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Medical Malpractice Mediation: Benefits Gained, Opportunities Lost

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MEDICAL MALPRACTICE MEDIATION: BENEFITS GAINED, OPPORTUNITIES LOST

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I
INTRODUCTION

In the past decade, the United States healthcare system has begun to use mediation to facilitate communication between patients and physicians after an adverse medical event, to ease tensions among members of care-giving teams,[1] to resolve medical malpractice claims,[2] and to help family members and medical professionals make awesome and wrenching decisions at the end of life.[3] Implementation of the Patient Protection and Affordable Care Act of 2010 will produce new controversies and increase the need for mediation. Patients, families, physicians, nurses, other healthcare professionals, and administrators will require help managing the disagreements that arise as they adapt to the altered healthcare system.

The Department of Health and Human Services understands this. The Agency for Healthcare Research and Quality recently announced seven grants as part of the Patient Safety and Medical Liability Initiative.[4] Four grants, totaling $10 million, went to programs focusing on the interactions among patient safety goals, the litigation system, and physician–patient communication.[5] Intelligent use of mediation and mediation skills can help us

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* Clinical Professor of Law, Columbia Law School. Much of this article is based on work the author has done in collaboration with Chris Stern Hyman, whose vision and persistence have been invaluable. Thanks to research assistant Rebekah Allen for her work on this article.

1. NANCY N. DUBLER & CAROL B. LIEBMAN, BIOETHICS MEDIATION: A GUIDE TO SHAPING SHARED SOLUTIONS (2011).

2. Chris Stern Hyman, Carol B. Liebman, Clyde B. Schecter & William M. Sage, *Interest Based Mediation of Medical Malpractice Lawsuits: A Road to Improved Patient Safety?*, 35 J. HEALTH POL. POL'Y & L. 797 (2010).

3. DUBLER & LIEBMAN, *supra* note 1.

4. U.S. Dep't of Health & Human Servs., *Medical Liability Reform and Patient Safety*, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (June 2010), http://www.ahrq.gov/qual/liability/demogrants.htm.

5. *Id.* Those grants were made to Timothy McDonald, University of Illinois at Chicago, IL; Eric Thomas, University of Texas Health Science Center, Houston, TX; Judy Kluger, New York State Unified Court System, New York, NY; Alice Bonner, Massachusetts State Department of Public Health, Boston, MA.

achieve a safer and more efficient healthcare system. But for mediation's potential benefits to be obtained, government officials and healthcare professionals must decide how conflict should be handled and what the role of lawyers should be when difficult physician–patient communications are required. The potential benefits from mediation are significant: improved patient safety; teamwork; relationship repair; and financial savings for physicians, hospitals, and patients. But achieving those benefits requires understanding of what recent scholarship has reported about successful and unsuccessful uses of mediation in the world of healthcare and sophisticated training of healthcare professionals, so that they can make informed decisions about when to use mediation and how to participate effectively in mediation.

This article will review two recent studies evaluating the use of interest-based mediation to resolve medical malpractice claims. The first studied cases brought against the New York City Health and Hospitals Corporation (the HHC study);[6] the second, Mediating Suits against Hospitals (the MeSH study), studied cases brought against private New York City hospitals.[7] The article will then consider how non-participation of physicians in mediations diminishes opportunities to achieve noneconomic goals that plaintiffs desire.

II

SUMMARY OF THE HHC AND MESH STUDIES

A. Overview of the HHC and MeSH Studies

Both studies used an interest-based model of mediation to test whether mediation of medical malpractice cases can lead to economic benefits for the parties by reducing litigation costs and providing compensation sooner while promoting the sort of discussion that contributes to improved patient safety and repaired patient–physician relationships. The HHC study investigated mediation of cases brought against the New York City Health and Hospital Corporation.[8] MeSH studied mediations of lawsuits against private hospitals in the New York City area.[9] In the HHC study, the Health and Hospitals Corporation referred twenty-nine cases for mediation; in twenty-four cases, the lawyers agreed to mediation and nineteen cases were actually mediated. In the MeSH study, thirty-one cases, drawn from a pool of sixty-seven, referred

6. Chris Stern Hyman & Clyde B. Schecter, *Mediating Medical Malpractice Suits Against Hospitals: New York City's Pilot Project*, 25 HEALTH AFF. 1394 (2006).

7. Hyman, Liebman, Schecter & Sage, *supra* note 2, at 798.

8. Hyman & Schecter, *supra* note 6, at 1394.

9. Hyman, Liebman, Schecter & Sage, *supra* note 2, at 797–99. In both the MeSH and HHC studies, the defendants made the decision about which cases to refer to mediation. They were not explicit about their selection criteria.

lawsuits involving eleven non-profit hospitals in New York City, were mediated.[10]

B. Settlement Data

In the HHC study, 68.4% (thirteen of nineteen) of the cases settled through mediation,[11] while in the MeSH study, 70.6% (twenty-two of thirty-one) of the cases were settled as a result of mediation.[12] In the HHC study, initially only cases with claims of $400,000 or below were selected for mediation. Halfway through the study, that limit was removed. The mean HHC settlement amount was $111,000 with a range of $17,500 to $400,000,[13] while in the MeSH study, settlements were higher with a mean of $250,000 and a range of $35,000 to $1,700,000.[14]

C. Mediator Style

Both studies used co-mediators and an interest-based model of mediation. A principle investigator co-mediated eighteen of the nineteen HHC mediations,[15] and one of the two principle investigators co-mediated all but three of the MeSH cases.[16] Because of the focus on the question of whether and how mediation might contribute to patient safety and improved quality of care, the other mediators in both studies were chosen for their comfort discussing highly emotional issues and their skill in helping participants explore a broad range of noneconomic issues. Mediation services were provided without charge in both studies.

D. Party Participation

During pre-mediation conference calls with counsel, the mediators in the MeSH study pointed out the potential value to clients—both physicians and patients—of participation in the mediations. In the MeSH study, 80.6%

10. North Carolina medical malpractice mediations were the focus of a 1995 study which concluded that the "mediations" were "nothing more than a structured, traditional settlement conference conducted by a neutral third party." The settlement rate in that study was 44.2% (eighty-seven of 197). Thomas B. Metzloff, Ralph A. Peeples & Catherine T. Harris, *Empirical Perspectives on Mediation and Malpractice*. 60 LAW & CONTEMP. PROBS. 107, 151, 137 (Winter 1997). A second article examined more of the 1995 North Carolina data regarding how the forty-six directly observed mediations were conducted. Ralph A. Peeples, Catherine. T. Harris & Thomas B. Metzloff, *Following the Script: An Empirical Analysis of Court-Ordered Mediation of Medical Malpractice Cases,* 2007 J. DISP. RESOL. 101 (2007).

11. Hyman & Schecter, *supra* note 6, at 1395.

12. Hyman, Liebman, Schecter & Sage, *supra* note 2, at 807. In the MeSH study, sixteen cases settled at mediation (sixty-eight percent), another five settled afterward at amounts discussed during the mediation, and three cases settled after the mediation had been scheduled but before it took place.

13. Initially, only cases with claims of $400,000 or below were sent to mediation in the HHC study. Midway through the study, that cap was lifted. Hyman & Schecter, *supra* note 6, at 1395.

14. *Id.*

15. *Id.*

16. Hyman, Liebman, Schecter & Sage, *supra* note 2, at 806.

(twenty-five of thirty-one) of the plaintiffs attended the mediations,[17] but not a single physician attended. In the HHC study, it was known from the outset that physicians would not participate. In that study, 84% (sixteen of nineteen) of the plaintiffs attended the mediations.[18]

E. Participants' Assessment of the Mediations

Most of the plaintiffs who attended the mediations in both studies found it a positive experience.[19] Using a five-point scale with a score of one being the most positive, MeSH plaintiffs rated the mediation process and their experience during the actual mediation at a mean of 1.98,[20] while the HHC plaintiffs gave mediation a mean rating of 2.22.[21] Attorneys also rated their experience in the mediations positively. For many, this was their first experience with interest-based mediation.[22] Unlike the plaintiff participants, many MeSH attorneys (eighty percent of the defense lawyers and forty-two percent of the plaintiffs' attorneys) had previous experience in mediation.[23] They gave their MeSH experience a mean score of 1.9.[24] In the HHC study, the City was represented by a single attorney who had not previously participated in a mediation; her positive experience is reported in an article in the New York Law Journal.[25] The HHC study lawyers gave the mediation process a mean rating of 1.95 and rated the results of the mediation at 2.56.[26]

A few of the MeSH lawyers would have preferred an evaluative approach to mediation. Five of nineteen plaintiff's lawyers and three of sixteen defense lawyers were critical of the mediators' non-evaluative approach,[27] and one felt the process was inefficient because of the amount of time the plaintiff was allowed to speak.[28]

As Hyman et al. report, in the MeSH study,

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17. *Id.* at 807.

18. Hyman & Schecter, *supra* note 6, at 1397.

19. Hyman, Liebman, Schecter & Sage, *supra* note 2, at 802–03. In the MeSH study, research assistants asked all participants in post-mediation telephone interviews questions designed to measure their satisfaction with the mediation process.

20. *Id.*

21. Hyman & Schecter, *supra* note 6, at 1397. For a detailed analysis of party response to eight questions in a post-mediation interview that measured their attitudes toward the mediation process, see Hyman, Liebman, Schecter & Sage, *supra* note 2, at 803–04.

22. *See* Hyman, Liebman, Schecter & Sage, *supra* note 2, at 818.

23. *Id.*

24. In twenty cases, either an insurance representative or a hospital representative also attended the mediation. They rated their experience at a mean of 2.5 with no significant difference between the two groups. Six relatives of the plaintiffs also attended the mediation. *Id.* at 809–10.

25. Amy G. London, *Mediation Offers Promise, But No Cure for System's Ills*, N.Y. L.J., Feb. 16, 2006.

26. Hyman & Schecter, *supra* note 6, at 1396.

27. Hyman, Liebman, Schecter & Sage, *supra* note 2, at 818–19.

28. *Id.* at 815.

> Attorneys, especially on the defense side, showed some reluctance to try mediation despite the considerable financial benefit to their clients of avoiding or limiting trial preparation and trial. In theory, decisions about whether or not to mediate should be made jointly by lawyers and clients (ABA Model Rules of Professional Conduct 2006). As a practical matter, attorneys act as gatekeepers, either making on their own the decision whether to mediate and whether clients will attend and participate or heavily influencing clients' choices.[29]

F. Time Savings

Both studies found that mediation was time-efficient. In the HHC study, lawyers estimated that they spent approximately one-tenth as much time preparing for mediation as for litigation.[30] In the MeSH study, lawyers reported three to ten hours of preparation for mediation (median six hours), contrasted with estimates of 100 hours that would be needed for trial preparation.[31]

G. Discovery

While discovery was completed in ten of twenty MeSH cases and partially completed in eight others, there was no correlation between the stage in litigation and the likelihood of settlement.[32] Seventy percent of the cases where discovery had been completed settled at mediation and seventy-five percent of those with partial discovery settled.[33]

III

BENEFITS GAINED

The MeSH and HHC studies show that mediation can save transaction costs, give plaintiffs the opportunity to be heard, and allow defendants to obtain information that might improve the quality of care. But the decision not to have physicians participate in the mediation minimized the last benefit. While the overwhelming majority of cases settle before trial,[34] most do so late in the litigation process, on the proverbial courthouse steps. If parties make increased use of mediation to reach settlement closer in time to the adverse event, defendants will realize significant savings in litigation costs, plaintiffs will receive compensation sooner and when they may need it most, and plaintiffs' lawyers will still receive adequate compensation for their work. As argued in previous articles,

> While risk managers and lawyers need to gather information in order to value a malpractice claim, the amount of information needed to guide a settlement negotiation is not as great as the amount required to prove a case at trial. Early

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29. *Id.* at 813.

30. Hyman & Schecter, *supra* note 6, at 1394.

31. Hyman, Liebman, Schecter & Sage, *supra* note 2, at 812–13.

32. *Id.* at 809.

33. *Id.* at 812.

34. Marc Galanter, *The Vanishing Trial: What the Numbers Tell Us, What They May Mean*, DISP. RESOL. MAG., Summer 2004, at 3.

> mediation offers the opportunity for patients to receive compensation soon after the event and for defendants (and to a lesser extent plaintiffs) to avoid the financial costs of prolonged discovery. Early settlement also spares patients and physicians a brutal and emotionally draining discovery process. In addition, when there is only a short gap in time between the harm and the mediation, information that might suggest a need for changed procedures is more likely to seem salient and lead to improved patient safety.[35]

Of course, early mediation will not always be appropriate. Sometimes it takes time for the long-term consequences of an injury to be clear. In other cases where defendants are certain that care was appropriate, they may not be willing to make an offer. Even in those cases, both sides may benefit from giving the plaintiffs the opportunity to be heard and explaining to the defendants what happened and why, especially if communication between the caregivers and the patient or patient's family has been poor. Finally, early mediation may not be appropriate when there is a suspicion of a cover-up.

Participants in the MeSH study reported some noneconomic benefits as well: the opportunity for a relative to speak about what had happened (the mother of a child with Erb's palsy),[36] for the plaintiff to tell her story in a professional setting (a defense lawyer commenting on mediation of case brought by a breast cancer surgery patient who suffered complications from intravenous (IV) chemotherapy infusion),[37] and for a plaintiff to understand the other side's perspective on the case (plaintiff's lawyer discussing the impact of mediation in a contaminated platelets wrongful death action).[38] In addition, in the MeSH study, in four instances, hospital representatives reported they had obtained information from the mediation that might lead them to suggest changes in policy.[39]

IV

OPPORTUNITIES LOST

While twenty-five plaintiffs participated in the thirty-one MeSH mediations, and sixteen in the nineteen HHC mediations, not a single physician took part.[40] When defendant physicians do not participate in mediations, those physicians, the defendant hospitals, the plaintiff patients and families, and the general population of patients all lose. Non-participation of defendant physicians leads to a loss of the opportunity for patients and physicians to reconcile, loss of the opportunity for the physician to be forgiven and for the patient or family to forgive, loss of the opportunity for the physician and family members to forgive themselves, loss of the opportunity for information giving and gathering, and loss of the opportunity to consider changes in institutional policies and

35. Hyman, Liebman, Schecter & Sage, *supra* note 2, at 813.
36. *Id.* at 811.
37. *Id.*
38. *Id.*
39. *Id.* at 823.
40. *Id.* at 807; Hyman & Schecter, *supra* note 6, at 1396.

practices. When physicians are not included in the mediation, they are also deprived of "voice, representation and participation," key elements in what procedural-justice scholars have identified as critical to a process being perceived as fair.[41]

There is a known mismatch between what patients and families want following a medical error and the way physicians communicate after such events. Patients and family members want to receive a detailed explanation of what happened and why it happened, want to know how the problem will be corrected and future errors prevented, and want to receive an apology.[42] They also want reassurance about the medical and, ultimately, financial consequences.[43] These findings about patient and family goals after an adverse medical event are consistent with procedural-justice research, which finds that litigants are often after more than winning or losing or money, instead evaluating their experience in the courts in terms of criteria such as "vindication, attention, accountability, information, accuracy, comfort, respect, recognition, dignity, efficacy, empowerment, [and] justice."[44]

However, "when unexpected clinical outcomes occur . . . [p]hysicians frequently avoid conversations with the patient and patient's family about what occurred, rarely apologize or explain the steps that will be taken to prevent recurrence of the harm, and vary widely in the type and amount of information they disclose."[45] And while there is a clear trend toward greater disclosure as a matter of ethics, institutional policy, and regulation,[46] other studies show that implementing new policies is difficult and actual rates of disclosure remain low.

Another equally troubling mismatch is that between attorneys' perceptions of their clients' goals in medical malpractice litigation and the goals actually reported by plaintiffs. An important and insufficiently noted work by Tamara Relis[47] found that lawyers for both defendants and plaintiffs believe that

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41. Nourit Zimerman & Tom R. Tyler, *Between Access to Counsel and Access to Justice: A Psychological Perspective*, 37 FORDHAM URB. L.J. 473, 486 (2010); *see also id.* at 486 n.38.

42. Thomas H. Gallagher et al., *Choosing Your Words Carefully: How Physicians Would Disclose Harmful Medical Errors to Patients*, 166 ARCHIVES INTERNAL MED. 1585, 1585–93 (2006).

43. *Id.*

44. Zimerman & Tyler, *supra* note 41, at 482 (quoting Judith Resnik et al., *Individuals Within the Aggregate: Relationships, Representations, and Fees*, 71 N.Y.U. L. REV. 296, 364 (1996)).

45. Hyman, Liebman, Schecter & Sage, *supra* note 2, at 800 (citing Lauris C. Kaldjian et al., *Disclosing Medical Errors to Patients: Attitudes and Practices of Physicians and Trainees*, 22 J. INTERNAL MED. 988 (2007); Rae M. Lamb et al., *Hospital Disclosure Practices: Results of a National Survey*, 22 HEALTH AFF. 73 (2003); Gallagher et al., *supra* note 42).

46. Joint Comm'n on Accreditation of Healthcare Org., *Ethics, Rights, and Responsibilities*, *in* COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS: THE OFFICIAL HANDBOOK (2003), Standard RI.1.2.2, [which went into effect on July 1, 2001]; AMA COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS: CURRENT OPINIONS WITH ANNOTATIONS § 8.12 (1994); DOUG WOJCIESZAK ET AL., SORRY WORKS! DISCLOSURE, APOLOGY, AND RELATIONSHIPS PREVENT MEDICAL MALPRACTICE CLAIMS (2007).

47. TAMARA RELIS, PERCEPTIONS IN LITIGATION AND MEDIATION: LAWYERS, DEFENDANTS, PLAINTIFFS, AND GENDERED PARTIES (2009). Relis gathered data through 131 interviews, observations, and questionnaires of participants in sixty-four Canadian "fatality and medical injury

plaintiffs are primarily after money when they sue. Ninety percent of the physicians' lawyers thought that money was a plaintiff's sole goal, while only ten percent recognized plaintiffs' desires for answers.[48] Relis found that hospital lawyers also saw money as plaintiffs' primary goal (67%) but did recognize other interests including: (1) obtaining answers (25%), (2) acknowledgment of harm (25%), (3) either vindication or justice (17%), (4) blame (17%), and (5) prevention of reoccurrence (8%).[49] Eight percent of the hospital lawyers thought money was only a secondary goal.[50] Plaintiffs' lawyers' views had more in common with the views of other lawyers than with those of their clients. Sixty-seven percent (the same percent as hospital lawyers) thought the primary goal of plaintiffs was to obtain money,[51] but they also recognized other goals: (1) obtaining answers (50%), (2) retribution (33%), (3) acknowledgment of harm (28%), (4) accepting responsibility (17%), (5) apology (17%), (6) to be sure the harm never happens again (6%), and (7) either revenge or punishment (6%).[52] Twenty-two percent of the plaintiffs' lawyers saw money as a secondary goal of their clients.

Plaintiffs in the Relis study tell a very different story. For them, it is principles that matter and not money.[53] Plaintiffs reported that their primary goal in suing was to get an admission of fault or responsibility (59%). An additional 59% sued to ensure that the harm never occurred again. Fifty-three percent sought answers, 41% retribution, and 41% apology. Thirty-five percent named money as a secondary goal, 35% wanted an acknowledgement of harm, and 24% sought punishment. Only 18% stated that money was their primary goal and a mere 6% stated that money was their only goal.[54] Forty-one percent did not mention money as a goal.[55]

Relis explains these results as follows:

> [I]n assisting disputants to understand their cases and what can be done about them, lawyers as gatekeepers to legal institutions virtually always transform disputes. . . . [L]itigants' experiences and extralegal aims are translated, reconstituted, and coerced

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cases," the equivalent to medical malpractice cases in the United States. Even though, by law, defendants were required to be present for the mediation, they usually were not. The requirement was avoided by having the lawyers, the plaintiff (if present), and the mediator agree to go forward without the participation of the defendant. *Id.* at 87. In the sample, the defendant physicians rarely attended a mediation. While the Canadian healthcare and tort systems differ in significant ways from those in the United States—including a single payer healthcare system, court-imposed limits on some categories of damages, provincial government reimbursement of part of physicians' malpractice insurance payments, a single rate for insurance regardless of physician specialty, and an aggressive approach to defense of claims by CMPA—her data is nonetheless instructive.

48. *Id.* at 37 fig.1.
49. *Id.* at 38 fig.2.
50. *Id.*
51. *Id.* at 40.
52. *Id.* at 40 fig.3.
53. *Id.* at 42.
54. *Id.* at 43 fig.4.
55. *Id.*

> by lawyers to fit into legal and monetary compartments, ignoring aspects deemed irrelevant in law and ultimately translating them into money.[56]

Relis identifies four reasons for the differences in plaintiff and lawyer identification of plaintiffs' goals:

1. Lawyers focus on money damages because they are trained "to operate according to rights and rules, applying law to facts and placing people and occurrences into legal categories including damages."[57]

2. In response to the legal system's limited ability to deal with human and emotional needs, lawyers react to what Relis calls "system conditioning," redefining and lowering their expectations for what they can expect the legal system to offer their clients.[58]

3. In the process of translating and transforming their clients' litigation goals, plaintiffs' lawyers may also be reinforcing their own limited views of those goals.[59]

4. As a result of translating and transforming goals in communication with their clients, plaintiffs' lawyers reinforce their own views and may, as a result, stress only limited economic goals in discussions with defense counsel. Since the defense side only communicates indirectly with the plaintiff through their lawyers, they never hear about any other goals.[60]

In the MeSH study, lawyers explained their decisions not to bring physicians to the mediation by pointing to their clients' busy schedules or saying that they wanted to avoid having their clients hear plaintiffs' attacks or that it was not the usual practice.[61] The Relis study also found that lawyers sought to avoid emotional confrontations by mediating without their clients. Those lawyers also felt—consistent with their view that the litigation was only about money—that physicians were not needed at the mediation and that their presence would not aid in settlement since insurance companies, and not the physicians, make the final decision about settlement amounts.

Some of the lawyers in the Relis study did see unfocused potential gains from having defendant physicians participate.[62] Forty-four percent of the physicians' lawyers said that physician participation might be helpful to plaintiffs and sixty-seven percent thought their clients would benefit personally and that the nonfinancial issues were important to their clients. Even so, they

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56. *Id.* at 53 (see n.18 for sources cited).
57. *Id.* at 62.
58. *Id.* at 62–63. Relis calls this "dispute translation."
59. *Id.*
60. *Id.*
61. Hyman, Liebman, Schecter & Sage, *supra* note 2, at 817.
62. RELIS, *supra* note 47, at 93.

did not bring their physician clients to mediation. Perhaps, as Relis notes, these decisions resulted from the defense lawyers' view of the physician's irrelevance to settlement, with only twenty-two percent thinking that having the doctors at the mediation table would help settlement.[63] Plaintiffs' lawyers tended to have views similar to those of the defense lawyers: they recognized the importance of noneconomic issues to the clients, but, on the whole, also saw the defendants' presence as irrelevant since the physicians were not involved in the monetary decisions. It is possible that some lawyers feared that the defendant physicians' anger and upset feeling at being sued or lack of communication skills might lead to unproductive discussions during the mediation. Although, in most cases, mediators, through process management, coaching, and modeling are able to guide participant communication in a productive direction, occasionally, aggressive or offensive behavior by a mediation participant can either decrease the likelihood of settlement or drive up settlement costs. In the MeSH study, lawyers "did not seem to consider the physicians' own emotional needs after a patient has been harmed by medical care and the possibility that participation might have been helpful to a physician coping with feelings of guilt or remorse."[64] In dramatic contrast with the responses of all of the attorney groups, 100% of the seventeen plaintiffs and twelve defendant physicians interviewed in the Relis study said that the doctors should attend the mediation. The physicians recognized the value of attendance to the doctor, to the plaintiff, and for learning information that can contribute to improving the quality of care.[65] In Relis's plaintiff group, 76% thought attendance would be beneficial for the physicians, 94% for the plaintiffs, and 53% for learning. Twenty-nine percent of the plaintiffs and 64% of the defendant physicians thought physician presence would aid in settlement.[66] In the MeSH study, twenty-five percent of the plaintiffs mentioned their frustration at the lack of communication with their physicians after the event,[67] a problem that could have been remedied had the physicians attended the mediation.

The views of mediators in the Relis study were consistent with the desires of the parties. Most of the mediators in her study thought that the non-participation of the defendant physicians made it more difficult to settle.[68]

The quest of patients and, moreso, of surviving family members for answers to their questions about what happened to their loved ones is well and often

63. *Id.* at 95.

64. Hyman, Liebman, Schecter & Sage, *supra* note 2, at 817 (citing Michael Rowe, *Doctors' Responses to Medical Errors*, 52 CRITICAL REVIEWS IN ONCOLOGY/HEMOTOLOGY 147 (2004); Albert W. Wu et al., *To Tell the Truth: Ethical and Practical Issues in Disclosing Medical Mistakes to Patients*, 12 J. GEN. INTERNAL MED. 770 (1997)).

65. RELIS, *supra* note 47, at 104–09.

66. *Id.* at 105 fig.11.

67. Hyman, Liebman, Schecter & Sage, *supra* note 2, at 820.

68. RELIS, *supra* note 47, at 94 fig.9.

painfully documented.[69] In mediation, patients and their families may finally obtain the information they have been seeking. Moreover, if a physician or other clinician participates, he or she might provide a comprehensive explanation of complex and uncertain medical situations rather than the often fragmented communication that too often occurs in a hospital where a number of busy nurses and physicians and other clinicians may be involved in a given case with each assuming the others have taken time to communicate with the patient or family.[70]

Without a physician or other person responsible for, and knowledgeable about, patient care at the table, mediation will not lead to improved quality of care because information with clinical significance may be overlooked or given too little attention. For patient safety to benefit, someone is needed at the table who has technical clinical knowledge, appreciation for the institution's culture—who are the power players, who makes decisions and has influence—and who has an understanding of policy and procedures.

In a number of mediations, it has been clear that, especially after a death, family members blame themselves for not doing more—not asking more questions, not getting their loved one to the hospital sooner, not spending more time at the bedside.[71] The traditional adversarial defense of claims only heightens their guilt and their grief. Information and, when appropriate, assumption of responsibility for error by the medical team can provide release for family members and allow them to forgive themselves for failing to prevent a tragic outcome.

In one MeSH mediation, the behavior of the defense lawyer damaged the possibility of settlement, may have increased the costs of settlement, and was perceived by the plaintiff as an additional offense. His failure to adopt behavior appropriate to mediation and his aggressive approach led the plaintiff's lawyer to label his decision to have his client attend as "a foolish mistake. I should not have put my clients through that.... [T]he defense lawyers lacked any sympathy, were abusive, and said things that are now torturing my clients."[72]

Other opportunities to satisfy plaintiffs' goals were missed when defense attorneys in two MeSH cases identified changes in procedures that might help

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69. *See, e.g.*, NANCY BERLINGER, AFTER HARM: MEDICAL ERROR AND THE ETHICS OF FORGIVENESS, (2005); SANDRA M. GILBERT, WRONGFUL DEATH: A MEDICAL TRAGEDY (1997); Richard B. Hovery, Mitchell L. Dvorak, Tessa Burton, Sherry Worsham, James Padilla, Martin J. Hatlie & Angela C. Morck, *Patient Safety: A Consumer's Perspective*, QUALITATIVE HEALTH RESEARCH (Feb. 22, 2011), http://qhr.sagepub.com/content/early/2011/02/18/1049732311399779.long, DOI: 10.1177/1049732311399779.

70. In some settings, it is not unusual to have only lawyers or lawyers and insurance representatives attend mediations without ether plaintiffs or defendants. For the reasons discussed in this article, non-participation of the defendant physicians in medical malpractice cases is especially counterproductive.

71. *See, e.g.*, the case of Mr. D. in CAROL B. LIEBMAN & CHRIS STERN HYMAN, MEDICAL ERROR DISCLOSURE, MEDIATION SKILLS, AND MALPRACTICE LITIGATION: A DEMONSTRATION PROJECT IN PENNSYLVANIA 64–65 (2005), *available at* http://www.law.columbia.edu/null?exclusive=filemgr.download&id=12462.

72. Hyman, Liebman, Schecter & Sage, *supra* note 2, at 816.

avoid repetition of the harm. They chose not to share that information with the plaintiffs, thus frustrating one of the goals that plaintiffs often cite: avoiding the same harm happening to other patients. In some cases, the lawyers were apparently not oriented toward those sorts of concerns. In four cases, mediators identified changes in practices that might prevent future harm which were not identified by the lawyers for either side.[73]

Several recent articles have explored the possible negative impact of lawyers in mediation. Poitras et al.,[74] in an empirical study, examined seven ways in which attorney participation in mediation might have a negative impact on: (1) settlement rates, (2) the length of time spent in mediation, (3) the parties' view of mediator effectiveness, (4) the clients' view of whether the mediation was fair, (5) the clients' satisfaction with a mediated agreement, (6) parties' trust that the other side will abide by the mediation agreement, and (7) party reconciliation. They found that attorney participation had no impact on the settlement rate, minimal impact on the amount of time spent in mediation (on average, mediations lasted thirty minutes longer when attorneys participated), and no difference in parties' view of mediation fairness, party satisfaction with the agreement, or parties' belief that the agreement would be followed. The areas in which attorney participation did make a difference were the parties' evaluation of mediator helpfulness and whether or not parties reconciled. The authors speculated that the negative impact of attorney presence on reconciliation may be the result of lawyers' tendencies to focus on legal rather than interpersonal matters, to advise their clients not to apologize, and to substitute their voice for that of their clients by speaking for their clients.[75]

The authors suggest several strategies to control the negative impact of lawyers on reconciliation between the parties. These include: (1) spending more time prior to the mediation educating the attorneys about the process and how to use it effectively[76] (an attempt that was not particularly successful in the MeSH study[77]), (2) specifically stating in mediation agreements that apologies or statements of regret that an event occurred will be protected[78] (some literature

73. *Id.* at 810.

74. Jean Poitras, Arnaud Stimec & Jean-François Roberge, *The Negative Impact of Attorneys on Mediation Outcomes: A Myth or a Reality?*, 26 NEGOTIATION J. 9 (2010); *see also* Roselle L. Wissler, *Representation in Mediation: What We Know from Empirical Research*, 37 FORDHAM URB. L.J. 419 (2010). The authors found that, while lawyer presence does not appear to increase conflict in mediation—or interfere with discussions of feelings or exploration of settlement options—lawyer presence does appear to decrease party satisfaction with their own level of participation as well as parties' learning about the other side's concerns. They also found that attorney presence correlated with a lower rate of settlement.

75. Poitras, Stimec & Roberge, *supra* note 74, at 10.

76. *Id.* at 20.

77. Hyman, Liebman, Schecter & Sage, *supra* note 2, at 802.

78. Poitras, Stimec & Roberge, *supra* note 74, at 14.

suggests that apologies which receive this type of protection have less value),[79] and (3) encouraging the parties to speak to each other directly.[80]

It seems clear that the nonparticipation of physicians in the mediation destroys any chance for patients and physicians to reconcile. It also deprives patients of the opportunity to know that the physician involved cares enough about the bad outcome to come and sit with the patient or family in the mediation. Patients interpret nonparticipation as an indication of indifference, lack of respect, and shirking of responsibility.

In one MeSH case for wrongful death,[81] a patient was admitted to the hospital with multiple co-morbidities, developed sepsis (system wide infection), and remained in the hospital for six months steadily wasting away despite the efforts of the medical team. She died two weeks after being transferred by the family to another hospital. The story that the plaintiffs' lawyers had developed—their theory of the case—was that the defendant hospital had neglected the patient and, in the words of the plaintiff's daughter and her lawyer, "allowed her to starve to death."[82] The hospital was represented by its lawyer. No physician or other representative of the hospital attended the mediation. In the course of the discussion, an alternative version of the story became apparent to the mediators—that the hospital had continued to fight for the patient and against her diseases for an extraordinarily long period and, despite this fight, it was the disease that ultimately killed her. The mediators raised this possible alternative narrative and it seemed to give some relief to the daughter. Imagine how much more credible and comforting it would have been to have a physician at the table to describe the fight, the complexities and difficulties of this case, the frustration of seeing treatment after treatment fail, and the healthcare team members' sadness at the death of the patient. In addition, the physician might have heard from the daughter about ineffective communication with the family—a breakdown that ultimately led to total lack of trust and the transfer.[83]

It is unfortunate, but understandable, that physicians do not act on their realization of the potential benefit of their participation in mediation. One reason is obvious—most people are conflict-averse and try to avoid difficult conversations. With lawyers discouraging mediation participation, physicians are happy to have a reason to avoid a difficult discussion. Jay Hoecker, discussing the underrepresentation of physicians at a conference on Alternative

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79. Aaron Lazare, *Apology in Medical Practice: An Emerging Clinical Skill*, 296 J. AM. MED. ASS'N 1401 (2006) (citing Lee Taft, *Apology and Medical Mistakes: Opportunity or Foil?*, 14 ANNALS HEALTH L. 55 (2005); Lee Taft, *Apology Subverted: The Commodification of Apology*, 109 YALE L.J. 1135 (2000)).

80. Poitras, Stimec & Roberge, *supra* note 74, at 14.

81. Hyman, Liebman, Schecter & Sage, *supra* note 2, at 801.

82. Author's notes from a MeSH mediation.

83. *Id.*

Dispute Resolution (ADR),[84] points out that physicians are scientists and scientists base action on data.[85] The studies of medical malpractice mediation discussed above are beginning attempts to provide data about the efficacy of an approach different from the deny-and-defend tradition that will lead to increased physician participation. Hoecker also argues that employer institutions are more likely than individual physicians to accept the use of ADR[86] for so long as those processes are seen as an extension of the legal system rather than integral to quality patient care.[87] However, discussions with individual physicians frustrated by instructions from their insurers to take an adversarial, non-communicative approach toward their patients suggest that, with a bit of organizing, a change might come just as easily from the ground up as from the top down.

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CONCLUSION

Lawyers discourage their physician clients from participation in mediation for a number of reasons. First, they may be trying to protect their clients from what certainly would be an emotionally trying, even if ultimately satisfying, experience. Second, they see mediation as part of the legal system and, lacking knowledge and understanding of the full range of benefits of mediation, have a constricted vision of what is possible or productive in mediation. Third, their experience with evaluative mediators may have blinded them to the noneconomic benefits for their clients of client participation. Fourth, they may fear either that their clients might say something that damages the legal case or that offends the plaintiffs. Finally, given the fact that most defense counsel are paid on an hourly basis, some may be hostile to a process that offers less expensive resolution.

Sending a litigator to settle a case may make as much sense as asking a surgeon to provide holistic noninvasive medical care. Litigators, whose advice about communication with patients and their families and approach to client participation in mediation seems so flawed, may only be doing their job—that is, shaping all client interactions with the opposing side with an eye to the impact on the legal case. Of course, this is a narrow definition of the lawyer's job and typifies the often criticized defend and deny mentality—most recently seen in the British Petroleum disaster and Toyota malfunction—which fosters mistrust. Toyota was widely criticized for its decision to withhold information about possible problems with the gas pedal. Former Merrill Lynch media relations executive, Eddie Reeves, said of that response, "People are

84. Jay L. Hoecker, *Guess Who Is Not Coming to Dinner: Where Are the Physicians at the Healthcare Mediation Table?*, 29 HAMLINE J. PUB. L. & POL'Y 249, 249 (2008).

85. *Id.* at 254–55.

86. *Id.* at 256.

87. *Id.* at 257.

reasonable. They know companies make mistakes, and people will forgive an honest mistake. They will not forgive a dishonest cover-up."[88]

In both law and medicine, people turn to educated and trained professionals for help with problems—often serious problems. Also, in both law and medicine, individuals are dependent on institutions—hospitals and courts—with their own traditions, cultures, and hierarchies. Beginning with the anti-paternalistic patients' rights movement of the 1960s, patients have become more involved in their own care (even if at times producing a suspicious vigilance not always good for a patient's mental state or the physician–patient relationship). Patient involvement has been increased by readily available medical information on the internet.

Interestingly, there is no similar movement in law, except perhaps recently among high-end consumers of legal services where post-recession attitudes about how much clients are willing to pay and for what may be changing. The difference in the development of patients' active, questioning approach to healthcare and the passive approach of many defendant physicians may result from the fact that most malpractice clients are single or only few-time players compared to patients who are regular and, in many cases, constant consumers of medical care. Medical malpractice plaintiffs are unlikely to be involved in repeat litigation, so they are less likely to understand the system well enough to insist to their lawyers that the mediation not proceed without physician participation. But many defendant healthcare institutions—hospitals, nursing homes, and group practices—are repeat players. It is interesting to think about ways that those defendants might learn from the patients' rights movement in their selection of, instructions to, and collaboration with their lawyers.

88. Peter S. Goodman, *In Case of Emergency: What Not To Do*, N.Y. TIMES, Aug. 22, 2010, at BU1.

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