A Mediation Skills Model To Manage Disclosure Of Errors And Adverse Events To Patients

A quicker, less alienating route to closure than malpractice litigation.

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ABSTRACT: In 2002 Pennsylvania became the first state to impose on hospitals a statutory duty to notify patients in writing of a serious event. If the disclosure conversations are carefully planned, properly executed, and responsive to patients’ needs, this new requirement creates possible benefits for both patient safety and litigation risk management. This paper describes a model for accomplishing these goals that encourages health care providers to communicate more effectively with patients following an adverse event or medical error, learn from mistakes, respond to the concerns of patients and families after an adverse event, and arrive at a fair and cost-effective resolution of valid claims.

In the past fifteen years the U.S. health care system has been unsettled by research showing problems in the delivery of medical care. Most notably, the Institute of Medicine’s study *To Err Is Human* found that a frightening number of hospital patients die each year because of medical errors. But the tort system responds imperfectly. The Harvard Medical Practice Study found that the tort system fails to compensate the majority of patients injured by their medical care. These research findings have spurred the development of the patient safety movement. At the same time, the growth in medical malpractice litigation has reached crisis levels in many states, with physicians unable to afford (or in some high-risk specialties even obtain) malpractice insurance. States are beginning to address both sets of problems through tort reform laws. One reform requirement—that hospitals inform patients about quality problems in their medical care—also creates an opportunity for improved patient safety. To realize benefits for both patient care and litigation risk management, these discussions must be carefully planned, properly executed, and connected to processes for dispute resolution and quality improvement. They also need to be responsive to patients’ and families’ desires for information, an apology, assurance that steps have been taken to prevent others from being similarly harmed, and fair compensation when appropriate.

This paper describes a model that offers a template for accomplishing these...
goals. It was developed in a two-year demonstration project funded by the Pew Charitable Trusts in cooperation with selected hospitals in Pennsylvania. The model encourages physicians, hospital administrators, and other health care providers to communicate more effectively with patients following an adverse event or medical error, learn from mistakes, respond to the needs and concerns of patients and families after an adverse event, and reach a fair and cost-effective resolution of valid claims. While the study focuses on Pennsylvania, discussions with physicians in other jurisdictions suggest that the challenges and opportunities described here have broad application.

- **Legal and professional obligations to disclose “serious events.”** In March 2002 Pennsylvania became the first state to impose a statutory duty on hospitals to notify the patient (or patient’s family) of a “serious event” in writing within seven days. A “serious event” is defined in the law as “an event, occurrence or situation involving the clinical care of a patient in a medical facility that results in death or compromises patient safety and results in an unanticipated injury requiring the delivery of additional health care services to the patient.” Nevada and Florida followed Pennsylvania’s lead by imposing requirements that patients be notified (in person rather than in writing) by the medical facility after an event that causes serious injury. These new notification laws have the practical effect of forcing more discussions between health care providers and their patients about errors and adverse events. We call these discussions “disclosure conversations.”

The mandatory disclosure laws put teeth in existing disclosure standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the American Medical Association (AMA) Council on Ethical and Judicial Affairs, and the American College of Physicians Ethics Manual. Despite the ethical standards, the disheartening reality is that physicians resist disclosure of the most serious adverse events. It remains to be seen whether the recent laws, which include consequences for failure to disclose, will achieve an increase in the number of disclosures. If so, other states are likely to follow Pennsylvania, Florida, and Nevada.

- **Definitions.** A short explanation is in order about the terms adverse event, medical error, and serious event. An adverse event refers to “an unintentional, definable injury that was the result of medical management and not a disease process.” A medical error is defined as “the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim.” Often medical error is used to refer to a preventable systemic problem rather than a problem resulting from poor performance by a health care provider. Depending on the facts involved, a serious event could be a medical error or an adverse event.

- **The relationship between error communication and malpractice litigation.** The relationship between poor physician-patient communication and litigation has been documented by several researchers. However, their findings on the factors that put physicians at risk of being sued are counterintuitive. For example, it is not the quality of the medical care, the quality of the chart documentation, and
negligent treatment per se that leads to litigation, but, rather, ineffective communication with patients. The important factors leading people to sue physicians include families' perception that the physician was not completely honest; the inability of family members to get anyone to tell them what happened; the sense among family members that the physician would not listen; and their being told by someone, often a health care professional but rarely a lawyer, that they should sue.

Research also shows a mismatch between what patients want and what physicians provide following an adverse event or medical error. Patients want basic information about the event; assurances that they won't suffer financially because of it; an apology; and prevention of similar events or errors in the future. Physicians respond by choosing their words carefully; mentioning the event but not that an error occurred; and failing to reveal what caused the error, how it might have been prevented, and how they may act differently in the future.

The Pew Demonstration Mediation And ADR Project

■ Overview. For the past two years we have worked with four Pennsylvania hospitals/health care systems, including a large, decentralized network of urban teaching and suburban hospitals with more than 2,500 staffed beds and a suburban community teaching hospital with approximately 500 beds. To date, this participant-observer study has provided training services to three hospitals and mediation services to one, at no cost.

As a result of our work, we recommend the following: (1) that physicians and other health care professionals develop an awareness of the communication skills most likely to be useful during disclosure conversations; (2) that hospitals develop in-house process experts available as consultants to aid in planning, conducting, and debriefing disclosure conversations; (3) that hospitals encourage physicians, patient safety officers, and risk managers to spend time planning before conducting disclosure conversations; (4) that physicians, hospital leaders, and other health care providers offer an appropriate apology after an adverse event or error; (5) that hospitals and senior physicians provide opportunities for debriefing and support for health care professionals after an error; and (6) that hospitals use mediation as soon as practicable after an adverse event to settle potential claims.

■ Error communication: training the communicators. Physicians have experience in delivering bad news to patients and discussing hard choices about treatment options. Much of the expertise they have developed in that context is relevant to disclosure conversations, but there are other skills—often referred to as active listening skills, used routinely by mediators and conflict resolvers—that are less familiar to physicians and that should be the focus of training.

Mediators spend a great deal of time (typically, four or five days) in initial training developing the active listening and conflict resolution skills likely to be critical when conducting disclosure conversations. Mastery of those skills does not come easily. Practice is required, and skills can only be maintained with use. In the
hospital, where medical procedures are increasingly complex, patients are sicker, and staffs are being reduced, time is a valuable asset that is closely guarded and likely to be invested only when there is a clear payoff. It is hard to convince health care professionals to spend the time needed to develop the skills, especially since most will be involved in only a few such conversations during their careers.

In addition, physicians, other health care professionals, and hospital administrators face a greater challenge than mediators do in learning to use these skills effectively during disclosure conversations. Mediators are, by definition, neutral and do not have a stake in the outcome. After an adverse event or medical error, the physician or nurse may experience strong emotions: guilt, shame, remorse, or fear about the impact on his or her career. They are not neutral and are likely to have had little time to process their own reactions to the events.

**Goals of communication skills training.** Given the limited occasions when a physician will be engaged in a disclosure conversation, the goal of training health care providers should be twofold. One goal is to give hospital staff a brief introduction to the conflict resolution and communication skills used in disclosure conversations. The second is to prepare a core group of skilled and experienced staff members who can help others prepare for disclosure conversations, can participate when appropriate, and can debrief afterward. Brief introductory training for as many members of the staff as possible can make them aware of the complexity of disclosure conversations, give them elementary communication tools, and sensitize them to the value of a consultation with a process expert.

Having a core group of staff members with these skills increases the likelihood that the conversation will go well. Such staff members can also encourage participation of the patient and family members and ensure continued communication with them after the initial discussion. The members of the core group of communication process consultants might also be charged with linking the disclosure conversations and what is learned during them to steps to improve patient safety. They can ensure that each disclosure is accompanied by consideration of how systems might be changed to prevent recurrence of the error. The patient safety officer or risk manager and the chiefs of various services might be good candidates for membership in this core group. Researchers have identified another pool of hospital staff members who would be suitable process consultants—those who are looked to within the institution, regardless of title or status, as natural problem solvers and conflict resolvers and who exhibit many of the skills needed during disclosure conversations.13

**Planning the discussions.** The task of disclosing a medical error or adverse event is difficult, and the consequences of doing it badly can be severe: breakdown in relationships, failure to prevent future error, increased emotional stress, and litigation. Although time pressures will often require truncation of the model presented here, it can be useful to have a guide to the planning process.

Planners need to consider who should participate, what is known about the
event, what further investigation is being conducted, the consequences for the pa-
tient, who should lead the discussion, and what questions the patient and family
are likely to have. Physicians should have answers to patients' questions about
their treatment and prognosis. Physicians or other participants in the disclosure
conversation should be prepared with answers about who will pay for additional
treatment. It may also help to take time during planning to consider the actual
words to be used in explaining the medical error or adverse event.

During planning, it is helpful to be aware of the useful insight provided by
Douglas Stone and colleagues that each difficult conversation has three compo-
nents: a conversation about what happened; a conversation about the feelings be-
ing experienced by the participants; and an identity conversation, which is each
person's internal conversation about what this situation means to his or her self-
image. Understanding the complexity of the conversation allows the person
leading it to address the issues raised by these simultaneous components.

Who should participate? Factors to consider in deciding who should attend the dis-
closure conversation include who has the most information about the adverse
event, who has the best relationship with the patient or family, who has good pro-
cess skills, and who is emotionally able to handle the conversation. The impor-
tance of having the person with the best available information participate is rein-
forced by research on attribution theory, which examines both how people arrive
at attributions about the causes of behavior and the implications of attribution on
emotions and reactions. Most people tend to attribute other people's negative be-
havior to the others' innate disposition, while attributing their own behavior to
circumstances. The person harmed by negative behavior attributes the behavior to
causes under the control of the other and responds with anger. At the same time,
the person who has caused an injury attributes his or her behavior to circum-
stances beyond his or her control. The resulting difference "in judgment of the
harm doer's responsibility...can lead to the most destructive kinds of anger-
driven-conflict." Given the research on attribution, it seems important during
disclosure conversations to provide the patient and family with information
known at that point about what happened and why, especially if events were be-
yond the physician's control. Absent that information, the patient and family are
likely to attribute negative motives to the physician, and their anger may escalate.

Critical skills for participants. While the focus of the health care professionals en-
tering a disclosure conversation is likely to be on what they are going to say about
the error, they will also need to respond to the patient and family. Developing skill
as an active listener allows the physician to show attentiveness to the patient and
family members, to check on whether the physician is accurately gauging their
concerns, to acknowledge the patient's or family member's feelings, and to encour-
age their participation in the conversation. We have found that even physicians
who were committed to full disclosure and were comfortable with participating
in difficult conversations, showing concern, sharing information, and remaining
nondefensive were ineffective listeners. That is, they did not use a summary to show that they had been listening and failed to acknowledge the feelings that had been expressed.

Also, during some disclosure conversations, the person leading the conversation may need to draw out frightened, confused, or disempowered patients or family members. Families who feel that their views are valued may reveal information such as failure of a provider to listen when the patient questioned an action; poor communication between providers; or ignored patient or family observations, complaints, or suggestions. This sort of information can be key in selecting measures to improve patient safety. Inviting patient and family input also may reveal concerns about how they were treated, which, while not material to health outcomes, may be critical to how families interpret and respond to adverse events.

Goals of disclosure conversation participants. The goals and motivations of the physicians and other health care professionals during a disclosure conversation may be different from those of department heads or hospital administrators. A physician may be anxious to get the conversation over with as quickly and painlessly as possible with minimal damage to the relationship with the patient and to the provider's reputation and self-image. The hospital, on the other hand, may be interested in additional goals such as gathering information—for example, about system failure, communication problems among caregivers, or failure to listen to the patient's or family's attempts to question what was going on. Being aware of the possible diversity of goals and motivations among participants allows disclosure conversation planning to be responsive to the interests of each participant.

Conducting the discussions. After a medical error or adverse event, the proper type of apology can have a powerful impact on the patient or family, making them less angry and suspicious. An apology can lead to open discussion from which the hospital may obtain information that will help avoid similar errors in the future. And a prompt apology coupled with an explanation of the event and a fair offer of compensation are critical steps in rebuilding trust between the physician and the patient.

It is helpful to distinguish between two types of apology: an “apology of sympathy” and an “apology of responsibility.” A health care provider or hospital administrator who offers an apology of sympathy is saying, “I’m sorry this happened to you.” By contrast, when an apology of responsibility is offered, the physician or hospital representative is saying, “I’m sorry we did this to you.”

We began this project thinking that apologies of sympathy were always appropriate and should be offered whenever something has gone wrong even if the physician and hospital believe that there is no legal liability or that liability is unclear. But recent research by Jennifer Robbennolt on the effects of apology in civil litigation suggests that such limited apologies may have uncertain benefits and some risks. She found that when liability is clear, a partial apology that does not include an acknowledgement of responsibility negatively affects the injured party's
perception and decreases the likelihood of settlement. In that situation, no apology may be preferable to a partial apology. While more research is required about the transferability of Robbennolt's findings to medical malpractice litigation, a recent study by Kathleen Mazor and colleagues suggests that the outcome is likely to be the same. They found that after full disclosure and an apology, respondents were more trusting, satisfied, and less likely to change physicians.

These studies indicate that lawyers, risk managers, and insurers need to rethink their leery approach to apology. By training and habit, these professionals focus on the risk that an apology might be seized upon as an admission of wrongdoing in future litigation, since in some jurisdictions, apologies are admissible as evidence of liability.

While lawyers can best advise their clients about the legal consequences of an apology, the clients—physicians and hospital administrators—are the ones best qualified to choose between the benefits and the risks. Clients need to decide whether the risk of a negative impact of an apology on the fact finder—should the case be one of the small number of cases that actually goes to trial—outweighs the likely benefits of an apology both to the patient and family and to the health care provider who made the mistake.

After The Disclosure Conversation

- Providing emotional support to health care providers. When a medical error or adverse event occurs, health care professionals are likely to experience powerful emotions such as shame, guilt, or failure. Without time to process those reactions, they will have difficulty focusing on the needs of the patient or family, much less thinking about what they can learn from the event to improve patient safety.

Physicians have told us that they wish discussion with colleagues about medical errors or adverse events were part of hospital culture. If senior staff members responded to news of an error by discussing their own past mistakes, such openness would be a powerful source of support for other physicians. Moreover, health care providers who feel emotionally supported are more likely to feel comfortable talking to patients after an error, answering questions, and expressing their own feelings.

- Resolving claims. Hospitals should develop a system for resolving claims that, when appropriate, includes an early and fair offer of compensation and the opportunity for mediation. It is too soon to know whether fuller disclosure to patients of medical errors or adverse events will lead to increased litigation and higher compensation. Our hypothesis is that litigation and the amount of payments need not increase if communication is open and accompanied by an appropriate apology and a fair offer of compensation for any harm, and if institutions take steps (and inform patients of those steps) to prevent recurrence. The best evidence to date to support this hypothesis is the experience of the Veterans Affairs Medical Center in Lexington, Kentucky, with such a model, although there are legitimate questions
about whether these findings would apply in nonfederal hospital settings.23

A similar program run by COPIC Insurance Company, a physician-owned medical professional liability insurer in Colorado, is in an early stage. In 2000 COPIC started a postincident risk management program that also encourages an early disclosure conversation described as open, honest, and empathic. Physicians answer patients' questions, explain what happened, and offer an apology if appropriate. COPIC pays for the patient's out-of-pocket expenses related to the injury and does not ask the patient for a waiver or general release from liability—patients are free to pursue a lawsuit if they choose. The anecdotal evidence is that few patients who have participated in the COPIC program have sued.24

We have thus far mediated only two cases as part of this project. Experiences with that tiny “data set” are consistent with research on apology and research on why people sue after a medical error or adverse event, with studies of mediation in disciplinary complaints against physicians, and with our experience mediating in other contexts.25 In our cases, apologies, the exchange of information, and changes in policies or practices were important factors in reaching settlement.

Mediated dispute resolution. Mediation is an informal, private, voluntary, and confidential process in which a neutral third party—the mediator—helps the participants negotiate their differences and craft a mutually acceptable resolution to their dispute or decide to deal with their problems in some other manner, including litigation. Mediation is based on three core principles: party autonomy; informed decision making; and confidentiality. The participants may end the mediation at any time without adverse consequences. If, however, the resolution is a settlement, it is memorialized in writing, signed by disputants, and made a binding agreement.

Mediation agreements can be more nuanced than judgments obtained from a court proceeding and can include provisions, such as changes in a policy, that address issues that are important to the parties but that would not constitute a legal cause of action. The fact that mediation communications are confidential makes more open, less strategic conversations possible because parties need not fear that what they say then will come back to haunt them in a later proceeding.

Mediation provides a setting in which physicians, hospital representatives, and patients or family members can offer and request information. In medical cases, plaintiffs may gain information about the complexities and uncertainties of medical care and about exactly what happened to them or their loved one. Hospitals and physicians may learn about missed or ignored information and about insensitive treatment of the patient or family that contributed to the decision to litigate.

The Value Of An Early, Interest-Based Mediation Model

The mediation model used in the Pew Demonstration Mediation and ADR Project is designed to encourage settlement of claims as soon as the parties have adequate information to evaluate the case and to give participants the opportunity to consider noneconomic concerns.26 In this model the mediator facilitates an ex-
change of information and encourages discussion of ways to avoid similar errors in the future. In support of those goals, parties should mediate cases soon after the claim has been filed and before expensive and hostility-escalating discovery has been conducted. The type of information needed by parties to settle a case is quite different from that needed to try a case. In some cases early mediation may be inappropriate—for example, when the long-term consequences, such as the future costs of care, are not yet clear; when the plaintiff is not emotionally ready to consider settlement; or when there are concerns that information is being withheld or is not yet available.

The model differs greatly from the best-known (and very successful) model for mediating medical malpractice cases developed by the Rush University Medical Center in Chicago. In the Rush model, mediation does not take place until years into the litigation process, and the focus is on finding a dollar figure at which the case will settle. Until recently, apologies were offered only after the case settled and were limited to apologies of sympathy, not responsibility. While the plaintiffs are present during Rush mediations, they rarely speak, and agreements almost never include nonmonetary provisions.

This project's mediation model recognizes and respects the fact that parties are often concerned about more than money. Certainly in situations where an injury will require lifelong care or where there has been a death of a primary wage earner, money is critically important. In other situations money is the only way the legal system can approximate the value of a lost life, but it does not satisfy plaintiffs' interests in knowing what happened and what is being done to prevent a recurrence. In mediations that provide the opportunity to consider a nonmonetary remedy, such as specific education for staff or a memorial space outside the hospital, both the grieving family and the hospital representatives may feel that the resolution has given meaning to a tragic event.

In the mediation model we recommend, much time is devoted early in the process to a physician's explanation of the medical facts of the case and the events that caused the claim to be filed. Often this is the plaintiff's first opportunity to hear a coherent explanation of what happened and to ask previously unanswered questions. For the defendant, the review of the events and the questions asked by the plaintiff may reveal information about how systems actually worked—or failed to work. Both lawyers and parties are encouraged to speak in joint sessions and private sessions with just one side, known as a caucus. Plaintiffs usually speak extensively, asking and answering questions and expressing their anger, their understanding, and their empathy. An early apology of responsibility, when appropriate, can be a powerful way to defuse anger and create trust, a crucial commodity when building a settlement agreement.

The second portion of the mediation usually addresses possible remedies with attention continuing to be paid to both nonmonetary and monetary provisions. These discussions may take place in caucus or in joint session. Often agreement on
a nonmonetary remedy—a new checklist for carrying out a procedure, training to address a specific problem among staff, or a change in an administrative rule—reassures the plaintiff that others will be spared similar harm and thereby makes a monetary offer acceptable.

It is too soon to measure the impact of recently enacted statutes requiring prompt disclosure of medical errors or adverse events to patients and family members. The greater transparency required by the new laws may point the way toward more open, honest, and empathic disclosure conversations between physicians and their patients and patients’ families. But these discussions will be difficult and require consultation with disclosure conversation experts who can aid in planning and facilitating the conversations. If these discussions are treated as learning opportunities, they have the potential to contribute to improved patient safety. But changing the focus of these conversations will require leadership from hospital administrators and senior physicians to alter traditional norms of self-protection and “say as little as possible” that have developed in reaction to malpractice litigation. Leadership, and possibly legislation, is also needed to incorporate the findings of recent research about apology during disclosure conversations. When the disclosure conversations do not go well or when there are claims for compensation that cannot be resolved informally, the model of mediation recommended in this paper will sometimes be a quicker, more nuanced, needs-based, and less alienating route to closure than malpractice litigation.

Errors and adverse events will happen, and we predict that disclosure will increasingly be imposed by statutes throughout the country. Taking steps to improve disclosure conversations and using alternatives to litigating medical malpractice claims will help hospitals reduce costs, improve patient safety, and restore trust.

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NOTES


10. Levinson et al., “Physician-Patient Communication.”

11. Hickson et al., “Factors That Prompted Families to File Medical Malpractice Claims.”


16. Ibid., 245.


18. Robbennolt, “Apologies and Legal Settlement.”


26. The model of mediation that we advocate in this paper is what most mediators would consider simply good, nonevaluative mediation.


28. Telephone conversation between Chris Stern Hyman and Max D. Brown, vice president and general counsel, Rush University Medical Center, Chicago, 12 November 2003.
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