicians actually disclose medical errors and only twenty one percent of physicians apologize for medical error. Albert W. Wu, et al, *Do House Officers Learn From Their Mistakes?* 12 Quality & Safety in Health Care 221 (2003).

[316] Rick Boothman, Chief Risk Offices, University of Michigan, states to physicians "I serve you best by helping you avoid litigation. And if we made a mistake, the best way to avoid litigation is to make it right, right now." Shapiro, p. 12.

[317] This fear may be unjustified in many situations. From 1990 to 2002, just five percent of doctors were involved in fifty four percent of the payouts reported to the NPDB. Of the 35,000 doctors with two or more payouts, only eight percent were disciplined by state boards. Among the 2,774 doctors who had made payments in five or more cases, only 463 (one in six) had been disciplined. Wachter, et al, p 324.

[318] "It may be that the causes of under reporting are broader than fear of malpractice and are linked to a general provider reluctance to report errors for a wide variety of concerns, including a dislike of regulation, bad publicity,

suggests that admissions of harm and apology strengthen, rather than jeopardize, relationships and diminish punitive responses."[319] (emphasis added)

In spite of substantial evidence that admission and apology strengthen the physician/patient relationship,[320] there remains considerable resistance to admission and disclosure. One possible explanation for such resistance to admitting error/apology is the theory that physicians need to maintain a self-image for themselves and others of being strong, always in charge, unemotional, and perfectionistic. The fear of loss of self-image may lead to the unbearable emotion of shame and subsequent feelings of depression. An apology may expose vulnerability, remove emotional armor, and allow emotions to be exposed. Medical professionals and colleagues need to work at tolerating and supporting their own humanity and that of their colleagues. They need to regard apologies as evidence of 'humanity, generosity, humility, commitment and courage.' "[321],[322]

"Nothing is perhaps more spiritually injurious following a physical injury than to feel the chill of silence from those who have committed the wrong. *It is exactly what is meant by adding insult to injury,* even though doctors, ironically, are in the business of treating injuries."[323] **"**It makes no sense that a doctor would ignore a patient, or the surviving relatives of a deceased patient, at the very time when these people are in need of a specialized kind of care called compassion-which only the doctor, the one whom they trusted and who performed the procedure,

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loss of market share, etc." Mimi Marchev, *Medical Malpractice and Medical Error Disclosure: Balancing Facts and Fear,* National Academy for State Health Policy, December, 2003, Prepared with Support of The Robert Wood Johnson Foundation, p. 13, <http://www.nashp.org/files/medical_malpractice_and_medical_error_disclosure.pdf>**,** accessed June 5, 2008**.**

[319] Aaron Lazare, *Apology in Medical Practice: An Emerging Clinical Skill, 296* JAMA 1401-4 (2006), p. 1403.

[320] As to physicians, at The University of Michigan Health System, which has in effect a disclosure policy, Rick Boothman, Chief Risk Officer, states: "I believe we've tapped into something physicians intrinsically want to do, anyway, but have been afraid to do and have been told not to do for their entire careers." Shapiro, p. 13.

[321] Ibid; Lazare, *On Apology*, Oxford University Press: New York, 2004.

[322] A med mal plaintiffs' attorney in Florida told me at a dialogue that he knew of a *legal malpractice* carrier that encouraged its attorney insureds to disclose, apologize and offer compensation as quickly as possible after an error is discovered. Thinking in terms of disclosure has penetrated the legal culture as well, at least in Florida.

[323] Rosenbaum, p. 198.

can provide."[324] Taking disclosure out of the shadows, making it automatic, a normal, ethical, and required part of patient care, helps in taking the culture of blame out of the picture. Acknowledging grief and encouraging discussions about medical error are essential ingredients in changing the culture of a health care facility from one of blame to one of learning.[325]

Dr. David Hilfiker, a physician, speaks of the patient, public and physician view of the physician as infallible, "We are not prepared for our mistakes, and we don't know how to cope with them when they occur. Doctors are not alone in harboring expectations of perfection. Patients, too, expect doctors to be perfect. Perhaps patients have to consider their doctors less prone to error than other people: how else can a sick or injured person, already afraid, come to trust the doctor?"[326] As Lucian Leape explains, "Physicians are socialized in medical school and residency to strive for error-free practice. There is a powerful emphasis on perfection, both in diagnosis and treatment. In everyday hospital practice, the message is equally clear: mistakes are unacceptable…[A]ll physicians recognize that mistakes are inevitable. Most would like to examine their mistakes and learn from them. From an emotional standpoint, they need the support and understanding of their colleagues and patients when they make mistakes. Yet, they are denied both insight and support by misguided concepts of infallibility and by fear: fear of embarrassment by colleagues, fear of patient reaction, and fear of litigation."[327]

Dr. Hilfiker further stated, "At some point we must all bring medical mistakes out of the closet. This will be difficult as long as both the profession and society continue to project their desires for perfection onto the doctor. Physicians need permission to admit errors. They need permission to share them with their patients. The practice of medicine is difficult enough without

[324] Rosenbaum, p. 196-7.
[325] Wu, *Medical Error,* pp. 771-2; Wu, *Handling Hospital Errors*, pp. 970-2.
[326] Hilfiker, David, quoted in Marlynn Wei, *Doctors, Apologies and the Law: An Analysis and Critique of Apology Laws,* Yale Law School Student Scholarship Series, Year 2006, Paper 30, p. 46.
[327] Todres, quoting Leape, p. 687.

having to bear the yoke of perfection."[328] "Unable to admit our mistakes, *we physicians are cut off from healing*. We cannot ask for forgiveness, and we get none. We are thwarted, stunted; we do not grow. "[329] (emphasis added). Although Dr. Hilfiker wrote these words twenty-five years ago, medical errors are still locked away in many closets. Keeping them there cuts off not only the patient and physician from healing, but the entire health care system and our communities as well.

Lucian Leape, addressing the effect of medical error on physicians, states " 'the most important reason physicians and nurses have not developed more effective methods of error prevention is that they have a great deal of difficulty in dealing with human error when it does occur….[P]hysicians, not unlike test pilots, come to view an error as a failure of character…' even more to the point, the emotional impact on a physician of an error that causes patient harm is often profound. Nonetheless, under the existing systems of external liability and internal peer review, 'physicians are typically isolated by their emotional responses; seldom is there a process to evaluate the circumstances of a mistake and to provide support and emotional healing for the fallible physician.' "[330] The IOM recommended "Congress should pass legislation to extend peer review[331] protections to data related to patient safety and quality improvement that are collected… for internal use or shared with others solely for purposes of improving safety and

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[328] Hilfiker, *Facing Our Mistakes,* January, 310 NEJM 118-22 (1984*),* http://www.davidhilfiker.com/docs/miscellaneous/mistakes.htm>, accessed October 10, 2008.
[329] Hilfiker, quoted in Wei, p. 54.
[330] Dauer, et al, *Adapting Mediation,* p. 199. <http://www.law.duke.edu/shell/cite.pl?60+law+&+contemp.+probs.+185+(Winter+1997>, accessed October 5, 2008.
[331] Peer review is a process used by physicians to hold each other accountable for performance. Medical peer review committees are usually comprised of physicians who review the credentials and medical practices of their peers to ensure that they comport with acceptable quality and safety standards. To encourage participation and candor in the process, all states, except New Jersey, have enacted laws that protect peer review information and participants from the legal process. Lynda Flowers, Trish Riley, *State-Based Mandatory Reporting of Medical Errors*: *An Analysis of the Legal and Policy Issues*, March 2001, p. 46. <http://www.nashp.org/files/GNL_36_Reprint.pdf>, accessed October 7, 2008.

quality…The free flow of this information to create an epidemiology of error can occur only if secrecy regarding the information is assured." [332]

Having said that, some physicians believe that the litigation system may be the safest way to handle patient complaints. According to Dr. Barry Schifrin, a physician and expert in medical malpractice litigation, Winston Churchill's "war metaphor" is now widely applied in medicine, "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."[333] The circumstances he is referring to involve the physician suffering the "pain of a generally punitive reporting system" if s/he agrees to pay anything in settlement (on the federal level, reporting a settlement is a requirement of the National Practitioner Data Bank, if there has been a *written* claim prior to settlement; as to the various states, reporting requirements differ). Under this analysis, since the likelihood of a jury verdict in favor of plaintiff is miniscule, with only 1.3% of all claims resulting in a jury award to the plaintiff, the physician should stick with litigation.[334] (The physician, under most liability policies, has the final say on whether a case should be settled or whether it should go to trial.)

Reading between the lines of Lebed and McCauley, attorneys are generally not involved in any part of the process until litigation begins.[335] Once physicians go to battle, opportunities for healing have been lost. My frustration with this analysis is that it appears to be all about numbers and percentages and not about ethics, trust, respect and dignity; there is nothing about the

[332] Sharpe, p. 8.
[333] Barry Schifrin, M.D., quoted in Lebed, et al, p. 923.
[334] Lebed, et al, p. 921.
[335] Although attorneys can be tremendously useful as advisers and counselors, long before litigation becomes an option, our culture is such that, generally, because of mistrust and misconceptions, attorneys are not brought into the process when they could do the most good and the most healing.

legitimacy of claims or the sanctity of physician/patient relationships[336], other than mention that physicians and patients come from widely divergent cultures, which makes conflict resolution difficult. Attorneys, when properly trained, can assist physicians and patients in bridging the cultures. Perhaps we could turn down the volume in terms of this type of analysis and take a few steps back. Perhaps look at this from a different perspective.

If litigation becomes the chosen or the only option, there still are opportunities for healing. There are opportunities for healing during, or even after, litigation. It is difficult to estimate how often these possibilities exist after the litigation process has been moving full steam ahead. One factual situation I read about is instructive, although probably unusual. A physician delivered four children for a family. The fourth child, due to the physician's error, died within twenty-four hours of birth. The physician was discouraged from talking to the family and expressing his sorrow by the hospital administration. The couple felt ignored and betrayed as a result. The family then filed a malpractice action. During discovery and depositions, the physician was distraught about not being permitted to go to the family, express his sorrow, apologize, and seek forgiveness. The family suffered as well. The case went to mediation and the attorneys kept the parties apart. The case settled but the physician was unhappy, telling the mediator that the case was not finished for him, that he needed to talk to the family. The family had a similar discussion with their lawyer, wanting to talk to the physician. Such a meeting, after settlement, was arranged. The physician, in tears, was able to tell the family how sorry he was

[336] The physician has a fiduciary duty to her/his patient, that is, the relationship is based on trust. "The fiduciary character of the relationship can be further articulated in accordance with the principles of nonmaleficience [first, do no harm], beneficience [the patient's health comes first], respect for patient autonomy [they can't make decisions about their health care without all the information], and justice….[t]he fiduciary character of the doctor-patient relationship indicates that a physician has the ethical duty to disclose error to a patient when disclosure furthers the patient's health, respects the patient's autonomy, or enables the patient to be compensated for serious, irreparable harm." Wu, et al., *Medical Error*, p. 772.

and ask for their forgiveness. The couple forgave him, the wife hugging the physician.[337]

Who/What Are Blamed

Attorneys and Physicians

The medical malpractice litigation process is broken, as noted above, by Lawrence E. Smarr. A portion of his comments bears repeating, "*Incentives exist to cover up medical mistakes rather than acknowledge them and seek out ways to avoid them in the future….The only people benefiting from the current system are the attorneys who file lawsuits against doctors and their insurers.*"[338]

Smarr commented on the Public Citizen's Report of January, 2007, which Report was based on data only from the NPDB, which involved payments by physicians (ignoring the 70% of claims filed against physicians where no payment is made). "Each of these meritless claims can cost $150,000 or more to successfully defend. Medical Malpractice claims take 4.5 years on average to conclude, only three out of every ten claimants ever receive anything, and when they do, 40% or more goes to the plaintiff's injury lawyer. In fact, over 50% of all monies available to pay claims are consumed by the legal system. How can anyone call this a rational system?"[339] At another time, testifying before the Illinois General Assembly House Judiciary Civil Law Committee Hearing, Subject: Medical Malpractice, Lawrence E. Smarr, testified on April 7, 2005 that the cost of defense through trial approaches $100,000.

Mr. Smarr is not alone in his harsh criticism of attorneys and the legal system. Randolph W. Pate, an attorney with The Heritage Foundation, stated "the tort system is called 'adversarial' for a reason: *lawyers are modern-day mercenaries,* wielding briefs, motions and evidence as

[337] Eric R. Galton, R*ipples From Peace Lake: Essays For Mediators and Peacemakers.* Trafford: Canada, 2004, pp. 84-85.
[338] Smarr Statement, p. 2.
[339] PIAA News Alert, January, 2007. http://www.piaa.us/pdf_files/NEWS_ALERT.pdf, accessed October 10, 2008.

weapons in courtroom battles. Very often, lawyers aren't looking after the best interests of society, the medical profession or the health care system; they get paid to win. Except for lawyers, this system does not do anyone any good. Over the last few decades, as many judges have tilted the focus of tort law away from dispute resolution, they have substituted the "rule of more" for the rule of law: more lawsuits, more liability, and bigger verdicts. This has not reduced medical errors or significantly improved compensation for injured patients. But it has created a monster-an expensive litigation machine that delivers the bulk of awards to lawyers and leaves injured patients with little. Too often, injured patients and doctors alike are abused by this system" (emphasis added).[340]

However, a recent review and investigation, called the Malpractice Insurers Medical Error Prevention and Surveillance Study (MIMEPS), suggested otherwise. The MIMEPS report stated: "Like most branches of tort law, medical malpractice is largely premised on the notions that injuries arise from individual carelessness or lack of expertise, the culpable actors can be readily identified, and that their negligence can be deterred by setting damages sufficiently high to induce medical professionals to take due care. The emerging science of patient safety takes a very different view of the occurrence and prevention of medical injury."[341] The Study was conducted by a group of trained physicians, who reviewed a random sample of 1452 closed malpractice claims from five liability insurance carriers to determine if a medical injury had occurred and, if so, whether it was due to medical error. The report lists three key findings, all of which implicate tort law. "Each is at odds with conceptions of medical error and safety promotion in tort law."[342] One finding is that "individual failures play a causal role in the

[340] Randolph W. Pate, *How Should Malpractice Policy Put Patients First*, AARP Bulletin, April, 2006. This appears to be an opinion piece only, since there are no footnotes/citations to support the author's statements.
[341] Mello, et al, *Deconstructing Negligence*, p. 601.
[342] Ibid, p. 602.

overwhelming proportion of medical injuries attributable to error, but, in the majority of cases, they are precipitated, activated, or amplified by system failures. Only 30% of injuries were caused solely by individual facts, while 66% involved both individual and systemic factors. *Thus, in most cases, individual failures appear to be a necessary but not sufficient condition for injurious errors to occur"*[343] *(*emphasis added).

"Health care is a complex, rather than a linear, system. The etiology of health care accidents is a web of interactions among system components….[A] range of system factors may also be in play but bypassed altogether: inadequate physician staffing of the labor-and-delivery service; the obstetrics department's unwillingness to pay the extra salaries needed to attract experienced midwives; a hospital culture that discourages nurses from asking physicians for help; and so on."[344] "A key component of the MIMEPS study was analyzing patterns in the contributing-factor data in order to identify areas where avoidable injuries were prevalent, and preventive measures could be taken. However, the study found that few if any of the interventions were amenable to implementation by individual rank-and-file clinicians. Rather these proposed interventions require the commitment of organizational leadership, centralized planning, and other organizational resources.[345] Further, the physicians analyzed the prevalence, characteristics, litigation outcomes, and costs of claims that lacked evidence of error. They found that 37% did not involve errors; most of the claims that were not associated with errors or injuries, 72 and 84 percent, respectively, did not result in compensation; most that involved injuries due to error did (73 percent). Payment of claims not involving errors occurred less frequently than did the converse form of inaccuracy: nonpayment of claims associated with errors. Claims not involving errors accounted for 13 to 16 percent of the system's total monetary

[343] Ibid, p. 609.
[344] Ibid, p. 616.
[345] Ibid, p. 617.

costs.

In the MIMEPS study, it was determined that the average time between injury and resolution was five years, and one in three claims took six years or more to resolve. "These are long periods for plaintiffs to await decisions about compensation and for defendants to endure the uncertainty, acrimony, and time away from patient care that litigation entails….The need to constrain the number and costs of frivolous lawsuits is touted as one of the primary justifications for such popular reforms as limits on attorneys' fees, caps on damages[346], [347], [348], panels for screening claims and expert precertification requirements.[349] *Our findings suggest that moves to curb frivolous litigation, if successful, will have a relatively limited effect on the caseload and costs of litigation. The vast majority of resources go toward resolving and paying claims that involve errors. "[M]ost malpractice claims involve medical error and serious injury, and…. claims with merit are far more likely to be paid than claims without merit".[350] A higher-value target for reform than discouraging claims that do not belong in the system would be*

[346] An injured party is likely to be less able to find an attorney in states where there is a cap on non-economic damages. In states, such as California, where the cap is $250,000 (and has been for 35 years), by the time there is a settlement or verdict, years may have gone by and plaintiff's counsel may have spent many thousands of dollars taking depositions of parties, witnesses and experts, waiting on court delays, opposing motions, retaining experts and paying other costs of discovery. Therefore, it ceases to be financially feasible for many attorneys to take cases when faced with the huge hurdle of non-economic damage caps.

[347] The intent of caps on damages is to limit liability; caps are not meant to reduce the incidence of medical error and adverse events, and there is no reason to think they do so. In addition, caps disproportionately affect both those who are severely injured, as well as disadvantaged groups, such as low income wage earners, minorities, the elderly and the young, all of whom are likely to have lower economic damages. Mello, *Medical Malpractice,* Report No. 10, May 2006.

[348] The emphasis on caps and other measures designed to restrict the amounts of damage awards, such as abolition of the collateral source rule and joint and several liability, is aimed at increasing the predictability of awards and limiting the liability exposure of the insurance companies, so as to stabilize malpractice insurance premiums. However, this strategy is not designed either to increase reporting compliance or reduce the incidence of medical errors, and no evidence exists to indicate that it would do either one." Marchev, p. 11.

[349] Other proposed (and, in some states, enacted) reforms include joint and several liability reform (each defendant will be responsible ONLY for her/his percentage of fault that the jury determines for that defendant, rather than the traditional rule: if one or more defendants can't pay their share of the judgment, one defendant is responsible for the entire amount; plaintiff can collect the entire judgment from one defendant); shortened statutes of limitations, collateral source rule reform (injured plaintiff who receives compensation for her injury from other sources, such as her/his own insurance and/or workers compensation, traditionally does not have that payment deducted from the amount defendant has to pay), and periodic payments over a long period of time, rather than in one lump sum.

[350] Ibid.

streamlining the processing of claims that do belong"[351] (emphasis added). This study suggests that we need to move upstream, apparently against the current, to create change in the medical malpractice system. We need to look at and discuss how to change both the medical and legal cultures about medical error.

The most interesting reading in terms of the MIMEPS study, cited above, involves its conclusion: "*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. Rather, 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"*[352] (Emphasis added). Further, the study concluded: *"…[N]early eighty percent (80%) 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."*[353] Most suits are not frivolous; the study concludes, "Substantial savings depend on reforms that improve the system's efficiency in the handling of reasonable claims for compensation."[354]

As to patients/clients/plaintiffs, recent empirical studies have demonstrated in a very sturdy way that the predominant motivation of iatrogenically-injured claimants is *not* the desire for economic compensation. As previously mentioned, money is *not* what motivates most

[351] Studdert, et al, *Claims, Errors,* p. 2033.
[352] Studdert, et al, *Claims, Errors,* p. 2030.
[353] Harvard, *Study Casts Doubt,* p. 2.
[354] Dauer, *Accountability,* p. 187.

medical malpractice plaintiffs.[355] *Rather, claimants are often simply attempting to ensure that the error is not repeated.*[356] A pilot mediation program under the sponsorship of the Massachusetts Board of Registration in Medicine confirms these findings, suggesting that quality improvement can be an outcome of private dispute resolution through mediation. The outcomes tended to focus on future patient safety. "T*he process brings the private interests of the injured person into closer consonance with the public's interest in preventing injuries in the future…it offers direct and collaborative roles to patients and to doctors"*[357] (emphasis added). The authors of the report hypothesize that mediation in either a fault-based or no-fault environment can make claims resolution more efficient and simultaneously promote quality improvement in health care more effectively than does the litigation/settlement process. There are forms of mediation that are compatible with the goals of quality improvement and that can avoid the impediments to quality improvement that are structurally embedded in conventional tort litigation. This may be a workable process, even without attorneys, although concerns exist for the parties stepping into a mediation process without individual representation. For instance, patients, without an attorney, are often in the inequality-of-bargaining-power position.

Plaintiffs' medical malpractice attorneys often won't take cases if there is not enough of a "payoff" in them, i.e. person died/severally injured but is too old or too young to have an economic track record. Many states have a cap on non-economic damages: in California, in a wrongful death case involving med negligence, the cap is $250,000 and has been since 1973. In such a case, the only avenue to a big payoff is economic damages, i.e. a 35-year-old stock-broker who died making $1M/year. Also, cases are not taken for other reasons, such as the case is too hard to prove, the injury is not substantial enough (damages will be small), the plaintiff is not

[355] Ibid, Claims, p. 187-8.
[356] Ibid, p. 188; Dauer, et al, *Adapting Mediation,* p.185-6.
[357] Ibid at p. 186.

sympathetic (plaintiff comes to hospital with serious injuries after an auto accident in which plaintiff is drunk driver; plaintiff then dies through some hospital medical error.)

There is much talk, particularly at the federal level, of "frivolous" malpractice lawsuits which are, according to the Bush Administration, a driving force behind rising health care costs. It was accepted for purposes of this study (MIMEPS) that the great majority of patients who sustain a medical injury as a result of negligence do not sue. If frivolous claims are common and costly, they may be a substantial source of waste in the health care and legal systems. Judgment errors were the most common type of individual factor (70% of cases). Also, system factors were implicated in 56% of injuries; in particular, teamwork problems and other communication breakdowns were particularly prevalent types of system factors. Breakdowns leading to various injuries occurred across or within multiple stages of care, such as diagnostic errors, failure to communicate test results, failure to ask the right questions, and/or inappropriate follow up with the patient. The aim was to measure the prevalence, costs, outcomes, and distinguishing characteristics of claims that did not involve identifiable error. The study used IOM's definition of medical error: "the failure of a planned action to be completed as intended (i.e. error of execution) or the use of a wrong plan to achieve an aim (i.e. error of planning)". [358] The study found that 73 percent of all claims for which determinations of merit were made had outcomes concordant with their merit. Claims with evidence of injury or error accounted for 13 percent of total litigation costs.

Although attorneys are blamed for filing too many, or bogus, medical malpractice lawsuits, attorneys only represent patients. If we phrased the problem as, patients file too many

[358] Interest in medical error has grown exponentially over the last ten years. In 1999, Roxanne, Goeltz searched the internet for "medical error" and came up with one hit. Roxanne Goeltz, *In Memory of My Brother Mike, Accountability*, p. 53. On 12/30/07, I searched for "medical error" and found 43,800 hits. Even taking into consideration the number of websites, blogs, etc. added to the internet search engines over the last ten years, this is still a huge increase.

lawsuits, how would that change the conversation? Would we, our culture, be pointing the finger at injured patients, asking them why they are filing frivolous lawsuits? Should we turn the conversation on its head and, instead of the traditional question: Why do we have so many lawsuits?, ask, Why do we have so few?

As we go forward, let's keep in mind the results of the MIMEPS study, as set forth in detail herein, that the claims examined in the study do not square with the stereotype of the opportunistic trial lawyer taking any case that looks like there is a buck or two in it for her/him.

Insurers and Their Insured Physicians

Another point of view, more finger-pointing: insurance companies and their "scorched earth" policies of denying and fighting all claims, even the most legitimate claims, like wrong – side surgeries, is the chief cause of med mal crisis. Also, the archaic legal strategies employed by some defense lawyers literally pit doctors against patients and their lawyers and breed a lot of unnecessary hostility among all parties Further, the idea, often well-founded, that risk management is an effort to avoid liability rather than an effort to avoid error, according to many stakeholders. 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.[359], .[360]

Defense attorneys are given "marching orders" from insurers of physicians/hospitals; cases are assigned by carriers to defense counsel only after a complaint has been filed and served; often, defense attorneys are not brought to the process prior to litigation so that they can negotiate with patients on behalf of physicians, perhaps too late to advise physicians about disclosure and apology issues.

[359] Dauer, *Accountability, p. 188.*
[360] Sharpe, *Accountability,* p. 17.

In general, physicians often are instructed by insurers and/or attorneys to cease communication with their patients after an adverse event, just when their patients need them the most. This cessation of communication isolates the physician(s) from others, including her/his patient. How the process often unfolds is akin to: patient is injured and, if no health care provider is willing to speak with her/him, feels disrespected by physician/other health care provider; patient expresses concern, asks questions (generally referred to as a "complaint"), physician refuses and/or is prohibited by insurer and/or health care facility from responding, answering questions; patient/family can't get answers, so decides to litigate; physician becomes something of a bystander once litigation begins, the insurer and physician's attorney making all the decisions (except settlement, which has to be approved by the physician); the physician, fearful of the medical board, which requires settlements to be reported to it, will not authorize settlement, but chooses trial instead (where s/he is very likely to get a defense verdict); reporting to the medical board takes place if there is settlement or a verdict in favor of plaintiff/injured party or, if death has occurred, to the family.[361], [362]

Physicians are often held captive by their insurers; carriers often have material provisions in the insurance policy that prohibit physicians from speaking/explaining/disclosing/apologizing to patients for a medical error/"unanticipated outcome". At a time when physicians have the best opportunity for honest communication and development of trust with their patients, they are prohibited by their insurance carriers from doing so; the patient becomes a legal problem to be reckoned with. Physicians seem to live in so much fear about litigation, rooted in myths

[361] The fact of and/or the extent of a settlement/verdict that has to be reported to a state medical board varies by state.

[362] Oftentimes, as explained herein, verdicts in favor of plaintiffs are not based on negligence; rather, they are based on the extent of the injury. The injuries that can be the worst, most serious, and most sympathetic to a jury include brain injuries and delivery/neo-natal injuries. As a result, physicians who practice in these specialties, neurosurgeons and obstetricians/gynecologists, in particular, often pay much higher insurance rates, sometimes can't get insurance, and may be reported to state medical boards more often.

concerning liability, they speak of "choosing their words carefully", choosing words that conceal rather than disclose to the patient/family. If a physician chooses to reject the requirement to cease communication with the patient when there has been an error or the possibility of error, the insurer has the right to refuse to defend and/or indemnify the physician. (Physicians need to come together in large numbers to pressure insurers to change these policies.) Statistics that strongly indicate that it costs LESS money to disclose/admit error/admit fault than to litigate, as Steve Kraman, M.D. stated (see above), would likely have a strong impact on insurers, who, like everyone else in the process, are fearful of the outcome of telling the truth, of being accountable.

As noted, physicians are often in a difficult position vis-à-vis their insurers. Some of the problem may be communication. Carol Bayley, Vice President For Ethics and Justice Education at Catholic Healthcare West (CHW), writes of physicians who practice but are not employed by one of the CHW hospitals, who are prohibited from admitting liability[363] under their own liability policies. As a result, they were concerned about admitting error under the CHW policy. Under the circumstances, Bayley spoke to the physicians' liability carriers, only to find out that the carriers had a very similar disclosure philosophy to that of CHW. It seems that, often, there remains an unspoken misunderstanding among many physicians that they are prohibited by their insurers from admitting error.

[363] CHW's policy includes: "The disclosure process will not include acceptance of liability, placement of fault, statements of causation or other actions that may be inappropriate given the status of the investigation." Bayley, *Accountability,* p. 116.

Liability of Individual Physicians versus Organizations/Systems/Hospitals

As noted, traditional medical malpractice law focuses primarily on individual practitioners, which has a chilling effect on patient safety efforts, requiring as they do collecting and analyzing data about medical error. The medical malpractice system needs to be valid (system identifies and compensates events having certain characteristics), proportional (treat different cases differently, have rational basis for differential treatment), consistent (similar cases are treated similarly) and predictable (stakeholders need to be able to predict how certain behavior will be treated by the system).[364] Mehlman, the author of the study, believes that fairness should emphasize preventing future errors, rather than punishing individual malfeasance.[365], [366] The litigation system creates a culture of silence. In addition, the archaic legal strategies employed by defense lawyers literally pit doctors against patients and their lawyers and breed a lot of unnecessary hostility among all parties. Overwhelmingly, medicine is, to a great extent, interdisciplinary teams working with scans, computers, imaging, and various machines, as well as other sophisticated and complex technologies. Systems failures, not individual failures, result in medical error. "*Multiple* failures often contribute to a single adverse event[367], and early detection of the *first* such failure provides an opportunity to intervene and

[364] Mehlman, pp. 22, 35.
[365] Ibid, p. 3.
[366] Mehlman discusses one alternative to linking patient injury directly to compensating victims, suggested by the Institute of Medicine in 2002, that encourages providers to identify instances in which they injured a patient and aid in an investigation of why the injury occurred and how it could have been prevented. This approach would limit the liability of providers who admit error. The rationale is that "any loss of deterrence from not having to fully compensate the patient is more than made up for by gaining knowledge about what caused the mishap and how it can be avoided in the future." Since this is clearly unfair to the injured party, unless the injured party consents (having sought disclosure, explanation, and apology, to the extent appropriate, through litigation because the injured party had no other process available), a fairer approach would be to "compensate the victim fully, but relieve the provider of some or all of the burden of the compensation, such as by having it borne by a fund financed by all providers, all patients, or all taxpayers." Mehlman, p. 34.
[367] The term "Adverse Event" is an event "that results in unintended harm to the patient by an act of commission or omission, rather than by the underlying disease or condition of the patient." Institute of Medicine, *Patient Safety: Achieving a New standard For Care,* Quality Chasm Series, National Academy Press: Washington, D.C., 2004, p. 201.

stop what could become a chain of failures leading up to a serious adverse event." (Emphasis added.)[368]

"In the ongoing effort of states to guarantee safer health care, the systems designed to investigate and remedy errors (mandatory reporting systems) and to hold providers accountable and act as a deterrence to future errors (the tort system) appear, at times, to work at cross purposes. Mandatory reporting, as envisioned by the IOM, encourages a systems approach and looks to bring mistakes out in the open in order to fix system flaws and thus avoid future lapses. The tort system blames an individual for his wrongdoing and through punishment looks to deter future errors. Both approaches can be said to share the goal of safer health care delivery, but in the current environment of mistrust and fear, the balance may shift temporarily toward more protection of data at the expense of open and public airing of errors."[369]

In *Growing Pains: The Next Stage In Health Care*[370]*,* the presenters informed the audience that cultural change is required to change from a culture where "do no harm" is seen as an individual responsibility to seeing patient safety as a systems property[371]. "Conflicts arise as health care professionals seek to balance mandates for disclosure of unanticipated outcomes with concerns regarding legal liability. Calls for increased transparency from physicians and hospitals through mandatory disclosure requirements from JCAHO and some states laws are driving the need for well planned, flexible approaches for managing communication after there has been harm during treatment. From skill development to claims management, the area of clinical quality and safety is a fertile area for development of ADR applications that can balance

[368] Ibid, p. 18.
[369] Marchev, p. 13.
[370] Debra Gerardi, Virginia Morrison, Dale Hetzler, Karl Slaikeu, *Growing Pains: The Evolution of Healthcare ADR,* presented at the American Bar Association Dispute Resolution Conference, April, 2005 in Los Angeles, CA.
[371] To achieve the great successes of modern medicine, physicians often practice in interdisciplinary teams and depend on increasingly sophisticated equipment and supplies.

complex interests, incorporate mechanisms to address fairness and justice, and restore trust to damaged relationships among clinicians, patients and families while simultaneously promoting improved quality of care."[372]

The dynamic between institutional and individual accountability is one of the most important and complex issues at the heart of patient safety reform. Frequently, there are misaligned incentives that create conflict, such as between hospital policies mandating disclosure and liability carrier policies that continue to bar access to coverage if information is shared outside their specifications; between hospitals and physicians during settlement negotiations where amount and apportionment of contributions are determined; and between clinical service areas when an event occurs while care is provided by a consulting physician or a non-physician practitioner. [373] "Coverage remains sharply divided between companies catering to physicians, many of them chartered during previous crises, and those serving hospitals, reducing incentives for coordinated risk management."[374]

In the MIMEPS Study Report, mentioned above, plaintiffs named physicians as defendants in the vast majority of claims, while institutions were named in approximately two-thirds of claims. Institutions were no more likely to be named in cases where systemic factors and individual factors resulted in error than in cases in which only individual error took place, even though traditionally all likely defendants are named because no discovery has been done. Forty-one percent of injuries due to both individual and systemic factors targeted one or more physicians but failed to name a health care facility *at all*.[375] Institutional defendants contributed in less than one quarter of paid claims overall and were no more likely to pay in cases involving

[372] Gerardi, et al, Growing Pains, p. 24.
[373] Ibid, p. 24.
[374] William M. Sage, *Medical Liability and Patient Safety*, Health Affairs, 22, no. 4, (2003), p. 3.
[375] Mello, et al, *Deconstructing Negligence*, 96 Geo.L.J. 599 (2008), 613-4.

harmful system failures than in cases, in which the injury was linked solely to individual factors. Individual providers bore the brunt of liability even though system factors were frequently involved in causing the injuries for which they were held liable.[376]

Further, the MIMEPS Study Report states: **"**Holding individuals liable for a disproportionate share of the damages associated with medical injuries is problematic because it disrupts the possibilities for efficient deterrence."[377] It also disrupts the possibilities for improvements in the system and improved patient safety overall. The Report makes clear that, although there are tort doctrines like joint and several liability, hospitals are frequently insulated from liability. "Because medical malpractice doctrine does not embrace corporate liability for hospitals except in narrow circumstances, most of the system factors that contribute to medical injuries are unlikely even to be raised in malpractice litigation."[378] If the institution/hospital is not a defendant, raising institutional issues just cloud the issue of physician liability, something the plaintiff does NOT want to do. Also, systems issues/concerns are often ruled irrelevant or prejudicial and are excluded on that basis.

Prevention vs. Punishment

When we view medical error situations from a systems point of view, we open the doors to look at prevention, rather than punishment. A systems approach becomes less about punishing a few people and more about analyzing an entire system to see where the breakdowns/concerns arise. A systems approach allows us to focus on patient safety and the future. When the focus is always on the patient, with patients safety as the goal, punishment and blaming take a back-

[376] Ibid, pps. 614-5.
[377] Ibid, p. 615.
[378] Ibid, p. 616.

seat.[379]

The Department of Veterans Affairs ("VA") sees health care as a system. The VA actively promotes patient safety through reporting of error, root cause analysis and problem solving. The VA National Center for Patient Safety's mission statement states, "Only viewing the health care continuum as a system can truly meaningful improvements be made. A systems approach that emphasizes prevention, not punishment, is the best method to accomplish this goal." [380] The VA program is a model for disclosure and doing the right thing. The system is about accountability, not punishment.

Institution of the disclosure program at the VA was less cumbersome than it would be in a private hospital, although it is still a model to be admired and followed, since physicians employed by the VA are not individually liable for medical error. In the private hospital world of health care, physicians are independent contractors, not employees of the hospital. They physicians and the hospitals are separately insured, adding another layer of difficulty to the disclosure process, i.e., the physician and the physician's insurer may agree to disclosure, but the hospital and/or its insurer will not.

Patient Safety

"The best risk management strategy is patient safety."[381]

A patient safety process that grows organically within units and departments requires teamwork founded on trust. But, from childhood, most of us have been taught an individualistic, win/lose perspective, supported by such pop mantras as "looking out for number one." That

[379] This is part of what the dialogues are about: can we all, all the stakeholders with different interests and different experiences, agree that the focus, the goal, is on the patient? See below.
[380] Ansley Boyd Barton, *Recent Remedies For Health Care Ills*, 21 Ga.St.U.L.Rev 831-56 (2005) p. 833, citing *Creating a Culture of Safety,* VA National Center for Patient Safety <***http://www.patientsafety.gov/vision.html***>, accessed June 3, 2008.
[381] Shapiro, quoting Timothy McDonald, M.D, p. 6.

tradition carries over into medicine, a field thought of as radically individualistic, especially where physicians are concerned. Collaboration is built through conversation, information, and shared purpose in work. Medicine needs a global perspective to see the myriad linkages and couplings that bind together a patient safety culture. Systems thinking principles include that there is no single root cause: a number of other factors are involved. Expressed simply, investigate facts, not faults. Systems thinkers, who see error caused by multiple factors, not one individual, attempt to remove any aspect of the health care environment that inhibits incident reporting. Error reporting is often stymied by fault-finding. Health care needs to focus on processes, not outcomes. Learning to think in terms of interdependence changes our perspective from narrowly linear to globally circular. We can see how small changes in behavior can result in attitude change, followed by more behavior change and more desired attitude change, leading eventually to personal commitment and total involvement in a patient-safety process.

Patient safety culture is shaped by conversations both spoken and unspoken; the unspoken conversations are the customs or unwritten rules people heed without mention. The seeds of a patient safety culture are sown in conversation and are formulated in planning, brainstorming and dialogue. "The simple fact is that we need more talented people from many fields [medicine, ethics, law, psychology, engineering, information technology, group dynamics, to name a few) to devote themselves to the patient safety and quality movements, research new ideas and testing them under battlefield conditions and we'll only get them if we can offer the resources they need."[382] This, like so much of the entire process of bringing the best possible health care and patient safety to our communities, requires conversation and dialogue among the many professions to develop trust and collaboration.

When the legal system turns in the other direction, toward litigation and the adversarial

[382] Wachter, et al, p. 338.

process, patient safety loses out: because of the tension that always exists between the goals of the malpractice system and the goals of the patient safety system. Many in and out of the legal system believe that physicians practice more safely because they live in the shadow of the punitive and individualistic litigation system. The patient safety system, on the other hand, to function optimally, needs cooperation, transparency, open exchange and teamwork. One system is punitive, the other cooperative. These two systems are working at cross-purposes.

The clash between tort law and the patient safety movement undermines efforts to improve quality. Health care providers do not believe that the legal system is a legitimate purveyor of patient care standards, only of punishment. Physicians would like to see the focus shift to continuous improvement and cooperation and systems performance, not individual punishment. Punishment does not prevent error; it prevents the reporting of it. Concern about exposure to malpractice litigation diminishes the health care industry's interest in patient safety activities. The reluctance of physicians to engage in activities such as disclosure and apology stems from the belief that the physicians are being asked to be open about errors with little or no assurance of legal protection at a time when litigation is on the rise, malpractice insurance is increasingly expensive and difficult to find, and having even one claim may make insurance coverage difficult to obtain. This reluctance is manifested in several ways, but two of the most important are underreporting to adverse-event reporting systems and lack of communication with patients about errors. Before, during and after litigation, information about injuries and their surrounding circumstances is kept hidden. Risk management and quality improvement are divorced from each other.[383]

"Thus, in spite of malpractice law's mission to improve quality through deterrence-indeed, perhaps because of it- litigation fears obstruct progress in patient safety. The harsh reality

[383] Ibid, at pp. 7-8.

is that greater publicity about mistakes, disclosure to patients, and access to reported information probably would increase litigation. Such corroborative information promises reduced time and costs for initiating litigation, shifting the plaintiff attorney's calculus in the direction of more lawsuits."[384] But is that really true? Perhaps what collaborative information would mean is collaboration across and among patients, physicians, insurers, and attorneys. It is reasonable to believe that there would be more claims, not more lawsuits. There is a tremendous difference, as explained herein. Briefly, claims, if addressed expeditiously and fairly, likely can be resolved quickly, which a minimum of attorneys fees and other costs. Lawsuits, it bears repeating, take tremendous amounts of time, as well as emotional and financial resources.

Dr. Lucian Leape suggested that "patients have a priceless and unique perspective both on error prevention and on error resolution."[385] Recurrence of an error can only be prevented if all those with information contribute what they know. Family members or the patient may have observed details not seen by a health care provider.[386], [387] In spite of the patient's vantage point with money as the ONLY available remedy in the civil liability system. The potential learning and possibilities for reform of patient safety procedures is lost in litigation.

Physicians need attorneys to speak up for them, to talk about the usefulness of systems thinking, the usefulness of thinking about accountability, rather than blame. Focusing on one or two physicians is not changing the system. The likelihood that individual physicians, speaking to the public, the regulators, the insurers and the courts about zooming out to the entire health care system to address medical error and improve patient safety system, will be heard and considered

[384] Studdert, et al, *Medical Malpractice,* p 287.
[385] Dauer, et al, *Adapting Mediation,* p. 200.
[386] Liebman, et al, p. 38.
[387] As noted above, when my friend Nancy began having conversations with the ombuds/mediator at Kaiser, Oakland, after the death of her son, her observations led to MANY substantial changes at Kaiser. By the time she had these conversations, her family's litigation against Kaiser was resolved. If the process had ended at litigation/arbitration, none of these changes would have been made because the family member's input had never been sought. I call this a lesson for the ages and salute Nancy for her courage.

is slim. How many of us take seriously an individual "wrongdoer" of whatever sort who tells us that we should look at the system and hold it accountable, not just the individual. Could physicians ask lawyers for help? Could physicians and lawyers work together on this, particularly when they are not in an adversarial mode, removed from a particular situation/medical error? Could we work as a team to bring higher and higher levels of patient safety to our communities?

The In Between Programs Between Collaborative Law and Litigation

There are several programs and policies that fit into the category of the "In Between" but fall much more on the side of collaborative law in that they are non-adversarial and involve healing and responsibility.[388] There are also numerous organizations that support patient safety. Some of each include:

- NorCal Mutual Insurance Company, a physician owned insurer in California, Arizona and Rhode Island, headquartered in San Francisco: disclosure policies are extensive; risk management assists physicians in disclosure process, which fold into patient safety program. Company is committed to educating physicians in accepting their role in health care and communicating that role to patient, including unanticipated outcomes and apology. Company provides continuing medical education classes/programs on disclosure and apology.
- Physicians Reimbursement Fund (PRF), a San Francisco, CA physician-owned carrier founded in 1976, uses a process called Code Green for early resolution of adverse outcomes. It is a risk management program designed to "make the patient whole again"

[388] "Tort law is adversarial by nature, while a culture of safety is collaborative." Wachter, et al, p. 304.

subsequent to an untoward outcome arising out of medical treatment or procedure. The objectives are to provide the patient with the best medical care possible and to maintain a good patient/physician relationship, "even when things don't go as planned".[389] Physicians are asked to discover patients' interests, in terms of monetary interests and further patient care. Physicians are asked to give a full apology, including admitting error if accurate. The physician remains the primary contact, not the insurer or an attorney. "PRF paid an average of $586 for the usual early resolution case as opposed to an average of $19,541 for events that used any legal process".[390]

- VA/Lexington, Kentucky[391] began a process of disclosure and apology when a patient is injured through medical error or negligence. The VA fully discloses the facts to the injured party by apologizing, accepting, and stating full responsibility (including legal liability), and offering fair compensation. VA Program initiated in 1987 by Steve Kraman, M.D., who stated: "We didn't start doing this to try to limit payments; we did it because we decided we weren't going to sit on or hide evidence that we had harmed a patient just because the patient didn't know it…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."*[392] (emphasis added.) There have been tremendous financial savings through the disclosure/apology/compensation process.[393]

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[389] <http://www.prfrrg.com/code_green.shtml>, accessed March 1, 2008.
[390] Virginia Morrison, *Heyoka: The Shifting Shape of Dispute Resolution in Health Care,* 21 Ga.St.U.L.Rev 931-964 (2005), p. 953.
[391] The VA National Center for Patient Safety, which actively promotes patient safety through reporting of error, root cause analysis, and problem solving, noted in its mission statement: "Only by viewing the health care continuum as a system can truly meaningful improvements be made. A systems approach that emphasizes prevention, not punishment, is the best method of accomplish this goal." Barton, p. 833.
[392] *Accountability*, p. 7.
[393] The Veterans program, because it is part of the federal government, involves neither individual physician liability

Full disclosure is made as soon as consensus is reached that an error has occurred which harmed a patient. This process has been so successful that it is now mandated in all VA Hospitals in the United States. The statistics for the Lexington VA run counter to traditional legal thinking about disclosure and apology. Between 1990 and 1996, compared to the thirty five other VA hospitals in the eastern portion of the U.S., the Lexington VA hospital was in the top quartile in the number of claims made and the bottom quartile in the amount of payments.[394] The VA fully discloses the facts to the injured party; by apologizing, accepting and stating full responsibility (including legal liability), and offering fair compensation. By 1995, the DVA, because of the success of the Lexington, KY program, adopted a policy requiring ALL of its medical centers to inform patients or their families when medical errors result in injury, to offer appropriate medical follow-up, and compensation, if appropriate.[395] If these issues aren't resolved, the medical centers must advise patients of their right to file a claim.[396] A study of the effect of the VA policy at Lexington Center found that despite following a policy that seems designed to maximize malpractice claims, the Lexington facility's liability payment have been moderate. "It was believed that these findings were due, in part, to a policy that promotes prompt notification of substandard care and offers timely,

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nor punitive damages (verdicts are often high, perhaps to make up for lack of punitive damages).

[394] Norman Taber, *Should Physicians Apologize For Medical Errors,* The Health Lawyer, January 2002, Volume 19, Number 3, p. 24.

[395] The VHA issued Directive 2005-049, dated October 27, 2005, *Disclosure of Adverse Events to Patients, "*provides policy pertaining exclusively to the disclosure of adverse events related to clinical care to patients or their representatives. …VHA facilities and individual VHA providers have an obligation to disclose adverse events to patients who have been harmed in the course of their care, including cases where the harm may not be obvious or severe, or where the harm may only be evidence in the future. …disclosure of adverse events to patients or their representatives in consistent with VHA core values of trust, respect, excellence, commitment and compassion.. Providers have an ethical obligation to be honest with their patients." <http://www.va.gov/oig/54/reports/vaoig-06-02429-62.pdf> , accessed October 10, 2008.

[396] Although the literature indicates that this process is in effect in ALL VA hospitals, I've been told by the Chief of Medicine of one of the VA Hospitals that the process is not used in ANY VA Hospitals, other than perhaps Lexington, Kentucky, at the present time. Pressure from the lawyers was the explanation.

comprehensive help in filing claims. The researchers inferred that a policy of full disclosure diminished anger and the desire for revenge that often motivate litigation."[397] VA, Lexington, KY found that its average payout per claim dropped drastically after implementing, in 1987, the practice of full disclosure (apologizing, accepting and stating full responsibility, including legal liability and offering fair compensation) as soon as consensus was reached that an error occurred which harmed a patient. Kraman and Hamm further observed: "[t]his practice continues to be followed because administration and staff believe that it is the right thing to do and because it has resulted in unanticipated financial benefits to the medical center", and conclude that "an honest and forthright risk management policy that puts the patient's interests first may be relatively inexpensive."[398]

The VA Lexington is now in the lowest 1/6 of VA hospitals, and only eight claims proceeded to court. For the first seven years of the program, Lexington paid an average of $200,000 per year in total liability payments and had an average of eleven clams per year. Lexington's annual liability experience for the twelve years since it began keeping adequate records is similar: the organization reports an average of fourteen settlements per year totaling $215,000 per year, or about $15,000 per settlement. The mean malpractice settlement within the VA system in 2000 was $98,000. Kraman and Hamm state: Much has been written about how poor communication and denial of responsibility for errors generate outrage and the desire for revenge among patients.[399] It stands to reason that avoiding these incendiary behaviors would have the opposite effect, and in

[397] Steve Kraman, M.D, Ginny Hamm, J.D, *Risk Management: Extreme Honesty May Be The Best Policy*, cited in Flowers, p. 65.
[398] Berlinger, *Accountability,* pp. 129-130.
[399] Ibid, p. 130.

Lexington's case, at least, this assumption is true.

- The Joint Commission (formerly known as JCAHO), which accredits 15,000 health care programs and organizations in the U.S., put into effect on July 1, 2001, its new Patient Safety Standards, among them standard R1.1.22: "Patients and, when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes." "The responsible licensed independent practitioner or his or her designee clearly explains the outcome of any treatment or procedures to the patient and, when appropriate, the family, whenever those outcomes differ significantly from the anticipated outcomes." [400] JCAHO Sentinel Events Policy (SEP) mandates that certain adverse events be reported to the JCAHO, that the hospital perform a self-critical, systems-based root cause analysis of these adverse events, and that the hospital submit this root cause analysis to JCAHO for review and approval. JCAHO may disclose to third parties, such as the lay press, that the particular entity is under sentinel event review. Further, if the adverse report is not made or if the root cause analysis is not considered acceptable, JCAHO may place the provider on "accreditation watch" with the potential of revoking the provider's accreditation.[401] [402] The JCAHO standards do not address accepting legal responsibility or offering compensation although a disclosure would lead naturally to each such action. Approximately half the states in the United States require mandatory medical error reporting by hospitals to various state agencies. Much of the information required is quantitative, although some reporting involves narrative information, which enables

[400] Joint Commission, 2002 Hospital Accreditation Standards. Oakbrook Terrace, IL: Joint Commission, 2002.
[401] Although the JCAHO Patient Safety Standards are intended to improve patient safety, the "accreditation watch" is in direct contravention to the cooperative, non-threatening, blame free mechanism essential for reducing errors.
[402] This policy, as well as mandatory reporting systems, such as state laws requiring reports of adverse events, capture less than 1 percent of errors associated with patient injury in hospitals. This is in direct contravention to the cooperative, nonthreatening, blame-free mechanism essential for reducing errors. Brian A. Liang, *Error Disclosure For Quality Improvement, Accountability,* p. 64.

analysts to study safety culture issues. JCAHO SEP provides consultants to do root cause analysis. Physicians are required to disclose unanticipated outcomes to patients, which have been seen to require physicians to "tell patients when they received substandard care". Does this put hospital in position of intruding in the patient-physician relations if there is a JCAHO documentation process required for these disclosures.[403] Wouldn't it be more efficient and more responsive to have ALL the narrative information right in front of us, right in the room, from the parties, soon after the injury occurred? Patients, physicians and lawyers can create change sitting down together after a medical error. Analysts can, at a later time, study narrative reports, an important piece of patient safety, to determine such matters as to which senior management does or does not support patient safety, the extent to which a blame-free error reporting process exists, and whether or not all levels of staffing participate in reviewing adverse events.[404]

- The American Medical Association (AMA) Code of Ethics requires "honesty with patients and colleagues" and states that a physician must report an accident, injury, or bad result stemming from his or her treatment.[405],[406] The AMA's Council on Ethical and Judicial Affairs states, "Situations occasionally occur in which a patient suffers significant medical complications that may have resulted from the physician's mistake or judgment. In these situations, the physician is ethically required to inform the patient of all facts necessary to ensure understanding of what has occurred. *Only through full*

[403] Ibid, p. 81.
[404] Jill Rosenthal, Maureen Booth, *Maximizing The Use of State Adverse Event Data to Improve Patient Safety*, National Academy for State Health Policy, October 2005, pp. 8, 13-15. <http://www.nashp.org/files/patient_safety_GNL61_for_web.pdf> accessed Oct 9, 2008.
[405] American Medical Association, Principles of Medical Ethics, 1957. <http://www.ama-assn.org/ama/pub/category/2512..html>, accessed October 7, 2008.
[406] However, many physicians interpret these requirements to mean that they should report to their superior or to the hospital quality assurance or risk management committee, rather than to the patient. Wu, et al, *To Tell The Truth, p. 770.*

disclosure is a patient able to make informed decisions regarding future medical care." [407], [408] Further, the AMA's Council on Ethical and Judicial Affairs (CEJA) stated in 1994: "*Concern regarding legal liability which might result following truthful disclosure should not affect the physician's honesty with a patient"*[409] (emphasis added). The American College of Physicians' Ethics Manual provides that "society recognizes the 'therapeutic privilege', which is an exemption from detailed disclosure when such disclosure has a high likelihood of causing serious and irreversible harm to the patient." The College goes on to say, "On balance, this privilege should be interpreted narrowly: invoking it too broadly can undermine the entire concept of informed consent."[410], [411] The Manual also provides: "physicians should disclosure to patients information about procedural and judgment errors made in the course of care, if such information significantly affects the care of the patient. Errors do not necessarily constitute improper,

[407] 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.
[408] "If the AMA principles and guidelines and those of the JCAHO were to be cooperatively applied, the desired integration of individual and organizational ethics could be realized. Two "systems", the AMA and the JCAHO, and the individual physician's professional and ethical obligations, could act synergistically to reduce the prevalence of error." Edmund D. Pellegrino, *Prevention of Medical Error: Where Professional and Organizational Ethics Meet, Accountability*, p. 98.
[409] Wu, et al, *To Tell The Truth, p. 774,* citing the AMA Council on Ethical and Judicial Affairs and Southern Illinois University School of Law, Code of Medical Ethics. Annotated Current Opinions. Chicago, Ill: American Medical Association. 1994.
[410] Ibid, p. 771.
[411] Informed consent is the process by which a fully informed patient can participate in choices about her/his health care. It originates from the legal and ethical right the patient has to direct what happens to her body and from the ethical duty of the physician to involve the patient in her health care." <http://depts.washington.edu/bioethx/topics/consent.html>, accessed June 3, 2008. It is the "patient's agreement to a course of treatment based on receiving clear, understandable information about the treatment's potential benefits and risks." The California Patient's Guide: *Your Healthcare Rights and Remedies*. <http://www.calpatientguide.org/ii.html>, accessed January 6, 2008. "Given that patients have a legal right to be told what may go wrong with proposed treatment, it must surely follow that they have the right to be told what has in fact gone wrong." Wendy Levinson, MD and Thomas H. Gallagher, MD, *Disclosing Medical Errors to Patients: a Status Report in 2007,* CMAJ 177, July 31, 2007, p. 178, <http://www.cmaj.ca/cgi/content/full/1773265>, accessed October 6, 2008, quoting G. Robertson, *When Things Go Wrong: The Duty to Disclose a Medical Error,* Queens Law J 2002; 28:353-62.

negligent, or unethical behavior, but failure to disclose them may."[412]

- Catholic Healthcare West, CHW, is a 48 hospital non-profit in California, Nevada, and Arizona. CHW created a policy of mistake management, based on its core values of dignity, collaboration, stewardship, justice and excellence. CHW is self-insured, so have self-determination as to disclosure process. CHW's statement of principles: family/patient are advised to consult an attorney after an adverse event, family/patient is given copy of medical records and all relevant information about the event. They are told about event and cause and extent and their right to fair compensation.[413] "Quality improvement, fair and honest claims management and effective loss prevention can be achieved only through constant reflection on the meaning of the CHW core valves and their impact on our daily actions."[414]

  This type of practice, which promotes forgiveness or reconciliation, includes: identifying and challenging any aspects of institutional culture that deny the fallibility and therefore the humanity of clinical staff or that work against truth-telling, accountability, compassion, and justice in dealing with medical error and promoting patient safety."[415] The system should focus on continuous improvement and cooperation and system performance, not individual punishment.

- University of Michigan Health System instituted an apology policy in 2002, encouraging its physicians to apologize for mistakes. Rather than focus on medical malpractice, emphasis is placed on improving patient safety and physician-patient communication,

[412] Am. Coll. Of Physicians, Ethics Manual *(4th ed. 1998), < http://www.acponline.org/ethics/ethicman.htm>, accessed Jan 6, 2008.
[413] Bayley, *Accountability,* p. 105.
[414] Ibid, p. 105.
[415] Berlinger, *Accountability,* p. 131.

educating a patient as to the nature of his or her claim and why it may or may not be a compensable error. Richard C. Boothman, chief risk officer for the system, said that "this is not about making apologies, it's about being honest. Transparency, honest and open discussion all make sense to intercept patient claims that become litigation, because once they become litigation, they take on a life of their own." Further, he 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. That is where the real gold lies."[416] "Fear of adversely impacting subsequent litigation is virtually non-existent because the University of Michigan Health System is committed to acting consistently with its own conclusions about the reasonableness of care. Unfettered by fear of litigation, patients complaints travel through a process designed to prompt all involved to ask whether the care could have been better, whether anything can be done to avoid such complaints in the future, and whether there are lessons to be learned."[417] The principles followed at the University of Michigan include: "when we hurt someone through unreasonable medical care, we need to make it right; when the care our staff provides is reasonable, we need to support them even when something goes wrong; we need to learn something from medical errors that will help us to improve our care."[418] Boothman testified before the U.S. Senate Committee on Health, Education, Labor and Pensions, stating that claims against the University of Michigan dropped every year since

[416] Shapiro, p. 8.
[417] Shapiro, quoting Richard Boothman, p. 11.
[418] Ibid, p. 12; Testimony of Richard C. Boothman Before The United States Senate, Committee on Health, Education, Labor and Pensions, June 22, 2006, <http://help.Senate.gov/hearings/2006_06_22/boothman.pdf>, accessed October 5, 2008.

2001, despite increased clinical activity over the same period. As a result, there has been a substantial drop in the number of medical malpractice lawsuits. In August, 2001, there were 262 total claims; in August, 2002, there were 220 total claims; 193 claims in August, 2003; 155 claims in August, 2004; 114 claims in August, 2005; and, since then, the total number of claims has fallen to fewer than 100. Malpractice claims decreased by half and the cost of handling them by two-thirds.[419], [420] Another measure of the effectiveness of the program, in addition to the decrease in claims, is physician satisfaction with the process and the outcome. Boothman states, "I believe we've tapped into something physicians intrinsically want to do, anyway, but have been afraid to do and have been told not to do for their entire careers."[421] Trial lawyers (attorneys for injured patients) "have come to understand that Mr. Boothman will offer prompt and fair compensation for real negligence but will give no quarter in defending doctors when the hospital believes that the care was appropriate."[422]

- Dale Hetzler, Children's Hospitals of Atlanta (CHOA), general counsel for nine pediatric hospitals in Atlanta, represents hospitals in health care mediations that provide all medical records to patients, disclosure, and compensation, as indicated, without litigation. CHOA is a community health system with teaching as part of its mission. The legal dept promotes early, respectful contact, emphasis on continued relationship, openness and frequent use of mediation or other non-adversarial methods. CHOA works to rebuild trust

[419] Ibid.
[420] The University of Illinois Medical Center, after studying the process at the University of Michigan, established a disclosure policy. After establishing the policy, training physicians, spreading the word and implementing the policy, the lessons learned include: "persuade your lawyers that disclosing medical errors is the right thing to do ethically, legally and financially, despite their fears related to admitting liability, recognize that shifting the culture of an organization is not easy and takes time, get buy-in from all the stakeholders once your decide on a process." Shapiro, p. 4.
[421] Shapiro, quoting Richard C. Boothman, p. 13.
[422] "*Doctors Start to Say "I'm Sorry" Long Before 'See You in Court'*", New York Times, May 18, 2008. http://www.nytimes.com/2008/05/18apology.html?pagewanted=1&_r=2&HP.

relationships and feels its policies should be consistent with its mission (to enhance the lives of children through excellence in patient care, research, and education) and position in the community. General Counsel, Dale Hetzler, speaking at the ABA Dispute Resolution Conference in April 2005, said: CHOA's policy is to bring claimants in to talk because it is difficult for them to get attorneys to take cases that aren't high value and hospitals wants to do the right thing. Hetzler further stated that the interest-based approach at Children'sseeks to be more collaborative and less adversarial and aligned wit Children's values-integrity, respect, nurturing, excellence and teamwork."[423] CHOA has a tremendous success rate. Hetzler has developed a reputation among plaintiffs' attorneys for honesty and ethical treatment. As a result, plaintiffs' attorneys are willing to work with him in a collaborative process, rather than a litigation process, to resolve medical error cases.

- COPIC Insurance Company, a physician-owned medical professional liability insurer, principally in Colorado, has an early intervention no fault compensation program, called 3Rs (Recognize, Respond, Resolve), started in October, 2000. Within 48 to 62 hours of a complication or injury to a patient, this program seeks to have the physician and patient engage in open, honest, empathic conversation. In appropriate cases, COPIC offers patients immediate (before a written claim has been made)[424] monetary compensation for out of pocket losses without requiring a release of legal claims. Because no written claim

[423] Dale Hetzler, *Superordinate Claims Management: Resolution Focus From Day One,* 21 Ga.St.U.L. Rev 891-909 (2005), pp. 893, 897.

[424] COPIC has received national recognition in an article in the New England Journal of Medicine, June 28, 2007, which names COPIC the "best known private-sector disclosure program." The article further states: "Although the range of cases handled by the COPIC program is limited, the outcomes suggest that these events can be resolved in a less adversarial manner than they might be by means of traditional litigation. In addition, *the low average payment per incident reinforces the view that maximum compensation is frequently not the main objective for patients in the wake of medical injury." Gallagher, Disclosing Harmful Medical Errors ,* p. 2716.

has been made and no lawsuit has been threatened or filed, these payments are not reportable to the NPDB. The cap offered under this program is $30,000. COPIC found that twenty-five percent of patients received payments and the average payout was $5,400.[425], [426] Between Oct, 2000 and Dec, 2006, a total of 3,248 qualifying incidents from 2,853 qualifying physicians have resulted in 731 settlements to patients, totaling $3,940,651, or an average of $5,391 per paid incident. 52 of the 2,174 incidents that met 3Rs criteria have gone on to become formal claims. Of these, 7 claims of 731 have gone on to formal litigation; 2 of the 7 resulted in tort compensation. Sixteen unpaid cases subsequently went to litigation, of which 6 resulted in tort compensation. To date, NO 3Rs case has gone to trial.[427]

The COPIC program also includes disclosure training[428] for physicians and disclosure coaching for physician and case management personnel prior to disclosure conversations with patients.[429] COPIC does not include compensation if a patient's death is involved, if there is clear negligence, if there has been a written claim, a complaint to the state board, or if an attorney is involved. There is no payment for pain and suffering under the COPIC plan.

- KAISER programs: clinician to respond within hours to patient complaints or indications of harm during treatment. The clinician performs ombuds/investigatory work, acts as a liaison in solving problems, and conducts mediations on request. The ombuds/mediator

[425] Ibid
[426] The low average payment reinforces the view, discussed herein, that the maximum compensation is frequently NOT the main objective for patients who have suffered medical error.
[427] COPIC's 3R's Program, Volume 3, Issue 1, June, 2006, p. 1.
[428] A patient-centered, rather than a legalistic, philosophy toward disclosure makes sense in terms of disclosure training, particularly because physicians are more likely to buy-in to the process for ethical, rather than legal, reasons.
[429] Ibid, p. 2.

program is intended to serve a link between legal, patient, safety, and clinical departments, so that info developed during conflict resolution can be used for systems learning. The ombuds/mediator answers questions, discusses patient safety concerns for future patients, and works collaboratively with the Kaiser system on changes in the system.[430] Kaiser recently took "full responsibility" for the death of three people at Kaiser Hospitals in Northern California. The Senior Vice President of Kaiser Permanente Santa Clara said, referring to one of three deaths due to medication error in the last three years: "We are very sorry for this tragic loss."[431]

- Children's Hospital and Clinics, Minneapolis, MN 55404: How the hospital responds can reinforce a culture of secrecy and blame or advance a culture of safety: open disclosure, analysis, learning, prevention, and face-to-face accountability. "In a safety culture, administrative leaders stand shoulder-to-shoulder with affected family and caregivers." One policy: whenever a family member questions a medication or intervention, the process is immediately stopped, and reexamined. After a medical error, families become part of the follow-up process, immediately and whole-heartedly, a departure from historic responses of the risk-management and legal track that distances caregivers, families, and the organization's leadership. The physician managing communication should presume that all information which describes the specific event affecting a patient can and should be disclosed. After appropriate disclosure, Children's assists the family in referral to resources to help them obtain compensation if actual damages warrant.[432]

[430] Kaiser Permanente brochure on ombuds/mediator program.
[431] San Francisco Chronicle, *Death of Infant From Hospital Error Probed,* March 10, 2007.
[432] Julie Morath, Terry Hart, *Partnering With Families: Disclosure and Trust: Demonstrated Strategy and Results to*

- Johns Hopkins Children's Center: The Johns Hopkins Hospital Disclosure Policy reads, in part, "All health care professionals have an obligation to report medical errors as a means to improve patient care delivery and to help promote safety and quality in patient care. Since the majority of medical errors can be linked to environmental and system-related issues that may affect the actions of health professionals, a systems improvement focus will be used in all error analysis."[433] "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."[434] "The initial provision of information can be viewed as a natural part of the ongoing patient-physician dialogue rather than as an isolated disclosure."[435] The Johns Hopkins team is composed of nationally-renowned leaders in patient safety, who prepared a facilitators' guide, CD and manual on disclosing adverse events to patients, author articles, perform research, teach courses, and inform our communities on patient safety issues. The patient safety program at Johns Hopkins arose as a direct result of the death of 18-month-old Sorrel King at John Hopkins Children's Center due to medical mistakes in 2001. Sorrel King, Josie's mother, describes that nightmare as follows: "That night, we took her off life support and she died in our arms, on a snowy night, in one of the best hospitals in the world." Josie had those weekly phone calls, every Friday at 1 o'clock, described above, with George Dover, the head of the children's center. Most of the time I would call him and scream at him and threaten to call *The Baltimore* Sun, and threaten to call the *New York Times* and threaten

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Improve Care Delivery and Patient Satisfaction Through Enhanced Patient-Physician Communication, Children's Hospitals and Clinics, Minnesota. <http://www.npsf.org/download/Morath.pdf> , *accessed October 10, 2008.*

[433] Wu, *Removing Insult,* p. 8.

[434] Ibid, p. 8.

[435] Ibid, p. 9.

to go to Good Morning America. And he would sit and he would listen. *Hopkins did the right thing: they came forward. They told us exactly what went wrong, they apologized, and they said that they would fix the problem*."[436] (emphasis added).

Sorrel and Tony King were offered a large settlement, which, at first, they refused. However, their attorney told them to take the money and do something good with it. The Kings met with John Hopkins Children's Center physicians and told them that they wanted to give a substantial sum back to JH to start a children's safety program. The Kings also created the Josie King Foundation to fund safety initiatives at other hospitals. Sorrel King is a strong force in the patient safety movement, speaking to health care workers and other groups around the country about patient safety.[437]

- Geisinger Health System, the largest single rural health care system in the country, covering 41 counties in central Pennsylvania, began to communicate errors and adverse outcomes to patients and families in January, 2003, because it was the law.[438] Geisinger has now gone way beyond following the law; Karen McKinley, Vice President, Clinical Effectiveness, states: "Initially, physicians felt they had to do this because it was the law, but over time their thinking has evolved. Physicians and other providers gradually

[436] Ibid, p. 7.

[437] This is a classic story, very hopeful, in that the parties brought, out of the most horrific tragedy, positive change. This arose out of a voice of possibility, creating the beginnings of a new health care culture, the culture of disclosure, apology and patient safety as the transparent, primary goals of dealing with medical error. This is the type of creative thinking that can arise out of the collaborative law process. The voice of possibility was clearly present in the room with Sorrel King, her husband, the Johns Hopkins people and the attorneys for all. That voice would not have been present in the courtroom; the only voices that would have been present there would have been the voices of blame and deficit.

[438] In 2002, the Pennsylvania state legislature passed Act 13, the Medical Care Availability and Reduction of Error (MCARE) Act, which provides, in part, that a person "who has sustained injury or death as a result of medical negligence by a health care provider must be afforded a prompt determination and fair compensation" and that "every effort must be made to reduce and eliminate medical errors by identifying problems and implementing solutions that promote patients safety." 40 P.S. Section 1303.

discovered that this policy actually helps them."[439] One of the lessons learned from the process, according to McKinley, is the usefulness of adopting a patient-centered, rather than a legalistic, philosophy toward disclosure. This approach has allowed physicians to follow their ethical instincts, rather than being constrained by fear of lawsuits.[440]

- Although the following process is used in Sweden and not currently in the U.S., it is instructive. For the past twenty years, Sweden has had an administrative compensation fund, called the Swedish Patient Injury Compensation Fund, which compensates for all *avoidable* adverse events.[441] Injuries compensated lies between all adverse events (pure no-fault) and negligent adverse events (malpractice system)., [442],[443] "We were astonished to find that physicians in Sweden actively participate in 60 to 80 percent of the claims that are made, helping their patients complete and file the relevant forms. "*Compensation there appears to be culturally ingrained as a matter of social justice, not necessarily as an admission of provider guilt or negligence. Hence, it tends to support, rather than conflict with, the health care profession's commitment to the patient and to excellence in medical practice"[444](emphasis added).* This milieu appears to be ascribable, at least in part, to the structural separation of insurance and disciplinary mechanisms. The administrative process intentionally distances the physician disciplinary process from the

[439] Shapiro, p. 23.
[440] Ibid, p. 26.
[441] An avoidable medical injury is one that likely would not have occurred if care had been delivered with the level and skill of the best practitioner (or best system) practicing in similar circumstances. Allen Kachalia, MD, JD, , Presentation at Common Good conference on Medical Courts, Brigham & Women's Hospital, Harvard Medical School , November 7, 2007. Medical courts, while another option to medical malpractice litigation, does not give the patient/family a voice. Although it is a creative alternative to medical malpractice litigation, it is something akin to "more of the same".
[442] David M. Studdert, Troyen A. Brennan, Eric J. Thomas, *What Have We Learned Since The Harvard Medical Practice Study,* Marilynn M. Rosenthal, Kathleen M. Sutcliffe (eds.), Jossey-Bass: San Francisco, 2002, p. 22.
[443] I reference this process more in terms of the culture associated with it than about the legal standard, i.e. negligence vs avoidability vs no fault.
[444] Ibid, p. 26-27.

> resolution of claims. The avoidability-based compensation scheme could provide an enormous boost to error reduction efforts. …There is increasing recognition that the implementation and success of such strategies hinges on the free flow of information. The specter of litigation currently stands as a major barrier to the free flow of information about medical errors. Thus, removing it would align the foci of the compensation and quality improvement systems and center on precisely those injuries that are eradicable.[445] From initiation to final determination, the process takes six months – approximately one-third the time of Kaiser Permanente's improved arbitration system and one –sixth the average court disposition time.[446], [447]

A Punitive Measure

The Bush Administration recently announced that Medicare would no longer pay for preventable errors, injuries and infections that occur in hospitals.[448] The underlying premise of this change in Medicare policy, like the Joint Commission program, seems to be that these mistakes are made due to carelessness or malevolence; therefore, if enough punitive measures are threatened against health care providers, they will start acting with more care and concern for their patients. A friend who has spent her entire adult life in health care told me that this new Medicare rule, like so many others, puts the patient in the middle. The health care team has to perform testing, extensive examination and complete, literally, reams of paperwork to establish that the patient had existing injury, in addition to the admitting diagnosis, when they were

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[445] *Accountability*, p. 26-27.
[446] Flowers, p. 153.
[447] The concept of health courts has been studied and discussed. That concept seeks to use the avoidability standard to evaluate cases, rather than the negligence standard. Health courts have the same problem that trial courts do: the plaintiff/injured party still has no voice in the administrative process.
[448] The Bush Administration announced on August 18, 2007 that Medicare will no longer cover preventable errors, injuries and infections that occur in hospitals; *Medicare Says It Won't Cover Hospital Errors,* New York Times, August 19, 2008.

admitted so that they are reimbursed appropriated by Medicare. The presumption that liability imposed on one provider will cause others to be more careful assumes that the others believe their care or carelessness is related to the risk of being held liable.[449]

Collaborative Law

> "A higher-value target for reform than discouraging claims that do not belong in the system would be streamlining the processing of claims that do belong."[450]
>
> If medical malpractice complaints are lemons to the health care system, can we make lemonade?[451]
>
> "Collaborative law is a great process of enormous help to the people involved, making the experience of loss a more compassionate process."[452]
>
> "Only when we hear BOTH the doctor's and the patient's voice will we have a medicine that is truly human. [453]

The "legal system" is blamed for the traditional, unworkable medical malpractice litigation process. The law, the courts, lawyers and, by implication, their clients, as well as physicians, hospitals, and insurance companies, are the component parts of the legal system in medical error cases. Turning the system in a new direction is making it more workable, creating changes that both resolve and heal. Learning how to work collaboratively, when many of us have, traditionally, been adversarial, is a slow process, sometimes moving at a glacial pace, sometimes not moving at all. As I write this, there is tremendous frustration, since many of us

[449] Dauer, *Accountability,* p. 188.
[450] Studdert, et al, *Claims, Errors,* p. 2033.
[451] Speaker is unknown.
[452] Bob Silver, Psychologist, participant in Ft. Myers, FL dialogue, January, 2007.
[453] Anne Hunsaker Hawkings, quoted by Nancy Berlinger, *After Harm*, The Johns Hopkins University Press: Baltimore, Maryland, 2005, p. 6.

want collaborative practices to take hold quickly. In some geographic regions, like the Boston/Cambridge area, collaboration has happened quickly, change has occurred upstream from the litigation system, i.e. physician(s)/nurse/hospitals fully disclose medical error to patients/families as soon as information becomes available and are already seeing financial savings. There is much media attention to new ways of thinking/practicing, such as disclosure, transparency, and patient safety concerns. In most regions, however, the old rules of silence still apply. It appears that much of this disclosure process, to the extent it is taking place, does not involve attorneys as an integral part. Attorneys, apparently, according to many disclosure practices in place, are often thought to be unnecessary. Disclosure and compensation may resolve the medical error situation, such that litigation is never contemplated. However, in general, as set forth herein, most medical error is addressed far downstream (in litigation) from a disclosure process, after many missed opportunities.

We expect the shift from litigation to collaboration to be easy, or, easier than it is. In that regard, the frustration is something akin to trying to turn a cruise ship in an instant, just by turning the wheel. Somehow, the cycle of medical error/silence/litigation/settlement/ verdict/reporting has to be interrupted and moved in a new direction for the benefit of all of us. At which stages can we intervene, such that the often destructive litigation process can be brought more in line with a compassionate, healing sensibility?

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.[454] This process is controlled by the parties and involves both total

[454] 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

transparency and total respect for all involved. Collaborative law offers a "natural fit" in the medical error context, encouraging immediate participation of the parties, in consultation with their attorneys, once medical error has been alleged. The process encourages early discussions that can involve disclosure, apology (to the extent called for), 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.

Collaborative law involves 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. At the first meeting of the parties and attorneys, the participation agreement, explained herein, is discussed and signed.

Collaborative law will be tremendously advantageous to injured parties with legitimate claims who otherwise will likely go unrepresented. There are specific reasons for the failure of some would-be plaintiffs to secure legal representation. It is often not economically feasible for an attorney to take the case; the claim is too small; the injured party is too angry or just seeking revenge; or the claim is too difficult or too complicated to prove. It is particularly difficult for young or elderly plaintiffs to find attorneys because it is difficult, if not impossible, to prove

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to resolution much faster and much more compassionately than litigation. In the participation agreement, the parties commit to negotiating a mutually acceptable settlement without court intervention, to engaging in open communication and information sharing, and to creating shared solutions that meet the needs of both clients." Christopher Fairman, *A Proposed Model Rule for Collaborative Law,* 21 Ohio St. J. on Disp. Resol. 73, 76-80 (2005)

economic damages[455]; this difficulty is compounded in states that have caps on non-economic damages.

In a situation in which an injured party sues and the process becomes too daunting, expensive or time and emotion consuming, the injured party (and her/his attorney) could move into a collaborative process, in the hope that an interest-based, face-to-face process would bring a reasonably speedy resolution to the matter. These situations require a case-by-case analysis by the attorney and client to determine if the collaborative law process is useful and appropriate.

To a great extent, medical malpractice cases often end in defense verdicts. In a recent dialogue, I learned that b (85%) of medical malpractice cases that go to trial in Florida result in defense verdicts. The national statistics are quite similar: eighty percent (80%) of the medical malpractice cases that go to trial result in defense verdicts. 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 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. .

The collaborative law process, as set forth above, has been successful in the family law arena for approximately fifteen years, in part because the only parties to the case are the divorcing individuals. In family law, the process is something of a one-size-fits-all concept. This is not to suggest that collaborative family law does not involve many substantive issues (such as pensions, social security, child support, child custody, and business valuations), but rather that there are only two parties/deciders, in consultation with their attorneys. In contrast, collaborative

[455] Lance Stevens, a Mississippi lawyer and former president of the state's association of trial lawyers, is quoted in the New York Times, "I have not filed a lawsuit for a child or a stay-at-home mom in a medical malpractice claim since 2002, because they regrettably lack economic value in the tort reform scheme." Jonathan Glater, *To The Trenches: The Tort War Is Raging On,* New York Times, June 22, 2008, <http://www.nytimes.com/2008/06/22/business/22tort.,html>, accessed October 3, 2008.

law in medical error situations may include half a dozen or more parties, including the patient or the surviving family members, the physician(s), the hospital, and other health care providers, in consultation with their attorneys. Behind the scenes are the several insurers for the physicians, hospital, and other health care providers, as well as risk managers in self-insured situations. With so many stakeholders/decision-makers in the medical error context, consisting of many overlapping and complex relationships, collaborative law in this arena becomes, at once, more challenging and potentially more rewarding. The dialogue process provides an opportunity to build relationships among those ordinarily mistrustful of each other in these situations, such as physicians and attorneys. It also encourages a closer look at the real possibilities associated with collaborative law.

In the collaborative law context, the healing can begin in the first conversation between attorney and client, a conversation in which the attorney listens to the client and prepares the client for the compassionate, healing process to come, rather than preparing the client to do battle. In fact, doing battle is not a concept that needs to come up at all, since the collaborative attorneys will never do battle in the case.

Stakeholders and interested individuals and organizations need to keep talking about the significant issues to be addressed, including fair compensation, disclosure, patient safety, attorney fees, confidentiality, and the timing of and circumstances that indicate the need for withdrawal of collaborative attorneys.

Collaborative law in medical error has the potential to be very effective.[456] It provides a

[456] But see Jill Schachner Chanen, *A Warning To Collaborators*, ABA Journal.com, Tuesday, May 8, 2007 (from the May ABA Journal National Pulse), addressing the Colorado Bar Association's ethics committee's opinion regarding collaborative law. Colorado's bar association is the sixth state bar association to address the ethics of collaborative law and the only one to suggest that it is unethical. However, the Colorado opinion suggests that it is appropriate for the parties to sign a participation agreement and for the attorneys to limit the scope of their engagement to negation. The other state bar associations, including those of Kentucky, North Carolina, New Jersey, Pennsylvania and Minnesota, all approve the use of collaborative law. The ABA recently agreed with these states that found no

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 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.[457] Although inequality of bargaining power can and often does exist in both the litigation and collaborative law contexts, in the collaborative law setting such a difficulty can be addressed through open discussion and creative problem solving. In the arena

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inherent ethics problems with collaborative law. Because the Collaborative Law Participation Agreement provides for limited representation, the client must provide informed consent. The client's informed consent meets the requirements of Rule 1.2(c) of the ABA Model Rules of Professional Conduct: a lawyer "may limit the scope of the representation if the limitation is reasonable under the circumstances and the client gives informed consent." Eileen Libby, *Putting a Kinder Face on Litigation: ABA opinion gives collaborative law practice an ethics thumps-up,* ABA Journal, January, 2008. Comment 6 to Model Rule 1.2 provides that a limited representation is appropriate if the client has limited objectives for the representation and limited representation includes exclusion of "specific means that might otherwise be used to accomplish the client's objectives." <http://www.abnet.org/cpr/mrpc/rule_1_2_comm.html>, accessed February 15, 2008.

[457] Collaborative law is not the same as mediation. 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 move 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.

of litigation, the imbalance of power often exists but is one of the elephants in the living room that is never discussed or addressed; instead, it sometimes is used by the powerful party(ies) as a hammer to force an early settlement or to end to the litigation.

In the collaborative process, participants have the opportunity to share information and seek solutions with the physician(s) and, possibly, other health care providers in order to prevent future harm.[458] In addition, there is more likelihood of receiving compensation quickly (and a greater percentage of it, since the attorney's fee is reduced, based on a speedy resolution). Parties have the chance to begin the healing process; to continue a relationship with their physicians; and to begin to repair/strengthen the trust in the patient/physician relationship. This process, serves the entire health care system, rather than one individual/family, while giving that individual/family a role in helping others (future patients) going forward. It takes the medical error out of the narrow realm of financial settlement in a private dispute. This process has the potential to bring the private interests of the patient/family into close alignment with the public interest of advancing patient safety to the benefit of the many, rather than the few.

Advantages to injured party/family member:

- Injured Party has the immediate support of a collaborative attorney in a situation in which the injured party may feel at a disadvantage in a face-to-face meeting with a physician(s);
- Injured party has a full and fair opportunity to be heard, to ask questions and have them answered, and to share information and seek solutions with the physician(s) to prevent future harm;
- Injured party receives compensation quickly;

[458] Physicians/hospitals could invite patients to be part of the hospital's quality improvement process, to allow them, if they wish, to take an active role in working with clinicians and administrators to create a patient-centered culture of safety by sharing their experiences of medical harm and their perspectives on hospital culture.

- Injured party can become part of the hospital's quality improvement process to allow patients to take an active role in working with clinicians and administrators to create a patient-centered culture of safety by sharing their experiences of medical harm and their perspectives on hospital culture[459];
- Injured party can begin to heal;
- Injured party can continue her/his relationship with her/his physician;
- Injured party and physician have opportunity to work jointly, at an early stage after injury, to avoid future problems for others; (questions asked by injured party/family may reveal new information about how the system failed; key to preventing recurrence);
- Permits patients/injured parties with claims other than high value claims, such that litigation could not be an option, to be heard and to receive compensation;
- Disclosure[460] to injured party/patient as matter of respect, trust, responsibility and partnership;
- Trust between physician and patient can be strengthened and/or repaired.

Benefits to physicians include:[461], [462], [463]

[459] Sharpe, *Accountability,* p. 22.
[460] Without disclosure, there is only silence: no learning, only secrets and withholding.
[461] Many of these benefits to the physicians also benefit their insurers. For instance, the opportunity to address patient safety issues quickly benefits the insurers because claims based on similar mistakes are lessened after open discussions and changes in policies and procedures.
[462] Reviewing the transcripts of the San Diego dialogue, I noticed a reference to Stephen McPhee, M.D., UCSF School of Medicine, who brings physicians together to write about what went wrong. Each physician writes for fifteen minutes, then McPhee "shuffles the deck", gives one story to each physician to read, all anonymous, lets them know they are not alone. Then they have a follow-up discussion regarding what they've read and the expectation of perfection by and for physicians in our culture. Talk about healing!!
[463] Physicians are often referred to as the "second victims". Dr. Albert Wu of Johns Hopkins writes, "Virtually every practitioner knows the sickening feeling of making a bad mistake. You feel singled out and exposed-seized by the instinct to see if anyone has noticed. You agonize about what to do, whether to tell anyone, what to say. Later, the event replays itself over and over in your mind. You question your competence but fear being discovered. You know you should confess, but dread the prospect of potential punishment and of the patient's anger." Albert Wu, *Medical*

- Immediate access to a collaborative attorney who understands the process and can advise on disclosure and other issues after an adverse event;
- Confidentiality;
- Control, along with the patient/family, of the process;
- Early opportunity to offer an explanation and to answer questions;
- Opportunity to offer an apology, if appropriate,[464] (expression of sympathy, but not expression of fault,[465] is protected from disclosure in California. A total of twenty-nine states protect apology, the large majority of which protects expressions of sympathy, but not expressions of fault. [466] In states without apology statutes, expression of sympathy and fault are protected from disclosure by the Participation Agreement, which provides for confidentiality and is signed by all parties and attorneys at the outset of the process);
- Early opportunity to strengthen the relationship with one's patient;
- Atmosphere less inclined to blame;
- Opportunity to begin healing;
- Based on timely communication with patient/family, a chance to examine, in collaboration with the injured party or the injured party's family, patient safety issues quickly, while the lessons are still fresh, thereby providing opportunities for improvement

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Error: The Second Victim, 320 BMJ 726-727 (2000), p. 726.

[464] Norman G. Tabler, Jr., Esq., *Should Physicians Apologize For Medical Errors?* The Health Lawyer, Volume 19, Number 3, January, 2007, pp 23-26. .

[465] California Evidence Code Section 1160(a) provides: "The portion of statements, writings, or benevolent gestures, expressing sympathy or a general sense of benevolence relating to the pain, suffering, or death of a person involved in an accident and made to that person or to the family of that person shall be inadmissible as evidence of an admission of liability in a civil action. *A statement of fault, however, which is part of, or in addition to, any of the above shall not be inadmissible pursuant to this section"* (emphasis added).

[466] Arizona, California, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Louisiana, Maine, Maryland, Missouri, Maryland, Massachusetts, New Hampshire, North Carolina, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, West Virginia and Wyoming.

in the health care process[467];

- Emotional/financial/energy savings because there is no lengthy, stressful, expensive and painful litigation process;
- Focus on patient safety going forward, rather than error that may have occurred five years ago;
- Potential extensive cost savings;
- Physician has opportunity to work collaboratively with patient/family to ensure quick action to protect future patients;
- The possibility for non-monetary agreements, such as lectures in the patient's name or improvement in hospital procedures;
- Peace of mind when issues are resolved quickly without a written claim having been filed (Although no reporting is required to National Patient Data Bank, absent a written claim or complaint,[468] to the extent a practitioner might consider using this process to avoid the reporting requirement, all incidents can be subject to peer review, which can be included in the Participation Agreement.);
- Opportunity to invite patients to be part of the hospital's quality improvement process, to allow them, if they wish, to take an active role in working with clinicians and administrators to create a patient-centered culture of safety by sharing their experiences of medical harm and their perspectives on hospital culture;[469]

[467] "Patient Safety and physician welfare will be well served if we can be more honest about our mistakes to our patients, our colleagues, and ourselves." Albert Wu, *The Second Victim,* p. 727.
[468] National Practitioner Data Bank Guidebook, Chapter E, page E-8.
[469] Sharpe, Accountability, p. 22.

- Chance to shift the focus to systems failures[470], which is often the place it needs to be, rather than individual failures.

These opportunities can be compared with physician defendants in medical malpractice cases who experience:

- Powerlessness in the process;
- Inability to make any creative contribution to resolution;
- Wait and worry, as litigation drags on and on[471];
- Constant distraction;
- No opportunity to influence future patient safety.

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

[470] Shifting the focus to systems failures has been referred to as "systems thinking", a careful set of rules and standards within a culture that prizes patient safety. An organizational psychologist, Karl Weick, observes, "postmortems of medical errors tend to focus too much on the last few minutes and the last error just before the adverse event, and too little on the contributions to error that were laid down in the preceding days and decisions and that made these last few minutes so harrowing and inevitable." Wachter, et al, p. 21.

[471] Woods, in *Healing Words,* shares his experience*:* "The legal depositions began months after the actual events. As I grew increasingly anxious about the suit, I began to see my patients in a much different light than before. I perceived each one as a possible adversary. I began habitually working out strategies for defensive recordkeeping in my head, so I would be in an advantageous position in the event of another suit. My job was no longer about care; it was about defense. It was no longer about trust and open discussion with patients; it was about cautious commentary and limiting my exposure to risk." p. 8.

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), allowing them 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.)[472]

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; I don't 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 both future patients and the health care team, whether the case resolves in total or not, as determined on a case-by-case basis.

There is a disconnect between need for open reporting of errors and near misses to prevent future harm and the risk reporting creates in a fault-based tort system.[473] We need to look at: what changes to the current medical liability system are necessary to encourage transparency and reporting, while meeting the needs of patients and families who have been harmed during treatment. The collaborative law process can function as an alternative to

[472] 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.

[473] Punishment does not prevent error; it prevents the reporting of it.

litigation that fosters the non-punitive environment necessary for improving open reporting of adverse events, which in turn supports clinical practice changes that can prevent future harm to patients. . Concerns of liability and fear of being reported to the NPDB are barriers to open reporting by physicians. These are very real concerns that need to be addressed to make this or a similar process work.

Imagine taking a case out of the win-or-lose litigation process into a non-adversarial, compassionate process with the opportunity to share information and seek solutions with the physician(s) and, possibly, other health care providers in order to prevent future harm is empowering to all participants. The magic of the process is it works and it's such a rich, compassionate, and healing alternative to litigation. The collaborative law process was first used in the family law setting in Minnesota in about 1990 by a sole practitioner who decided that he wasn't going to fight on behalf of his clients anymore and started working collaboratively with his client, the other spouse and the other spouse's attorney. They developed a process known as the four-way, in which the four of them sat down and talked to each other about how to come to resolution about the children, finances, living arrangements and other issues that arose when a family was splitting up. It was truly a kinder, gentler approach to divorce *and* it worked! This process, as applied in family law, took off immediately, spreading throughout most states in the United States and even into Canada. The process in the family law arena often brings in, in addition to the parties and the attorneys, a financial planner and a therapist or coach.

We have come up with a description of collaborative law in medical error situations that begins to explain how the process we envision will work: collaborative law is a structured, voluntary, non-adversarial dispute resolution process that can begin immediately after an adverse event/medical error takes place. It involves face-to-face communication between patient/family

and physician and/or hospital, total transparency, total respect for the parties, and collaboration. As so aptly said by Anne Hunsaker Hawkins, "Only when we hear *both* the doctor's and the patient's voice will we have a medicine that is truly human."[474] (emphasis in original) In contrast, medical malpractice litigation involves blame, expends huge financial and emotional resources, takes years to resolve and, when resolved, impacts only plaintiff(s), without regard to communities/other potential patients.

As one researcher so aptly asked: If med mal complaints are lemons to the health care system, can we make lemonade? Could the energy causing the claims be redirected to a purpose more consonant with the public interest in medical error prevention? Collaborative law does just that: redirects the energy normally put into litigation to a purpose more consonant with the public interest in medical error prevention. It involves patients, physicians, hospitals, and attorneys working together. *It permits the lawyers to set the tone: one of dignity, respect and trust.* Patient safety is a primary concern of collaborative law, bringing as it does the private interest of the injured person into closer consonance with the public interest in preventing injuries in the future. In cases of medical error, unlike litigation, the collaborative process permits and encourages patient safety issues to be addressed immediately on a global, rather than an individual, basis. Patients are able to find out what happened, take part in putting protections from this type of mistake/error in place into the future, and receive apologies/expressions of regret for the injury, as well as monetary compensation, to the extent indicated. Collaborative law turns the litigation process into a tremendous learning opportunity involving a discussion of the adverse event(s)/medical error with error risk reduction as a primary remedial goal. The process is one of unlimited flexibility. It shifts the conversation from one of blaming to one of collective learning.

Collaborative law requires the parties and their attorneys to sign a Participation

[474] Berlinger, *After Harm*, p 6.

Agreement, which provides for: (1) full disclosure, (2) confidentiality, (3) retained experts, (4) consulting only experts, (5) outside legal opinion and (6) withdrawal of collaborative counsel, if the matter doesn't settle, requiring the parties then to each choose trial counsel.[475] The Participation Agreement provides for collaborative/settlement counsel; if the matter doesn't resolve during the collaborative process, collaborative/settlement counsel withdraws and new counsel, trial counsel, is chosen by the parties.

- *Full Disclosure:* Parties and their lawyers are required to disclose all relevant information. The process may, as determined on an individual case basis, involve apology. This process includes the full and timely disclosure of errors which affect the patient's health and well being. Unless otherwise agreed in writing, parties do NOT engage in formal discovery, but affidavits may be used as confirmation of positions taken. Should a party refuse to honestly disclose all relevant information or otherwise compromise the integrity of the process, the lawyer must terminate the collaborative process on behalf of the client.

- *Confidentiality:* Linked to the full disclosure requirement is the promise of confidentiality of all oral and written communications involved in the collaborative process. Obviously, without confidentiality, no party or lawyer would agree to make full disclosure of information which might be used in an adversarial proceeding.

- *Retained experts:* The procedure outlined by the model Participation Agreement facilitates joint engagement of retained experts as unbiased neutrals whose work product is available to all parties and their lawyers. Such experts may not testify and their work

[475] This requirement, often referred to as the "collaborative commitment", is intended to ensure that the attorneys, as well as the parties, are fully committed to the collaborative proves. In addition, it acts as additional protection for the confidentiality of the process. This collaborative commitment keeps the focus on interest-based negotiations.

product is not discoverable and is inadmissible unless otherwise agreed by the parties.

- *Consulting Only Experts:* In addition to retained experts who are jointly engaged and whose work is openly reported to all parties but is confidential and non-discoverable, any party may privately seek the advice of an expert engaged for consultation only. The identity of a consulting only expert must be disclosed but the work product is privileged. Consulting only experts are prohibited from testifying in any adversarial proceeding.
- *Outside Legal Opinion:* Parties to collaborative proceedings may privately engage a lawyer for the purpose of obtaining an opinion on issues. As with the consulting only experts, the identity of the outside lawyer must be disclosed and the parties shall agree in writing prior to such engagement whether or not the outside lawyer is disqualified from testifying in any adversarial proceeding or from serving as litigation counsel in any adversarial proceeding. An outside lawyer may be jointly engaged to give an opinion and thereby becomes a retained expert subject to the governance of retained experts.
- *Withdrawal:* The model Participation Agreement provides that a party has the right to terminate collaborative proceedings at any time for any reason and that termination requires withdrawal of all attorneys and their affiliates. The agreement provides further that a party refusing to act in good faith obligates the lawyer to terminate the process "on behalf of their clients" which presumably also requires no further representation by all lawyers.

  Some advantages of withdrawal:

    - Attorney clearly committed to non-adversarial process, since s/he knows from the outset that their only opportunity to resolve the case is through the collaborative process;

    - Confidentially provision is doubly protected in that attorneys in collaborative process withdraw if litigation is necessary; for parties, creating another layer of protection for the parties;
    - Gives patients/families increased trust in the process;
    - Attorneys are trained in the collaborative, non-adversarial process
- Stakeholders: The stakeholders we need concern ourselves with include physicians, hospitals, medical ethicists, other health care providers, including nurses, plaintiffs' medical malpractice attorneys, defendants' (physicians, other health care providers, hospitals) medical malpractice attorneys, mental health providers, case workers, social workers, patients/families, patients rights advocates, insurance companies and risk managers. As previously noted, risk management is generally thought to be an effort to avoid liability rather than an effort to avoid error. Negligence standard, because it is embedded in an adversarial process, is inconsistent with attempts to learn from errors and improve quality.[476]

Challenges Facing Collaborative Law

Collaborative law faces significant challenges, not the least of which are attorneys who doubt and/or fear an unknown/untested (in other than family law cases) nonadversarial process. The challenges include contingency fees, "zealous advocacy" concerns, confidentiality, and informed consent. Under the circumstances, with these and other challenges, the dialogue process has been particularly useful since I, as the convener and facilitator, along with the other participants, didn't come to the process with all the answers. I didn't even THINK I had all the answers. The hope for the dialogue process was to create something new, something that hasn't

[476] Ibid.

been done before. The more we were able to talk about what various organizations/participants were doing that was effective, the more we had the opportunity to create something new.

Without dialogue, some kind of opening to talk freely about what we are doing, about what our goals are going forward, about what isn't working, we were stuck in the same place; finger pointing and nay-saying, along with mistrust and misunderstanding. There is no opportunity for a cultural shift, either in law or medicine, unless we work together and bring new insights and new possibilities into the center.[477] With lawyers blaming doctors and doctors blaming lawyers and both groups blaming insurance companies, we had to start somewhere. We had to involve those who were doing some of this work already and having some successes to start the shift in thinking.

In conversation with attorneys from around the United States, all members of the ABA, we discussed various proposals for a uniform collaborative law statute through the National Conference of Commissioners on Uniform State Laws (NCCUSL).[478] There is considerable controvery, which I imagine will continue, about the "disqualification" (or "withdrawal") clause, requiring collaborative counsel to withdraw if settlement isn't agreed to and the case proceeds toward trial. Use of language is still a major concern, as well as the requirements of collaborative law. Instead of the language of "disqualification", suggesting the decision is made by someone other than the parties, I suggested: "Collaborative/settlement counsel withdraws if the matter isn't settled through the collaborative process and assists the client in finding litigation counsel." Attorneys need to language collaborative law in a positive light, so that clients can see its benefits easily and quickly.

[477] Recall what Bill Isaacs said: "Dialogue is a conversation with a center, not sides." Isaacs, p. 19.
[478] NCCUSL provides states with non-partisan, well-drafted that brings clarity, stability, consistency and uniformity to state laws. Members of the Conference are attorneys who draft, review, discuss and redraft proposed statutes, which are then submitted to the various states for consideration.

As described herein, collaborative law, outside the family law arena, is still controversial, thought by some attorneys to be unworkable, and by others not to be "zealous advocacy", especially by those who view the adversarial nature of representation as fundamental. There seems to be a strong cultural pull, among attorneys, as well as among the public, that the adversarial process is the ONLY way to represent a client. The ABA supports collaborative law, but that is just the first step. There are still many, many lawyers to convince in part by creating the space for a shift in thinking by them.

Finally, we must always keep in mind what is best for the clients, what is most approriate and healing for them.

Chapter Five: Research Method

Dialogue

Building on the foregoing, before collaborative law in medical error could take hold, I sought to bring the stakeholders together so that the benefits of the collaborative law process could be explored. This clearly was no easy task. Coming from a place of appreciative inquiry thinking, I wanted to stay focused on what has worked, what is working, and other possibilities, keeping in mind that each person had a piece of the answer.

I decided that conducting dialogues with necessary stakeholders to discuss the use of collaborative law in medical error situations was an ideal process to begin to confront the isolation within which each stakeholder/discipline practices. It would also increase awareness of our common values and goals and begin to build a sense of "community" across disciplines, such that we could begin to explore working together, rather than in opposition to each other. In so doing, we could begin to build on common ground, to promote ways of communicating across misconceptions, misunderstandings and differences, and to think together about creative options for restoring community and reducing the impact of conflict in our daily practices.

Dialogue seemed to be an appropriate method because it offers a solid approach to dealing with so many professionals from different arenas, so many different philosophies and cultures, so many different issues, so much mistrust. As discussed previously, the assumptions and stereotypes about other professions-- lawyers are greedy ambulance chasers, insurance companies won't pay a dime unless ordered to by the courts, physicians think they are Gods and never admit error--create and maintain so much mistrust that it is very difficult to bring these groups together to have any type of productive exchange. A debate, a panel discussion,

individual speakers, all would likely bring disagreement and mistrust. All are competitive, rather than cooperative. Dialogue is cooperative, bringing us together in community so that we are listening[479], thinking and creating together. We came together to explore alternatives to medical malpractice litigation, since my research and conversations indicated that none of the professionals/stakeholders saw the litigation process as a workable solution to medical error.

Dialogue is defined in several different ways. For instance, David Bohm defines dialogue as a form of communication from which something new emerges.[480] It provides all participants with a chance to speak and a chance to be heard. Isaacs defines dialogue as "a sustained collective inquiry into the processes, assumptions, and certainties that compose everyday experience."[481]

Dialogue is a process in which all participants can tell their stories and be heard by others. There is no right or wrong answer in the process, no better argument, no more knowledgeable person/group, no win, no lose. Rather, each person has a piece of the answer, from which solutions can be crafted. No one person has THE answer. Each person tells her/his truth, then listens to the next person. This is a difficult shift to make, that each of us has a portion of the answer, for attorneys and physicians, in particular, since we are trained to have the answers and not say "I don't know." If we learn to listen, we can build community, dissolving our perceptions of separateness. In dialogue, I envisioned bringing together a group of participants/stakeholders, some of whom were participating in collaborative-types of practices, playing some role in healing after a medical error. Through the dialogue process, using the framework of appreciative inquiry, participants already using portions of the collaborative

[479] One business manager said, when discussing dialogue, ""You know, I have always prepared myself to speak. But I have never prepared myself to listen." Isaacs, p 83.
[480] Kenneth Gergen, Mary Gergen, Frank Barrett, *Dialogue: Life and Death of the Organization,,* http://www.swarthmore.edu/SocSci/kgergen1/web/page.phtml?id=manu33&st=manuscript
[481] Ibid

process to great success in their organizations were brought together. The hope was to expand the conversation from their experiences, i.e. how it works, how it was developed, how much money has been saved, how respectful it is, and both build on that and expand the dialogue to other stakeholders and other health care issues. Although not formally known as collaborative law/practice, these processes come from the same kind of compassionate thinking. For instance, the University of Michigan Health System in Ann Arbor, as set forth above, beginning in 2002, encouraged its physicians to apologize for mistakes, which was about being honest.

Dialogue, if done well, keeps the focus on the big picture. It is a tremendous opportunity to build community. Taking an appreciative inquiry stance, looking at processes that involve disclosure, healing, dialogue, teamwork, community after medical error, made all the difference. Although no formal appreciative inquiry process was used, both the conversations in preparation for the dialogues and the questions posed to the stakeholders, were drawn from my experiences of appreciate inquiry. I knew all too well that the participants would not generally, if ever, be talking openly with each other. Most of our culture just doesn't normally work that way. We tend to spend our time with like-minded people, people in the same professions and in the same socio-economic groups.

The goal for these dialogues was to begin to build collaborative relationships among the various participants, based on trust, understanding of the perspectives of others, learning and respect. One of the physicians present spoke eloquently about the process. At the beginning of the dialogue, he said that there were a lot of participants on the fringes, but, by the end, all participants were moving toward the center. That comment brought to mind Bill Isaacs'[482] description of dialogue, as previously noted, "Dialogue is a conversation with a center, not sides", a process of taking the energy of our differences and channeling it toward something that

[482] Isaacs, p. 18.

has never been created before.

If structured well, asking useful questions, would be a huge opportunity to plant the seeds of change in medical error situations. If the dialogues could be continuing, even better, even though that was unlikely since some of the participants came from the east coast to take part. We had to keep the process about listening, respect and curiosity. It had to be a process with no interrupting, no criticism, no argument, and no one-upping others. As long as the participants were carefully chosen, the likelihood that the dialogues would be respectful and create tremendous learning for all of us were greatly enhanced.

The San Diego dialogue brought together a plaintiff's medical malpractice attorney, a defendant's medical malpractice attorney, both of whom were unfamiliar with the collaborative process and were almost exclusively litigators. The other participants were all involved in a collaborative process, to one extent or another. I decided that the way to bring forth the stories of how the collaborative process worked for most of the participants was to ask to hear their stories of how their individual practices worked, how they got to where they are in the process, how they arrived at their shifts in thinking, such that their processes took on some aspect of healing. Talking about the problems with the processes would be more of the same, what I'd listened to whenever the topic of collaborative law in medical error arose. The way to keep focusing on the positive, what is working, is to keep asking about it, talking about it. That is appreciative inquiry. Rather than focus on problem-finding and problem-solving, the Appreciative Inquiry process focuses on what is working so we can do more of it. It focuses on the positive, the compassionate, within the framework of dialogue to seek mutual understanding. It is forward-looking and focuses on solutions, rather than problems. Our words, in dialogue, create new worlds, new processes that work to heal, to create learning opportunities, to do no harm.

This process was an attempt to take us out of our taken-for-granted ways of thinking: that litigation was the only answer in a case of medical error, that *the law* had all the answers, that we needed experts to tell us how to interpret the case, that we needed a jury to tell us who was right and who was wrong and what the punishment should be, that we needed case law and statutes to tell us what was just and fair. It also was an attempt at working together, as a community, to create change, rather than relying on our traditional cultural beliefs that one person had to be held responsible and one person had to be reported and punished. The dialogue process would give us the opportunity to expand our thinking, to start from a new place. It would allow us to start with "what if….." What if we started out with a healing mindset: how can we give all the stakeholders a healing voice in the non-adversarial process?[483]

I was reminded by many colleagues *not* to mention the word "healing," that neither the attorney/participants nor the attorney audience would take the process seriously if I referred to anything about it as "healing." I took their advice, although healing was always on my mind. Both the dialogue process and the collaborative law process are about healing. Both processes have much in common, including respectful listening, hearing each other's stories, face-to-face exchanges, trying to set aside assumptions[484]

I invited participants as I met them or read of their work. I developed the idea immediately after a session in Atlanta, with medical malpractice lawyers who didn't think the process was workable. By then, I knew there were stakeholders in the medical error process who were practicing disclosure, apology, and compassion. The first person I met who I invited was

[483] For instance, at another dialogue, I asked one of the participants, a collaborative/cooperative family law attorney and plaintiff in a medical malpractice case, what he brought to the litigation process that came from a place of collaborative/cooperative/compassionate thinking because his litigation experience had been such a nightmare and I hoped to get to something about it that he could shift, due to his own compassionate ways of practicing law. Sometimes, no matter how deep you dig, you can't find anything good to say about the process..

[484] Collaborative law training should include a module about trying to set aside assumptions.

Jim Heiting, President of the State Bar of California, who is a plaintiffs' medical malpractice attorney. I talked to him about collaborative law, which he was unfamiliar with. When I mentioned the VA program (see above), he told me he was familiar with it and agreed to take part in the dialogue. I was in the process of reading "Accountability", referenced extensively herein, and appreciated what Carol Bayley of Catholic Health Care West (CHW) (see above) had to say about medical error from an ethical perspective, so I went to her office in San Francisco to talk to her. She agreed to take part and also suggested I invite the CHW Counsel and Vice President of Risk Management, Hillery Trippe, which I did. Next, I had lunch with the ombuds/mediator at Kaiser Oakland, Amy Baskin, the nurse/attorney who was working with my friend, Nancy, after the death of Nancy's son, Eric. (She was so caring and compassionate, something I did not expect from someone associated with the culture of Kaiser. Talk about assumptions!!). Next, I had discovered a physicians' liability insurer, headquartered in San Francisco, which espoused disclosure, when appropriate, and helped train their insured physicians on how best to do it. While reviewing the website site for the insurer, I discovered that the Assistant General Counsel was someone I went to law school with. When I called her, she pointed me to the Vice President for Risk Management, Steve Farber, who, among other things, taught continuing education for physicians about disclosure. He agreed to take part. Next, I sought out Ginny Hamm, the General Counsel for the VA Hospital in Lexington, Kentucky, which facility had been practicing disclosure, apology and fair compensation, as appropriate, since 1987. Finally, I contacted the founder and director of an organization called MITSS (Medically Induced Trauma Support Services), Linda Kenney. Linda was injured in a situation involving medical error. As a result, she established MITSS, which offers support to patients, families and physicians who are involved in medical error situations. Finally, a colleague found

David Balfour, a partner in a defense medical malpractice litigation firm. I'm not sure he would have participated had it not been that Steve Farber, Vice President of Risk Management of NorCal, was one of his clients. All of them agreed to take part.

I had individual conversations with each of them about the process. I also sent follow up emails about the dialogue process, describing it and what I hoped to accomplish. One of the attorneys asked me several times how he should prepare, to which I responded that he couldn't prepare for the dialogue in the traditional sense. Especially for attorneys, this was difficult to comprehend: no cases to read, no arguments to make, no law to refute, no facts to question. I told the participants just to bring themselves, their experiences, and their wisdom. They really had to trust the process, trust me, and trust each other. If they could do that, we could create something novel, a new future together. We can do this if we are able to shed our traditional approaches, our individualist stances, having to know all the answers, having to be right, having to have the last word. If we speak, then practice silence and listening, unheard of in many of our professional capacities, we can create new thinking, we can plant seeds of change, and we can discuss our new ideas with our colleagues.

Chapter Six: The Dialogues

At the present time, I have facilitated three dialogues on this process. One, in California, included a vice president of risk management for a physicians' insurer, an attorney and director of risk management for a group of forty-eight hospitals, a plaintiffs' medical malpractice attorney, a defendants' medical malpractice attorney, a medical ethicist, a ombuds/mediator, a patient advocate, and an associate general counsel for the VA. The second dialogue, in Florida (convened by attorney Sheldon Finman), included a plaintiffs' medical malpractice attorney, a defendants' medical malpractice attorney, a psychologist, a medical ethicist/hospital chaplain, two risk managers for a hospital (former nurses), in house counsel for a hospital, three physicians, a collaborative/cooperative family law attorney, and two long term care consultants. A third dialogue, held in Toronto, is referred to herein only generally because it was beyond the scope of this dissertation.

The goals of the dialogues include:

- Discuss common goals and values regarding medical error;
- Overcome isolation and assumptions of each profession from and about the others;
- Form community;
- Expand the dialogue to new approaches to working with medical error;
- Expand the circle of professionals involved in the process;
- Support each other in developing new approaches to difficulties in implementing CL in medical error situations;
- Support forward movement/change through stories of success;

- Ask questions to create opportunities for new ways of thinking through looking at what is/has working/worked in various professions/areas of practice dealing with medical error;
- Brainstorm opportunities for further dialogue on these issues in our own professional communities;
- Create collaborative community among all the professions necessary to make the CL process useful, effective and compassionate; and
- Create the space for a shift in culture, such that patient safety is paramount for all and secrecy becomes a thing of the past.

Questions for Dialogue
(knowing full well that we wouldn't get to many of them):

I'd like to start by going around the circle and asking each of you to tell us about yourself, your work, and something you hope to experience or learn while you're here.

- Is there something you'd be willing to share about your life experience that might help others understand your way of relating to the issue under discussion?
- Many of you have established programs in your organizations in which disclosure and/or apology are encouraged when the situations warrant. How did these programs get started? What events led up to this expansion and/or change in policy? If there was urgency, what created it?
- Some of you have been parties to medical malpractice litigation. Would those of you who have be willing to share your experience with the group to help us understand what your experience of that process was?

- What are your experiences of effective collaboration with other stakeholders/professionals outside of your organizations (other attorneys, health care providers, insurers, patients, etc)?
- How do each of you in your organizations facilitate the resolution of disputes/conflict relating to allegations of medical error?
- What can be done here in this dialogue that cannot be done in other settings?
- How do we enlarge on the work you are all doing?
- What roles can attorneys play in this work, other than their traditional role, to bring the highest quality of support, service and advice to the patients and/or family members, as well as to physicians and hospitals?
- How can attorneys be brought into the culture of respect and disclosure, when appropriate, as we've been discussing here tonight, in a seamless way?
- What other stakeholders should be involved in this unfolding conversation/dialogue about this process?
- Where are the untapped or undertapped resources in our organizations/communities/professions? How do we tap them?
- Is there any way you can imagine you could offer support or receive support from the people in this room?
- What next step would you like to take individually or perhaps with others in this group? With what hope or purpose?
- What can be done here that cannot be done in other settings?

- What are the questions emerging out of the whole of this process? What is waiting to be said or done that goes beyond what any one person might have said, but is true for all?
- What is at the heart of this matter for you?
- Within your overall perspective on this issue, are there areas of uncertainty or a value conflict that you're willing to speak about? For example, can you think of a time when the values you hold dear related to this use bumped up against other values that are also important to you, or a time when you felt yourself pulled in two directions?
- Has an interesting theme or idea emerged that you'd like to add to?
- Is there something someone said that you'd like to understand better?
- Is there one idea, feeling, commitments, or question that you are taking with you?
- Is there something about what came up for you here that you may want to share with a friend, family member, or co-worker, or take out into your life in some other way?
- How can we give all the stakeholders, all of us in our various professions and experiences and our communities, a healing voice in a collaborative, non-adversarial process in medical error situations?
- What is hopeful for you in what you've heard so far? How can we bring this discussion (this process) to a larger audience? Where will we find the resources…to sustain our own commitments, and that of others, to this work?
- Are there creative alliances that could accelerate this process?
- What would have to happen to produce new networks/alliances that would take the work to a higher level of intensity and effectiveness?

Preparation of Participants

I prepared the San Diego participants in a teleconference call[485], explaining more about the dialogue process. I oriented them to the spirit and purposes of dialogue, and referred to their spoken expectations for the process, telling them:

The dialogue process involves proposing questions to encourage each of you to reflect on your experiences in your own lives and/or in your organizations in the context of medical error and/or medical malpractice. It is not about advocacy and not about competition.

It also involves listening to each other, to each other's successes in this arena, and each other's challenges and/or concerns. For instance, questions such as the above and: Are there others within your organization or within other organizations that you work with on these issues that you can include in your processes? Can you do more of it? What interests you about this subject? What is hopeful for you in what you've heard so far? Are there other stakeholders/interested parties/organizations that you think would be useful to include in this unfolding conversation? If so, who? How can we bring this discussion (this process) to a larger audience? Do you see any expanded role for attorneys in this process? If you've been a party to medical malpractice litigation, are you willing to share your experience with the group?

We hope, through this process, to begin to build collaborative relationships among all of us in our professions and organizations and to explore how we, as individuals, organizations and communities can work together; how we can bring our successes forward to the group to seek new and expanded options for doing more of this work; and how can we expand on our stories of

[485] The Florida participants were in the very competent hands of Shelly Finman, who spoke to me about the process after attending the San Diego dialogue. We decided to work together on a dialogue in Florida. Many of the attendees there said they came to the dialogue because "Shelly asked me to." Shelly and I hope to do another dialogue in Florida soon, expanding the arena of participants.

successes in our organizations/lives. We hope to have a generative dialogue, one in which people let go of their positions, views, stereotypes and/or assumptions. There will be the very real possibility of creating a shared commitment to the community.

We will explore connections among all of you as to your views and experiences. This process seeks to invent unprecedented possibilities and new insights. We'll look for "Pockets" of successes in disclosure/apology/related issues. We'll accomplish this by creating the space in which we, the professionals who everyone loves to hate for one reason or another, can come together to create change, or, at the very least, create an opportunity for all of us to shift and expand our thinking about possibilities.

Summary of Key Points of Medical Error Dialogues

The themes/issues about both the dialogue process itself and the medical error exchanges overlap extensively. They include respect for each other and the process; compassion for each other and the roles we play; respectful listening to each other's stories and being heard; supporting each other; letting go of assumptions. The themes/issues that came to the surface about the medical error process include care of the patient; patient/physician relationship; patients helping community so error doesn't happen to others; insurer and patient advocate support for physicians ("We have to heal the healer"); training for physicians re disclosure/apology; creating space for physicians to see healthy/healing alternatives to traditional litigation to resolve medical error; representation for injured parties, regardless of nature/size of claim; possibilities for healing for all parties; real possibility of speedy healing; participants working together going forward; **and** the opportunity for all participants to make a contribution.

Respect for each other and the process

What was immediately apparent as I reviewed the transcripts of both dialogues is the respect each person showed for every other person. The litigators in both the San Diego and Florida groups spoke more like healers than litigators[486]. There was no commentary masked as questions, no accusations, no confrontations. Each person listened to every other person. This was a true dialogue because, for one thing, there was listening without interruption. There was neither criticism, nor argument, nor one-upmanship. It was clear to me that each person was committed to making a contribution. Thinking about these dialogues, a sacred space grew in the middle of the circle as each person shared with each other person. The commitment grew; connection grew; community grew.

Respectful listening

Everyone really listened when stories were told. The stories helped connect us all, helped us see clearly the commitment of these various participants.[487] These stories seemed to strike all of us, making the group more intimate, even with, in San Diego, an audience, composed of many lawyers,[488] all of whom listened patiently.

People Letting Go Of Their Assumptions/Stereotypes

The attorneys, as set forth immediately above, talked of plaintiffs/injured parties' goal of ensuring that others don't suffer the same mistake. That goal is more important than money. That didn't sound like the greedy plaintiffs described in some of the literature. If the patients are more interested in helping others than in money, the attorneys who represent them must have the same philosophy, setting aside the greedy plaintiffs' attorneys stereotype as well. A plaintiff said to his

[486] Their presence was enough for me to feel that they WERE healers and in attendance as such.
[487] Although I did not share with the san Diego group what brought me to the process, I did share it with the enxt dialogues.
[488] One attorney in the audience seemed annoyed and eventually left.

attorney, after a verdict in his favor, that the litigation process wasn't worth it, that the money didn't make any difference. If a patient thinks she can make a change, have some impact, she will go with collaborative law, rather than litigation**,** according to plaintiffs' attorneys.

The greedy plaintiff's attorney stereotype was called into question at other times as well. The comments indicated a primary concern for the patient/client, NOT for the attorney, thinking only of herself/himself. A plaintiff's attorney talked of the benefits for injured parties of cases resolving quickly, including more money for the injured party (the attorney takes a smaller fee when a case resolves quickly) and the time and energy savings of not being tied up in litigation.[489] He also talked about the benefits to the attorney for the injured party, including the increased opportunity to take more cases than he could normally take, in part because of no discovery, such as cases with small values in which injured parties have difficulty finding attorney to take their cases. This plaintiff's attorney spoke of only taking 10-15 cases a year, since each case often involves upward of 30 depositions. This attorney talked of the constant stress for all parties in the litigation process. He further stated that he doesn't take cases in which the patient is interested primarily in punishment. I assume that is because the process becomes so adversarial and so angry that there is no possibility of any healing. The plaintiff's attorney acknowledged that the litigation process can be very unjust to both plaintiffs and defendants. The injured party wants to be acknowledged, wants to be seen, even if a determination made that there is no error. There is nothing of this sort in the litigation process; rather, the result of a determination in the litigation process that there is no liability involves more finger-pointing and blame.

[489] I spoke with an attorney at a conference in Omaha recently. He represented both plaintiffs/injured patients and defendants/physicians in his career as a medical malpractice attorney. He stated that he had, on several occasions, compromised his fee in order to settle a case; he also stated that he knew many plaintiffs' medical malpractice attorneys, some of whom readily compromised their fees to settle a case, and many of whom did NOT do so.

Another stereotype set to rest in one of these dialogues: defense attorneys/hospitals/physicians always try to hide the ball. One participant, a director and officer of a hospital, said it is never about hiding the ball. It is ALWAYS about doing the right thing. A defense attorney, one who represents physicians, was concerned about the genuineness of the physician's apology, mentioning that physicians may take this step just to save money

Dialogic Moments

A dialogic moment that gave me tremendous hope happened when one of the physicians said, close to the end of the Florida dialogue, that the participants, about twenty of us, came together from different places/perspectives/professions, but, by the end, we were all moving closer, toward the center. That comment almost brought me to tears. It was so similar to Bill Isaacs' statement that dialogue is about the center, not the sides. Another dialogic moment was when a psychologist said: at worst, the collaborative law process will do no harm; at best, it brings substantial aid and comfort to people involved.[490]

Yet, another dialogic moment occurred, for me, when someone said that collaborative law is an approach to inform patients about health care in general. It is an educational process, in which we can all educate each other; the participants then can educate their communities by telling their stories of the resolution process. And another: one participant stated that disclosure is really about the physician's relationship with the patient, not about legal liability; it is maintaining trust and communication. And another, "*cultural change takes place person by person, one person at a time."*

Another dialogic moment arose when an insurer said we must help the physician. Because physicians are not trained to make disclosures, to admit mistakes, to talk on a deep level

[490] That sounds like healing to me.

with their patients, they need help having conversations in a healthy way; they are very hard on themselves. Therefore, "we need to heal the healer first." Even if the physician doesn't know all the facts, s/he can disclose what s/he does know and can do so in a healthy way, with help. Otherwise, ugly lawsuits arise because the injured party doesn't know what happened and can't get anyone to tell her/him. They need help figuring out what to say, once they've spoken, they can't unring the bell. Physicians need to accept and embrace this process or it won't work. It is difficult to turn physicians into believers; if you get buy in from physicians, seeds start to germinate.

Other dialogic moments included the stories that people told of huge change as a direct result of some tragedy: the death at a Catholic Healthcare West hospital, resulting in the rethinking and revising of CHW's core values and mission. Also, there was discussion of the death at the VA Hospital in Lexington, KY, as well as the death of Josie King at Johns Hopkins Children Center. All these tragedies resulted in huge shifts at these facilities in terms of honesty, compassion, and listening. There were moments when people acknowledged being heard, moments when people appeared to refrain from judgment and asked questions to understand. When people told their own stories, several participants described huge changes in policy at hospitals after death and awareness that they needed to start doing the right thing. A hospital that moves quickly and makes disclosure expeditiously resolves one hundred percent of its cases.

Everyone involved is doing something to help others, something for patient safety. If patient thinks they have the opportunity to help others through the collaborative law process, by expressing what happened to them, making suggestions, explaining what they observed that health care providers may not have seen, they will gladly participate in collaborative law. CL is way to inform patients about health care in general. If patients are seen and heard after medical

error, they are not likely to sue. If physicians believe they can maintain and strengthen their relationships with their patients through disclosure and apology, without either interference from insurance companies or the threat of litigation, they will take that course. Physicians know that disclosure is really about the relationship with their patients. It is maintaining trust and communication. If insurance companies see the healing and the financial savings associated with disclosure and apology, they will move in that direction.

Stories of Healing

One participant, now a patient, family and physician advocate, almost died after medical error. She was treated with disrespect by the hospital staff. She said: "I was lucky; my physician went around the 'don't talk' system". (The 'don't talk' system is enforced by insurance companies that have a policy prohibiting the physician from speaking with his patient after medical error/adverse event.) Her physician spoke to her about what happened, took responsibility and apologized. She and her physician now work collaboratively on patient safety issues.[491]

Two other participants told the stories of hospital tragedies that brought their hospitals/organizations to rethink and revise their policies regarding medical error. One attorney, associated with the Lexington, KY Veteran Administration Hospital, told of the "totally preventable" death of a veteran, without family presence, due to medical error. The VA staff there knew there was no one to disclose the error to, since the decedent was estranged from his family, didn't know he was in the hospital and didn't know he had died. The VA Hospital decided at that point that the right thing to do was to find the family, tell them what happened,

[491] She told us that, if she, as a housewife, could create the program she has, MITSS, then the rest of us with multiple degrees and years of education, could do whatever we set our minds to.

and offer compensation. That began a new culture in that VA hospital that may have spread to other VA hospitals.

The other hospital tragedy was told by another participant, the VP for Ethics and Justice Education of a 48 hospital non-profit. A patient died at one of the hospitals through medical error. The legal counsel and risk management team "agonized" over the case, which went to their core values. The hospital was ready to meet with the family and disclose the error but the physician wanted to allow the family "to grieve unencumbered by the truth." Eventually, four months later, the hospital decided to disclose the error to the family but couldn't find them for an extended period, since they had moved away. This situation led to rethinking of the non-profit's culture and values; it took them one year to agree to a disclosure policy.

There was a time when I was conscious of the "tensionality" and "holding our own and letting the other happen to us", the descriptions I've read about the dialogue process. For instance, one of the attorneys said that apology was a "defense plot", one intended to keep the number of lawsuit down. He seemed to speak only half in jest. Although he was at all times concerned about getting the best for his client, he also was concerned with how this process might affect his bottom line, his own income. His concern for his own welfare is, of course, a concern we all share. He was and is a lawyer/healer, concerned always about getting the best possible result for his client, the highest possible amount.

Moments When All The Participants Came Together

There were moments that struck me, such as the ombuds/mediator reminding us that we are all lawyers, which means we are counselors as well as litigators, that we just need to develop a new skill set to get to (or get back to) our counseling role. At another time, an attorney said he'd be concerned, going into a collaborative process with a physician, whether or not the

apology was real.[492] A risk manager/lawyer stated later in the process that we don't need to concern ourselves whether or not the apology is real; we just need to put our money where our mouths are and focus on patient safety.[493]

There were moments when the entire group of participants came together. Everyone agreed that the patients/families wanted to make sure that the error did not happen to others. Several people believed that that was more important to the patients than money. The compassion and caring about others of the plaintiffs/families/injured parties came through these stories so clearly. The stereotype of the greedy plaintiff went right out the window. One attorney said he had a plaintiff, who at the end of the trial, said it wasn't worth it, the money didn't make any difference. Several attorneys said that they believe, based on their experiences, that, if injured parties think they can make a difference through a non-adversarial process like collaborative law, they will participate. Families, in wrongful death cases, often don't want money; instead, they want to meet with physicians and make a difference. Although there may have been several participants who were skeptical of injured parties wanting to do the right thing, wanting to help others, their skepticism waned with each anecdote.

The Pitfalls of Litigation

Attorneys get frustrated. "I'm dissatisfied with damages, results, many times unjust results for plaintiffs or defendants. The process creates constant stress for patients and for all parties while the litigation goes on. My role is as a problem solver, not a problem creator."

[492] That reminds me of an old saying, "If you can't think your way into right acting, act your way into right thinking." Thinking that way, it doesn't matter if it is "real" or not. Al that matters is s/he did it.
[493] In my opinion, it's not up to me or any attorney in the process to determine if a physician's apology is heartfelt and caring or if it is only about saving money or convincing injured party not to litigate. It is up to the patient and/or patient's family who are receiving the apology to decide if it is real.

Physicians often refuse to disclose for fear of litigation.[494] "When a doctor refuses to disclose when it is clearly called for, there is "nothing you can get from this except a lawsuit". This was the sentiment of one of the attorneys.

How/Why This Process Will Work

This process, the disclosure and apology part of collaborative law, took a hospital "back to its core values". The hospital was "interested in making it more possible for patients to heal." If parties sit down quickly after the event, there is neither anger nor entrenchment yet, nor hard and fast positions, nor adversarial proceedings, nor harsh words. Several people talked about patients "hardness" starting when litigators become involved. Many believe that litigators see "zealous advocacy" as their job. [495] Creating a culture of "hardness" seems to be part of that advocacy.

Those associated with hospitals/clinics informed us that, if the physicians are open and honest, the hospital does better, especially if the injured party thinks s/he is getting honest answers. As a matter of fact, these same people told the group that if physicians are willing to take part in the process early on, the percentage of early settlements is *one hundred percent*. A plaintiff's attorney told the group that, if a physician discloses and offers fair compensation, the injured parties, often, don't go to an attorney. If they've gone to an attorney, the physician calls the injured party's attorney, acknowledges error, negotiates compensation, and that is the end of it. Attorneys on both sides readily admit tremendous stress throughout whole litigation process. As long as the process continues, everyone is stuck. Disclosure is compassionate process.

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[494] In the University of Michigan Health System, "fear of adversely impacting subsequent litigation is virtually non-existent because the University of Michigan Health System is committed to acting consistently with its own conclusions about the reasonableness of care. Unfettered by fear of litigation, patients' complaints travel through a process designed to prompt all involved to ask whether the care could have been better, whether anything can be done to avoid such complaints in the future, and whether there are lessons to be learned." Shapiro, p. 11.

[495] The term "zealous advocacy" does NOT appear in California's ethics rules.

A psychologist said: At worst, the collaborative law process will do no harm; at best, it will bring substantial aid and comfort to people involved.

In terms of the physician-patient relationship, ("We can't underestimate the patient-physician relationship"), we need to take care of the physicians in the process.

Chapter Seven: Next Steps And Areas For Further Conversations/Dialogue

Ideas we came up with together: continue the dialogue, but involve physicians, which we did in the second dialogue in Florida. What other participants/stakeholders should we involve: other health care workers, directors and officers of hospitals, health care HMOs, insurers who don't agree with this philosophy/process, judges, mental health practitioners and nurses.

I will convene and facilitate another dialogue here in the Bay Area in April. My thought right now is to invite the VP of NorCal, who took part in San Diego, and suggested we reconvene and include physicians. I hope he will take part. Also, I hope my dearest friend, Nancy, who lost her 21 year old son due to medical error, will participate. In addition, I hope a dear friend, an oncologist and reviewer of possible medical error situations for Kaiser, will participate. Further, a friend who is COO of the California Hospital Association has been invited. I've also invited a husband of a woman who suffered irreversible brain damage due to medical error. He now speaks publicly on patient safety issues. Another possible participant is in charge of risk management for a multi-facility psychiatric program. Further, a nurse/supervisor at a local hospital will likely take part.

Further ideas include:

- Task Force on Civil Collaborative Law In Medical Error/Health Care;
- Committee in a medical society, jointly with a local bar association;
- Talk to medical schools, law schools;
- Keep focus on patient;

- Additional input from judges, other physicians, interest of other stakeholders;
- Form a committee that will be effective, more info out to medical and legal community; Need more info to medical, legal and insurance communities so these groups really; Bring stakeholders together for mutual exchange;
- Have a night meeting;
- Be selective as to cases, start at earliest possible time;
- Start to discuss how to address all the economic issues involved;
- Eventually broaden the process to more expansive health care conversation (economics of practice of medicine, case loads on physicians, etc.);
- Attorneys need to expand their focus beyond the needs of individual plaintiffs.

Further work/study/process:

- Continue to create shared meaning;
- Create continuing conversational space;
- What are the stories that lend coherence to this reality;
- How might others describe and legitimize this process;
- How else might I describe this;
- How might I make this better if I had the ability.

It is appropriate here to examine questions proposed by Diana Chapman Walsh[496] and some possible responses:

Can we move beyond our small dialogue circles to address larger issues that seem both

[496] Walsh, Difficult Dialogues.

pressing and intractable now, issues in our communities and institution, in our nation and in the world? I think we can, once we form something of a cohesive group. Or, if what we are talking about collaborative law and other collaborative practices and how this thinking grows and spreads through the health care culture, it will at some point take on a life of its own and we can broaden the conversation to other stakeholders and other issues.

Are there creative alliances that could accelerate this movement (to the extent that it is, or could be, a movement) and what would have to happen to produce new networks that would take the work to a higher level of intensity and effectiveness? The alliances are growing right now, through these dialogues. We need to keep working together, to build trust, continue the conversation but take it to a deeper level. One of the alliances I'd like to help build is with the Medical Board of California. See below.

What constitutes success in a difficult dialogue, how do we know it when we see it, and might our conventional notions of success be utterly wrong? I think success perhaps becomes evident when participants can articulate what they've learned, or what shift has taken place in their thinking or new possibilities they are thinking about or want to continue talking about. What comes to me immediately about success is that we've been successful if we are thinking together and creating new ideas together.

Work of the Medical Board of California/Working With the Board

Another next step that I intend to pursue is the possibility of working with the Medical Board of California (MBC). MBC is responsible to license physicians, surgeons and other health care professionals, to enforce the Medical Practice Act, and to promote access to quality medical care for all.[497] MBC, in January, 2008, established a Medical Error Task Force ("Task Force"),

[497] http://www.medbd.ca.gov.

which looks to address medical errors BEFORE a disciplinable offence occurs. The Board seeks to, through the Task Force, "assist in the prevention of medical errors". The Board asks, "Are there creative alliances that can accelerate this process, the process of bringing transparency, fairness and healing to all parties, a process that protects the public, reduces medical errors and promotes the highest levels of patient safety? What would have to happen to produce new networks/alliances that would take the work to a higher level of intensity and effectiveness?"

A member of the MBC commented that the Board spends ninety percent of its time on enforcement and ten percent on prevention, and that those percentages should be reversed. Further, the Board wants a system of accountability and responsibility, one that allows physicians to know that the Board is there to assist them and is not entirely about punishment. One member reported the challenge is how to take physicians, hospitals, lawyers, and others out of a litigation mentality and encourage them to cooperate to solve problems. [Dialogues, along with collaborative law and disclosure trainings, have the potential to do exactly that, providing a process in which attorneys and physicians can learn to develop community, work together, and collaborate in the best interests of all parties in the promotion of safer health care for all.] The board knows that one tremendous challenge is *cultural*; physicians fear their errors being discovered and are afraid that their discovery will bring disgrace, insurance increases, or punishment.

The Chair of the Medical Errors Task Force would like the Board to become part of a larger system to provide information to improve patient safety. The Task Force would like to promote a statement that would be conducive to creating a culture where providers are inspired to participate to reduce errors, with the goal to minimize discipline and maximize engagement early in the process to find ways to prevent future errors.

The Board will likely examine its role in promoting patient safety by creating a blame-free medical error/adverse event reporting system that encourages accountability, teamwork, learning and respect. The Board's enforcement mission will expand to protect health care consumers through increased patient safety efforts. The board will examine options to work collaboratively with physicians and other health care practitioners, as well as their counselors and advisers to increase patient safety efforts and reduce medical error.

The Health Care culture needs to shift in order to see disclosure/transparency about medical errors/adverse events in a blame-free environment that *promotes*, rather than impedes, patient safety. Collaborative law can offer its participants the opportunity address the source as well as the consequences of the immediate problem/medical error/adverse event. [498] Working with the MBC will be a real opportunity to do so.

The words the Board is speaking suggest a tremendous cultural shift, away form enforcement, and toward prevention. There is an opening here; there are real possibilities. This is another place where attorneys, as advocates and counselors, as well as community members and, yes, healers can play a substantial role.

Answer To The Question

In conclusion, one answer to the question, how can we begin to transform the cultures of law and medicine, among others, such that collaborative law, a non-adversarial, voluntary process in which the parties make their own decisions, becomes a viable option to traditional

[498] As Don Berwick, president of the Institute for Healthcare Improvement, has said, "I'm distressed at the amount of attention that [reporting] is getting…You can't improve safety without transparency. That's absolutely clear. But a reporting system is just a small step toward progress." Ultimately, we need new ways of thinking about error reporting and to apply far more resources than we currently do toward turning such reports into action.

medical malpractice litigation and give all the stakeholders a healing voice in the process, is through dialogue, through listening, speaking our experiences, telling our stories, telling what is working, talking about our concerns together and taking those ideas and stories back to our communities to continue and expand on those dialogue.

Appendix One

Transcription of San Diego Dialogue:

10/12/06 David Balfour introduces workshop, hands off to me, I hand off to Jeanne.

Overview of CL who don't know what that is. Want to hear from the leaders in the circle and connect them to each other. Open disclosure and apology, which actually work. And make good business sense. Adverse events.

Talk about CL, parallel program. Half people who don't know anything about CL. CL is system, developed by Stu Webb. There is CL and being collaborative. Lot of people in the circle are being collaborative. Innovations in medicine and how medical error is dealt with: open disclosure, dialogue, apology. In law, looking at what are better ways. CA doesn't have med mal because of MICRA.

Stu Webb 4 element process: suspension of court intervention (so not simultaneously litigating and showing up in court; sometimes get tolling agreement); voluntary disclosure of documents and relevant disclosure. What do we need to reach settlement, what evidence; parties engage in good faith negotiation (THIS IS MEAT), no threats, honesty, respect. Attorneys are settlement counsel only; if it goes to litigation, those attorneys are out. Sometimes called withdrawal and disqualification, it is really limited representations, settlement counsel. 4 way meetings, attorneys and parties are present. Joint and neutral experts: sometimes in family law, there is team approach: mental health workers involved in a coaching manner, financial experts, other team

members that help the process. Ginny Hamm talks about coming up against lawyers. We are trained in adversarial culture. CL is radical rewriting of zealous advocacy. Being advocate for whole contract. Felling driven practice area. What is it that litigation system does tto make people whole: remedies in traditional court system; can't make people change. Money is how they apologize: Jan Schlichtman. In litigation system, people get more entrenched; it may be that there is legally cognizable claim; lots of people can't get in system because they can't afford the lawyers; also, thrown out because missed date for motion, etc.

Parallel description of litigation and collaborative law pathways: pre lawsuit notices under MICRA, motions, fights, maybe medication, always after discovery. By then, clients are antagonized, lawyers are in pretty deep. What are the goals of the parties? If Interest based bargaining: what are people looking for here. no breach of s/c, physician has need for reputation. Look at needs. Practitioner reporting data base. Doesn't have to be money changing hands. Reach settlement, or, if not, attorneys withdraw.

Expanded options: resolution options: people dealing with these cases. (I have the handouts), this is what Jeanne is showing. Finger pointing at others: plaintiff's attorneys pointing the fingers at defense attorneys, etc. Insurance companies to blame. Defense says plaintiffs' attorney want huge contingency fees.

What this boils down to is getting everyone at table with process they can trust. Try being a lawyer getting into cooperative negotiations, people think you have a weak case. Lots and lots of mistrust. "You can't unilaterally collaborate. Stories of plaintiff's attorney saying I can't trust the

Childrens' hospital to collaborate. They'll do what they can to get me out of it.

We need to have system that provides alternative so plaintiffs' attorney or wherever knows about CL. So have preexisting trust among plaintiffs and defense attorneys and insurers. Need practice group or minibar. Dale Hetzler, Atlanta Children's Hospital: open disclosure, sit down explain things and engage in. Had lunches and lunch with defense counsel so they would trust him. He documented $50,000 cut in costs per case. He developed list of attorneys/references to give to new case counsel to check his honor, references, respected in the community.

Karen Fasler: common themes. Response of organization or individual practitioner. Finding that backing.

My intro, then Linda Kenney: founder and pres of MITSS; had medical incident that almost took her life, disclosure, acknowledgement, apology. She was lucky to have a physician who went around the system (don't talk); now, she is an advocate/supporter, talks about people needing the training. It is a process

Hillery Trippe, VP for Risk Management, senior risk management person at CHW. Half work on cleaning up bad stuff that happens and other working on patient safety. CHW is forward looking, has board policy on disclosing medical error.

David Balfour, partner with Dicoppo, co-chair of law and medicine committee.

Steve Farber, VP of Risk Management of NorCal. He educates the physician . Nor Cal has been committed to educating physician in accepting their role in health care and communicating that role to patient, including unanticipated outcomes and apology. Their program on apology; physician needs to understand responsibility to physician and how they communicate with that patient.

Jim Heiting: dissatisfied with damages, results, many times unjust results for plaintiff or defendants. Create constant stress for patient, for all parties while litigation goes on. Curious about how plaintiff's lawyer gets paid. Having been a member of Ca Trial Lawyers Assn: that organization is very concerned about how patients' lawyer gets paid. Inclination to change understanding, to accept apology, plaintiff's counsel looses control. He sees his role as problem solver, rather than problem creator, wants to learn more about CL and how to do that.

Carol Bayley, vice president for ethics and justice, 1998, senior legal counsel at CHW, senior risk manager, senior physician agonized over same case. Patietns had monitors crossed, one patient died. Nurse who discovered it talked to her supervisor, called administrator, everyone was prepared to tell family there had been terrible mistake. Someone said: have you called the doctor? Doctor said "they must be allowed unencumbered by the truth". Nothing you can get from this except a lawsuit. CHW was held hostage by physician. Counsel for CHW said disclose early, tell what you know, what you don't know. Ready, 4 months later, to talk to family but family had moved to Ohio. That case prompted them to go back to core values. Took one year to come to disclosure process. Internal event: safe harbor to employee if employee comes forward and says: I did this. Interested in making it more possible for patients to heal.

Amy Baskin, KP, Ombuds/mediator at Oakland Medical Center, RN, JD. At Kaiser, modeled after Bethesda Medical Center disclosure; AMA, as well as JC, have set out tenets of disclosure. Education of physicians, patients, managing expectations. Can't underestimate of patient/physician relationship. Amy wants to explore gray area, bad outcomes. How we care for patients and how we care for physicians.

Ginny Hamm, VA Hospital, Lexington: past general counsel, came into VA when risk management was issue. Patient died in a totally preventable accident. First comment is noone will ever know, her daughters are estranged, didn't even claim the body. Chief of staff said Ginny, you have to resolve. Attorney who represented girls is still big supporter of this program. Individual physician is in vulnerable position if they made or think they made a mistake. Chief of Staff, as CEO, makes disclosure. Their situation, as above, occurred in 1990, Washington doesn't like the program. They wrote article and it came out when IOM report was published.

Steve Farber: says how many believe that physicians have feelings and physicians do grieve. His story: unexpected death of patient after bypass surgery. Physician/surgeon didn't know what to do. Patient's wife wanted face to face conversation with physician. Steve said she thought pahysicianve told him to do one on one. No lawyers, etc. He flew down to LA and met with physician for 4 hours. Patient's wife felt physician was very honest and caring. NINE STEPS. Steve says physicians grieve. Still need to deal with people who are involved in the process, and that is the physician.

Linda: patient advocate; went through DISCLOSURE TRAINING. Dan O'Connor. Check in with yourself before going to patient. Figuring out what patient needs and there is just compensation, we won't even need collaborative law. How are attorneys going to get paid.

Ginny Hamm had a case that just settled. Make doctor major part of that process. Steve McPhee brings doctors together and each has to write fo r15 minutes, tell story about what happened, and DO NOT sign it. Shuffle papers and read someone else's experience. Let physicians know that they are not the only ones. Some doctors carry this around for years, not having told anyone. Conversation follows about physicians that are expected to be perfect all the time. Doctors practice in hospitals where they are not aligned.

Jim Heiting: what is full disclosure: he doesn't get incident reports, hospital investigation, would be so helpful to him if they could just get these things, would make it so much easier. His experience wit VA is VA lawyer gets expert, expert looks at materials/info and calls Jim and says: there was error, let's settle case. Another case: patient and doctor connected with each other, doctor, when it came to settlement, wouldn't consent. Jim worries about fear of reporting, privileges being affected, e lay it all on the table to make sure collaborative process isn't so hidden and fearful.

Amy sys her role in neutral in the process, her role is fact-finding, when there is adverse event, fear about full disclosure. How do physicians slows down, doctors normally hard on themselves, willing to take the major hit when something goes wrong. Take care of physician so they have conversation that is handled in a healthy way.

Ginny: go back to process; Jim says Q&A protected; that is not full disclosure because process has not been completed, so need whole factual picture. She has orthopedist who told patient that he negligently severed a nerve, which he hadn't. Talking to patients too fast? About too much? Without enough information?

Hillery Trippe: disclosure relates to telling someone what happened. Causation is not clear frequently. Legal liability and standard of care is another issue. Ugly lawsuits are when people don't know what happened and noone would tell them. Eve if you don't know all the facts, disclose what you can disclose. Describe circumstances of what happened. Two ELEMENTS: DISCLOSURE, POLICY FOR MANAGING CLAIMS AND COMPENSATION.

Ginny: everything is disclosed, medical/legal disclosure only happens when there is medical liability. Meet with family and tell them what happened.

Carol: working with other collaborative professionals; man who is 93, came in for surgery and they put a central line in and put nutritional materials into his lungs and didn't take ex-rays that showed that. He died two weeks later of infection. Settled quickly. Man's family lawyer said: don't even bother with a check unless it comes with an apology. When check came with apology, family was ready to finish it. Kidn of apology I'm sorry we did this.

Linda: culture at Brigham's, a Harvard hospital, Linda went to talk to risk manger, risk manager was mean and angry and intimidated, three years later, Linda is a friend with that woman. It is

about trust. Linda wrote a letter: want to make sure this doesn't happen to anyone else. The letter she got in responses was businesslike, formal and it made Linda really angry.

Ginny: says some of us there are already there as house counsel. Paul mentioned Steve: issue of apology, will it be genuine. Is this a genuine apology or is this the policy putting doctor in role of saying I'm sorry whether they are or are not.

Jim Heiting: Collaborative law is defense conspiracy. Apology holds law suits down, feeding people's emotions, they are satisfied. Allow plaintiffs attorneys to collaborate, to advocate for patient at the same time. To be involved at the same time as risk management so patient's legal rights, as well as emotional, are addressed.

Ginny Hamm: said that would be feasible, good process,

Amy: patient wants acknowledgement or apology; if no mistake, acknowledge me as a person, that I've been in pain etc. Next is apology. If lawyers can think about what patients want, dig deep into lawyers being counselors. Patients are willing to take part, patients in many wrongful death cases don't want money, rather they want to meet with physicians, make a difference, make sure it doesn't happen in the future. They want counselors and lawyers are counselors.

Jim H: have to represent interests of patients legally; wrongful death, family may be interested in explanation and apology but patients children don't get to go to college, etc. He agrees that we should be problem solvers.

Amy is talking about cases that are not clear liability; that med mal cases get defenses nine out of ten times. Other questionable cases, have ability to do things differently. Never about hide the ball; is always about doing the right thing. Lawyers now who don't want to take cases because too small because injured parties want reimbursement for travel or some small thing.

Hillery: Insurers are the ones who say don't go in and admit anything. : this is about putting your money where your mouth is. Ask: are people walking the talk and putting money and resources toward patient safety? Rather than is the apology for real.

Stacy: told opposing counsel to educate themselves about CL. Do fact finding together, hire neutral experts together. Beauty of collaborative process takes what you are doing and makes it confidential. Doctor makes apology, it is confidential, will not be used against them. What do insurers need to know from us, from the lawyers, to make this process work.

David Hoffman: mediator. Mediation, new client comes to him. They are discussing mediation, collaborative law. , is mediation more effective. Mediation is good, mediation is always preferable, lot of expense saved. Clients/physicians are concerned about their reputation, but more so about medical board. National Practitioner Data Bank: some of laws in CA make skeptical about National Practitioner Data Bank, because CA laws are stricter? What is their local medical board doing?

Implementation: highly sophisticated consumers; multiple potential defendants. Physicians are

sobbing in peer review after a death. Nurses who are hysterical as well. This is member of the audience. Hospital administration, chief of medical staff to come up with these processes. Patient safety issue is out there, with an engine of its own. Responses matched to event.

How can we enlarge on this work and how to build bridges between/among organizations doing this work?

Carol Bayley: so concerned that physicians would say: she made an appt with Steve, to find out from them that they'd been doing this kind of thing. We can do a lot together in offering continued ed for physicians that is co-taught by med mal insurer and risk manager. This is person by person shift in culture: AMY BASKIN. Difficult to make s believers.

How can the participants support each other. I would like to reconvene this group and do a CME program, stem all from closed claims. Physicians learn from that. Nor Cal is mutual company and in last ten years, continuing med ed, monitored physicians who took course from Steve on apology. Number of claims against these course trained physicians have gone down. Really need to talk about the doctors and talk about education.

Steve: study, 60% of physicians don't know how to do breast exam, not taught in med school, residency. Let's start healing the healer before we get to CL. They are the ones who create scenario and make the error.

Jim H: doctors have to buy in before anyone else can buy in. If you get buy in from doctors, seed

starts to grow. Have to have doctors buy ins.

Carol Bayley: doctors are not the ones who make most mistakes, nurses do. Doctors are regarded as leader, doctor prevented collaborative conversation even though what doctor did had nothing to do with anything.

IOM study of medical mistakes; 98,000 people per year were affected, died

Institute of Health Improvement, Don Berwick. Let's hear from someone who has been sued. Databank requirement is suspension of privileges of 30 days or more or a money pay out. Databank doesn't prevent these more creative ways to handle situations, such as follow up surgery. National Practitioner Data Bank, has to have payment of money, has to have written cliam: so if you start early enough, before a written complaint, you can resolve it and pay money but not get into national databank. COPIC, Colorado: their process is not required to report to national practitioner data bank. Then, also, each state has its own reporting requirements. Ginny does voluntary reporting[499] when peer review determines there has been deviation from the standard of care.

Steve said do things in stages, trust first, then maybe CL. Plaintiffs bar, using CL.

[499] Voluntary reporting systems complement mandatory reporting systems by collecting information about less serious mistakes that result in no harm (near misses) or minimal harm. Voluntary reporting systems may be maintained by a governmental entity or by a private entity. Voluntary reporting focuses on research, detection of systemic problems that could lead to more serious types of errors, and identification of prevention strategies. *State Based Mandatory Reporting of Medical Errors: An Analysis of the Legal and Policy Issues.*

Appendix Two

Transcript of Florida Dialogue:

Any experience that relates to medical liability, medical error: story to share; open discussion: Mary and Debbie deal with this type of situations every day; why physicians not involved in conversation: physicians' reluctance because insurance co doesn't want them to talk. Hospital tries to resolve without physicians. In cases where physicians are willing to take part in process early on, percentage of early settlement is ONE HUNDRED PERCENT.

Joanne: mistake on part of hospital, if there was a loss and doctor went to family and spent time with family, prevented situation from going further. Mary: upfront communication will help to resolve a lot of issues if communication is open and takes place quickly. Iif physician says bad outcome, research that outcome, if hospital knows there is liability if people are open and honest up front and admit that, hospital does better, especially if patient thinks they are getting the honest answers.

Bruce: says hospital is capped, individual physician says I killed your baby. Physician has lost ability to control that situation. Get investigated by DOH, can loose your license, subject to 3 strikes, if verdict against you, NPDB picks up any payment made, Dr. Murray, private practitioner, strictly sympathy, won't come in as evidence at trial, but other side argues that that was admission: statute re apology vs sympathy (varies by state). Has had battles to keep that evidence out. Sides in communication hear it differently, likely to be a dispute in a courtroom, to be decided by judge.

Collaborative law: Process can be instituted right at the start, right after there has been medical error.

CL: participation agreement, both physicians and patients have meetings and there is confidentiality (confidentiality agreement). Then, there is withdrawal if case goes to trial. Sit down with the parties and everyone is represented by attorneys, so no inequality of bargaining process. Everyone committed to confidentiality, to withdrawal of attorneys if collaborative process is not successful. Everyone is committed to collaborative process. Insurance companies don't often want physician to talk to patient, take part in disclosure process. No formal discovery process because no litigation at this point. Informal process, exchange of medical records, shared expert can review records.

Jeff: look at this problems we have now, dictated by financial issues involved. Much better crop of physicians, technology gets better and better; overall quality of health care is going down; layer of HMOs taking health care money off the top. 1.5% of health care costs pay malpractice insurance. Legislation in FL favors insurance industry, not physician, like caps. If physician says: I did it and I'm responsible to patient/family, often those patients/families didn't go to lawyers, as long as they get fair compensation, that is good result. Bruce is right: EIGHTY FIVE PERCENT OF CASES GET DEFENSED. Jeff looks at 100 cases before he takes one. Not just mistake: decision is much bigger than that, some good cases that you just can't win.

Jeff: particular event, oncology dose was way too high, someone picks up phone and says let's

talk. Case like that: he was only attorney involved and it resolved quickly. This hasn't occurred in a case where he looked at a chart and didn't know what happened. He hasn't seen this phone call approach in very complicated case. He was at mediation where carrier announced there is some liability but it is insurance carrier's policy not to offer policy limits/won't offer any money. Complex problem: not just the patient who has been wronged, it is physician's relationship with insurer and physician is often wronged. Not all carriers are that way, but there is one in FL with that reputation.

Jeff: Spent $3,000 or $4,000 having a physician look at case. There are circumstances in which they have early resolution and attorney gets less and family gets more. Plaintiff's lawyer reduces fee substantially. May be less than jury verdict, but don't have to give so much to lawyer. Emotional piece of the process: after electrocution case, client said this hasn't been worth it, it was too hard, brings it all back, and money doesn't make any difference.
Once you take on one case, lost opportunity as to other cases; on plaintiff's side, Jeff has to prove the case. Can only take 10 to 15 cases a year. If you take one, you then can't take the next one. For him, resolution with smaller fee up front, may be BETTER than doing all the discovery. Cases with 30 depositions set, takes away opportunity to take any other case. Quick resolution of claim is very much in lawyer's interest to resolve case, take a reduced fee and move on: in client's interest. Have to know noone is going to settle when they know there is 85% chance that they'll win, on the defense side.

Bruce: personal experience: represented physician in case where issue was 13 month old had congenital blastoma, get symptoms of brain tumor. [facts excluded] Pediatrician said if I was that

woman, I'd sue God. Then, Bruce realized that our system is used to deal with grief, blame shifting, guilt.

Shelly: voluntary, confidential process, process that would not involve formal discovery but informal process, like a pre-suit process, not a lot of time and energy involved in this early process, all stakeholders coming together, opportunity to communicate doctors to patients, patients to doctors, everyone has opportunity to confer, there can be feeling of guilt, but no admissions in confidential process. As long as process continues, everyone is stuck: anger, blame, guilt. Collaborative process has potential to remedy some of the concerns. Many, many stakeholders in med mal arena.

Kathy: NorCal Mutual, encourage this process, has saved tremendous amounts of money by using a process that in some ways is similar; this is voluntary process that can kick in from day one, has nothing to do with discovery, this is healing, not litigation. Serious impediments, so let's help each other talk about it.

Dr. Kash: asks if confidential process, can't be used in court. Expert opinion is also not admissible, it is confidential. Facts can come out independently, but not from the process. Can't use statements from collaborative law.

Jeff: FL law re mediation and none of that is admissible in court; take Kash question, doctor admits in mediation that he nicked colon; same attorneys, can still ask the question about nicking the colon at trial. Cross can ask same questions, even though you're not talking about what was

said at mediation. These are facts of case.

Kathy: process is informal, can retain neutral expert, own expert, review medical records, sometimes that isn't enough. Works well if issues are apparent. Some cases way too complicated, need formal discovery. Evaluate on a case by case basis; if doesn't work, then close it down and go to litigation.

Mike, radiologist: who institutes the collaborative process? It can be instituted by a doctor or a hospital. Radiologist, 25 radiologists, 425 employees, he is in charge, reviews everything, does a lot of high risk procedures. Interventional radiologist, intrigued by this process.

Bob Silver: wants to integrate everything; adverse med events generate extreme emotional reactions on part of physician, patient, family. Tend to distort motivations. People expect to be treated fairly and justly and appropriately and not be harmed, if not, seek redress, by providing forum to address psychological aspects of problem, CL can address emotional aspect of the problem. If so, people will be more rational about what is going on. Everyone is aware of the faults of the existing system and the constraints on problem-solving that they exert. This is voluntary alternative process that allows us to overcome some of the difficulties and limitations of using formal legal system. Won't work in every case; AT WORST, IT IS PROCESS THAT WILL DO NO HARM; AT BEST, IT WILL BRING SUBSTANTIAL AID AND COMFORT TO PEOPLE INVOLVED.

Joanne: everyone has to come to process with flexibility in mind.

Kathy: can step into process from day one before parties get too locked into their positions.

Dr. Kash: if physician has any sense of needs of family, can sit down and talk with them. What else re process?

Kathy: explain the process, talk to family with attorney right off the bat, from day one, tell family you want to work collaboratively and are they willing to consider using that process.

Dr. Kash: He has unfinished feeling about the confidentiality. Respected attorneys can come back and change the wording with language and info that came up in collaborative process when CL has failed and litigation is next piece of things.

Shelly: people will meet to be oriented to process with all participants. Want to make sure this is right process and everyone is comfortable that this will work. All parties sign participation agreement. All parties understand there is high possibility of success/resolution.

Jeff: theory re 90 day notice in FL, was, in effect, to cause something like this to occur. Statute was set up to do that and it has never occurred. DNK why it never happened, was it financial issues? Not sure. Lot of clients have goal that they don't want what happened to their family to happen to someone else. His client: said she didn't want this to happen to anyone else (asked by defense why she brought lawsuit).
Is there a way to sell this, is there a way where clients are saying I want to get involved in this

CL process so it won't happen to anyone else. Fair number of people, particularly older people, who don't need/want money, this was mistake and shouldn't have happened. Husband sat in ER with cardiac condition for 8 hours and noone spoke to him and that happens in Lee County.

Mary: part of negotiation is process hospital has put into place so it doesn't happen again; that is more important to patient than how much money they are going to get paid.

Kathy: along with participation agreement, patient safety statement that comes out of collaborative process, set it forth anonymously, if necessary, that can be agreed, Beauty of this is patient safety is what we need to focus on. Can focus on it, address it, even if case doesn't resolve at CL process and goes to litigation.

Jeff: HOW TO SELL: if someone thinks they are improving health care, that is good for selling purpose. If this can get sold that everyone looks at it to think she/he is doing something to improve safety for rest of us. All of us agree that collaborative process is good, but how do you sell it.

Kathy: INVOLVE JUDGES: S.F. judge supports and speaks in favor of CL in family law from the bench. How do we get judges involved, support. Can we get judges to mention this process? Judges just want to get cases off the docket.

Shelly: contacted judges, cooperative model/judges in Lee County familiar with it and they endorse it. Bill McIver is very interested, upset about the current system. Circuit Judge, 5

counties, wants to know more about this process.

Chris: stumbling block is confidentiality agreement: courts have power over attorneys, clients have heard things now. Collaborative law model, arises out of mediation process, facts not protected that would come out anyway. CL is voluntary process.

Jeff: if potential plaintiff wants to punish, he doesn't normally take that person's case.

Bob Silver: how to engage in this process without increasing future legal exposure. He thinks this is technical problem that requires a special set of rules. If they don't settle and want to go to court, limit topics or issues that you discuss so you're not discussing legal blameworthiness, but are doing exploratory work so everyone understands better each other.

Kathy: lot of it is about trust. Dale Hetzler, CHOA, uses plaintiffs attorney as references for next plantiffs attorney. He has reputation as honest and honorable, hands over medical records to plaintiff for review by their own expert, Collaborative mediation, sits down and meets with patient/family.

Richard: says we're losing focus, focus has to be on patient.

Kathy: what I was talking about in terms of patient safety, follow up care, patient safety statement. Kaiser flyer for Eric, in honor of Eric, what happened, what to beware of in the future. Patient safety must be focus.

Jeff: If patient really believed that they made a change/had an impact on the process, they might be much more inclined to take part in CL. Getting everybody talking about it and agreeing we want to make change in system.

Mike: Money controls the process of health care these days. Number of general surgeons is same as it was in 1975. How can that many general surgeons treat 100 M more people. CL process could take that into account, informing patients.

Kathy: Patients and physicians get to be heard.

Bruce: how you decide which cases go into this; family CL process is so different, from his experience, most of clients don't have merit. Have to go through expert review. Once it has been looked at by physician and she says there is case, then that is good for CL. Cases going away because there is such great exposure. Verdicts are very high. Doesn't think there will be big bucks in the future to take care of catastrophic cases. Doctors have minimal insurance and hospitals have sovereign immunity.

Bruce: Insurance industry in FL as to med mal in total turmoil right now; he doesn't know what they are doing; he represents small insurance companies, not big ones.

Mike: insurance carrier: first pieces of advice: mum's the word, only talk to attorney. Once you've been notified that there is intent to sue, stop any conversations with patients.

Me: NorCal: goes through process with physician, if thinks real possibility of negligence, about how to handle conversation with patient/family, encourage openness and honesty right off the bat.

Jeff: attorney's liability carrier in FL now espouses this process; talk to client, meet with client, apologize, offer compensation, etc. Call carrier right away. Instant intervention.

Jeff: There is no business model for med mal carriers in FL. There is one carrier that doesn't settle anything; another one, doing some talking about settlement. New companies stepping into FL now. Have everyone face to face right off the bat: very hard to be angry at someone you're sitting next to. Get everybody together to come to some resolution.

Jeff: Lot of plaintiffs believe the doctors just don't care. Clients come in and say doctor wouldn't talk to me about it. (This process would address that.) When family member hears that the physician is distraught, they often rethink what they've been feeling.

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