Maximize the Benefits of Outcome Disclosure with Early Mediation

Kathryn K. Wire, JD, MBA, CPHRM
Kathryn Wire Risk Strategies
St. Louis, Missouri

I. Introduction

The healthcare industry often rockets ahead with good ideas, curing one problem but creating others it isn't ready to solve. For example, in vitro fertilization has brought children to thousands of couples, but raises new ethical and practical dilemmas almost daily. Similarly, disclosure of unanticipated or adverse outcomes improves providers' relationships with patients and families, meets providers' personal needs,[1] and supports process improvement. But disclosure has created tremendous bottlenecks in the claim resolution process that can overshadow all the good disclosure brings us.

In 2001, the Joint Commission on Accreditation of Healthcare Organizations first required accredited facilities to develop procedures for informing patients of unanticipated outcomes. Since then, many resources have appeared to help providers through that process.[2] Clearly, disclosure is with us to stay and we are getting better at it, which are good things. However, the claims process has not evolved to support disclosure; so disclosure often leads to an awkward inability to take the discussion to the next logical step: settlement.

Why do we lead our patients eagerly to the proverbial resolution pond with openness about the event and then drop the discussion?[3] The "disclosure to claim resolution" hurdle arises from a number of process-related factors:

- Often, several providers and carriers are involved in the underlying events, and they disagree about evaluation and/or apportionment.
- Defense attorneys are accustomed to pinning down every possible fact before evaluating a case.
- Decision-makers rely on lengthy group processes to justify payment decisions and don't empower front-line claims experts.
- Rigid, hierarchical decision-making structures simply can't adjust to the fast pace required for early resolution.
- Defense decision-makers underestimate the value of the momentum established by disclosure discussions, and its role in identifying the claimant's true needs.
- Decision-makers won't acknowledge the full value of the claim early.
- The healthcare provider wants to settle, but the insurance carrier doesn't, or vice versa.
- If plaintiffs' attorneys are involved at this stage, they often expect a full fee of one-third to 40% of the settlement.

If we can address these challenges, we can dramatically change the topography of medical professional liability.

II. Why Early Resolution?

Tort reform only directly affects a subset of the cases that reach litigation. Mounting evidence strongly suggests that early resolution with or without tort reform leads to lower total payouts and drastically lower expenses. It also brings more equitable distribution of total malpractice dollars to the universe of claimants, a goal that tort reform can actually sabotage. Comprehensive early resolution programs also address "no pay" cases, a group that currently absorbs a high percentage of defense costs. We disclose both preventable and unpreventable outcomes, and while payment is not appropriate for most unpreventable outcomes, they still often result in litigation.[4] Accordingly, healthcare providers will still benefit from efforts to resolve the non-compensable "issues" that drive claimants to litigate.

Unfortunately, the published studies of early resolution programs have been limited. Some involve facilities in which all defense parties are employed and insured by the same entity.[5] Others, such as COPIC's 3R's program, have involved only low-value cases with unrepresented claimants,[6] and still others initiate mediation well into the litigation process, as with the well-publicized program at Rush Medical Center.[7] But the evidence from those studies credibly suggests that the approach can offer substantial financial advantages if expanded beyond the narrow margins of those efforts.[8]

Malpractice claims have always provided good information for patient safety analysis. Unfortunately, lawsuits don't dig up relevant details until years after the event. And the defendants don't hear the patient's or family's comments about their care until a deposition or mediation because the litigation system excludes them from early discussions of causes and solutions. Clinical safety improvement has been subjugated to the need to "protect" information in a litigation environment. Realistic dialog with the patient or family, which often contributes to process improvement, ebbs as the parties circle their wagons. Ironically, studies by the Robert Wood Johnson Foundation of very early mediation in the context of physician licensing complaints,[9] as well as considerable anecdotal evidence,[10] demonstrate that most patients have a strong interest in improving the system, which may overcome their interest in financial compensation.[11] Lawsuits simply can't do much to move that goal forward.

Also, consider the CFO. Uncertainty and wide variability of self-insured losses lead to higher IBNR (incurred but not reported) values and higher values of open case reserves. Auditors require larger reserves on the books to cover those potential losses. Carriers examine their insureds' ability to reduce uncertainty and variability in losses, as those two factors add dramatically to required premiums and internal reserves. Insurers that find a poorly controlled pattern will require higher premiums or refuse coverage.[12] Any of these outcomes leads to a reduction in available capital for the hospital or system. At the end of the day, a history of well-managed losses with early closure reduces the need to tie up the operating capital required as reserves on the balance sheet, funded in a trust, or as insurance premiums lost forever.

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III. The Role of ADR

When motivated by honest efforts to address *all* issues, early mediation can mitigate the perceived risks of early settlement, encouraging the flow of information and candid discussion of all options. By removing roadblocks, it allows the parties to continue an ongoing and productive process on many levels.

A. Resolving defendant-only disputes

When potential co-defendants disagree about value or apportionment, they cannot reach a complete settlement with the claimant. This often leads plaintiff to settle with less than all defendants, followed by an unpredictable and disproportionate result for the non-settling party, either higher or lower than the facts would otherwise dictate. And the initial settlement is often skewed to the high side because the plaintiff's attorney has to make up for the chance of losing in the subsequent proceedings against the non-settling party. Though the plaintiff usually benefits from these situations, the majority of potential resolutions fail at this point due to differences on the defense side. Defendant-only mediation allows the parties to present a united front and negotiate as a block, eliminating the opportunity for skilled plaintiffs' counsel to "divide and conquer." In this setting, mediation will also force a meaningful dialogue between insured and insurer.

B. Sharing information

Often, mediation occurs after substantial discovery has allowed for the exchange of factual information. That can become very expensive investigation. Mediation offers an ideal forum for simpler but structured sharing that facilitates compromise. Parties to a healthcare professional liability dispute start with a distinct advantage: they know each other in advance. The plaintiff tends to know the defense parties and their relationships to each other, and the defendants have a personal relationship with the patient and generally have almost all of the relevant medical records. If the parties feel they need outside experts, they can informally share their experts' opinions, and use the experts as resources during the mediation process. A skilled mediator can help each party assess the true value, if any, of missing information and then negotiate accordingly. Often missing information does not have a big impact on the value of a case.

C. Exploring true interests

One key element of mediation is interest-based negotiation. Mediators probe to develop each party's true interests and needs, attempting to develop those into a meaningful settlement. Parties experienced in the mediation process have undoubtedly encountered surprising personal needs underlying a claim. Often, those can be resolved without significant financial impact.[13] For example, patients of religious healthcare facilities often feel betrayed by what they perceive as a secular approach, and seek reassurance of the religious foundations of the provider to reconcile events with their faith. Most claimants express a very strong desire to make sure the underlying clinical issues that led to their injury have been fixed. That interest has value, and it will be lost in a lawsuit.[14]

D. Adjusting expectations

Some claimants have unreasonable expectations of high compensation. Often, their claims denied, they are left to find an attorney who understands them. When these parties team up with inexperienced attorneys who don't control their expectations, everyone suffers. An early meeting with a skilled mediator provides an educational forum that may offer a way out for the lawyer. Similarly, plaintiffs' attorneys sometimes use a mediator as an outside party to help manage their clients' expectations. Either way, the healthcare provider has avoided an expensive litigation experience.

E. Earlier settlements

Some cases are just going to cost a lot of money. But does any benefit of delayed payment overcome the cost of uncertainty, litigation, and the diversion of capital reserves? Generally, it does not. Some plaintiffs' attorneys recognize that settlements at this stage benefit both the attorney and the client, and will reduce their fees in early mediation sessions. If so, then the ultimate cost of the case will be lower.

F. Limiting open issues

Even if the case doesn't settle before litigation, early mediation often helps the parties crystallize the issues and narrow future discovery. Resulting litigation tends to be shorter and less contentious, with an open communication channel established. Once open factual questions have been explored, cases often settle without further formal processes.

IV. Summary

As attorneys for healthcare providers, we need to help our clients avoid the formidable obstacle they often encounter at the end of a productive disclosure process. Attorneys and insurance companies have counseled providers to avoid open discussion of liability issues, but now those issues have to be on the table. Our historical close-mouthed approach to early claim development wastes the forward momentum of the disclosure process. If we don't give our clients the tools to continue the dialog, we leave them with wasted opportunities that may, in fact, exacerbate the plaintiffs' anger and frustration. Mediation offers a controlled and neutral environment to move those discussions forward, solving some of the problems generated by our progress in disclosure.

Endnotes

1 *Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors,* Gallagher, T. et al., 280 JAMA 1001 (2003).

2 *See e.g.,* "Healing Words: The Power of Apology in Medicine," Woods, M., Doctors in Touch, 2004; "What do I say? Strategies for Communicating Intended and Unanticipated Events in Obstetrics," Woods J., Rozovsky F., Jossey-Bass, (2002).

3 *See A Mediation Skills Model to Manage Disclosure of Errors and Adverse Events to Patients,* Liebman, C. and Hyman, C., 23(4) Health Affairs (2004).

4 *Patient Safety and Medical Malpractice: A Case Study,* Brennan, T. and Mello, M., 139 Annal. Int.

Med 267 (2003*); "Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform,"* Brennan, T. and Mello, M., 80 Tex.L. Rev. 1595, 1599-1600 (2002).

5 *Risk Management: Extreme Honesty May Be the Best Policy*, Kramaan, S. and Hamm, G., 131 Ann. Intern. Med. 963 (1999).

6 *See 3Rs Newsletter,* http://callcopic.com/publications/3rs/3rs_newsletter.htm, accessed February 16, 2005.

7 Rush Hospital's Medical Malpractice Mediation Program: An ADR Success Story, M.D. Brown Illinois Bar Journal, 432-440, August 1998.

8 *House Calls,* Jones, A., Corporate Counsel, October 1, 2004.

9 *Adapting Mediation to Link Resolution of Medical Malpractice Disputes with Health Care Quality Improvement,* Dauer, E. and Marcus, L., 60 Law and Contemporary Problems 186 (1997). *See also* A series in the Baltimore Sun *How Medical Errors Took a Little Girl's Life* (December 14, 2003) and *From Tragedy, A Quest for Safer Care* (December 1, 2003), Niedowski, E., *available at* www.josieking.org/news.html.

10 The story of the King family's response to the loss of their young daughter, Josie, speaks volumes about this interest. Their Web site, www.josieking.org contains news articles and other resources.

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12 GAO Report, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Premium Rate Increases*, October 1, 2003, *available at* www.gao.gov/new.items/d04128t.pdf.; *Medical Malpractice Insurance Report: A Study of Market Conditions and Potential Solutions to the Recent Crisis*, Nordman, E., Cermak, D., McDanial, K., National Association of Insurance Commissioners (2004), *available at* www.naic.org/models_papers/papers/MMP-OP-04-EL.pdf.

13 *Adapting mediation to Link Resolution of Medical Malpractice Disputes with Health Care Quality Improvement,* Dauer, E. and Marcus, L., 60 Law and Contemporary Problems 186 (1997).

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AMERICAN HEALTH LAWYERS ASSOCIATION

1025 Connecticut Ave, NW
Suite 600
Washington, DC 20036-5405
202-833-1100
202-833-1105 Fax
www.healthlawyers.org

PRACTICE GROUPS STAFF

Wayne Miller, CAE
Deputy Executive Vice President/COO
(202) 833-0775
wmiller@healthlawyers.org

Eileen Bantel
Associate Director of Practice Groups
(202) 833-0778
ebantel@healthlawyers.org

Sarah Muenzenmayer
Practice Groups Coordinator
(202) 833-0765
smuenzenmayer@healthlawyers.org

Magdalena Wencel
Practice Groups Assistant
(202) 833-0769
mwencel@healthlawyers.org