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# BEST PRACTICES FOR PATIENT REPRESENTATION IN THE CARE PROGRAM AND OTHER CRPs

PREPARED FOR MACRMI AND BIDMC

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HARVARD NEGOTIATION AND MEDIATION CLINICAL PROGRAM

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# EXECUTIVE SUMMARY

The following report was prepared for Beth Israel Deaconess Medical Center (BIDMC) by the Harvard Negotiation and Mediation Clinical Program. It addresses the following question:

*How should patients be represented when they participate in Communication Resolution Programs (CRPs) such as BIDMC's Communication, Apology, and Resolution program (CARe)?*

The paper reaches the following conclusions:

1) **Participants in CRPs should be represented by an attorney with extensive experience in medical malpractice litigation.** Patients almost always lack the legal sophistication and medical knowledge necessary to understand the full extent of the damages they have sustained. Medical malpractice lawyers have a sophisticated understanding of both damage valuation and the long-term consequences of adverse medical events. Medical malpractice attorneys are therefore better situated to evaluate the fairness of an offer made by the hospital and its insurer than any other type of lawyer or mediator. Critics of CRPs contend that the programs are designed to encourage patients to accept less money than the amount to which the law entitles them. CRPs can defend against such charges if they strongly encourage all patients to consult with an attorney throughout the negotiating process.

2) **Hospitals should curate a list of top plaintiff's lawyers with expertise in negotiated settlement.** CRP participants must be able to find a competent and affordable lawyer without significant inconvenience. Otherwise, said participants may opt against retaining a lawyer. Although a hospital-curated list runs the risk of appearing biased in favor of the hospital, we believe that the convenience to the patient of such a list will benefit both the program and the patient far more than requiring the patient to seek out an attorney on her own. Of course, the hospital must do its utmost to ensure that the list contains only the best plaintiff's lawyers – any attempt to stack the list with hospital-sympathetic lawyers would undermine the credibility of the CRP.

   **The lawyers selected for this list must devise a compensation scheme that does not disincentivize patients from retaining an attorney.** We believe that hourly billing would be the most appropriate compensation system in the context of a CRP. The traditional contingency fee model assumes that medical malpractice lawyers should receive a large percentage of a patient's damages because the attorney has borne extensive risk in bringing the case to trial free of charge to the patient. The contingency model is dominant in the world of medical malpractice litigation because most plaintiffs are unable to pay their lawyers a standard hourly rate to cover the years of preparation which the lawyer must invest in the case. CRP cases are significantly less risky – the hospital has already offered a monetary settlement. The task of the lawyer in the context of a CRP is simply to review said offer and evaluate its fairness. If the offer is in fact fair, the lawyer need not expend substantial amounts of time reviewing it. Thus, an hourly fee

would be far more appropriate than a contingency fee for a lawyer tasked with reviewing the appropriateness of an offer made through CRP. Of course, if the attorney found the offer unsatisfactory and believed the case would need to be taken to trial, she would be free to negotiate a different compensation scheme directly with her client.

*3)* **Participants in CRPs require emotional support in addition to legal representation.** The hospital should provide the patient with a professionally trained specialist who can attend to the patient's emotional needs and network the patient with specialized resources where necessary. We anticipate that this role would be filled by social workers in most hospitals. The trauma of an adverse medical event makes it difficult for many patients to fully appreciate the gravity of compensation negotiations. If the patient is not provided with proper guidance in confronting such trauma, she may well be unable to adequately express her true interests in the negotiation process.

**A non-professional patient liaison should be added to the hospital's patient safety department if feasible.** This liaison would be an individual who had previously participated in a CRP. Her function would be to act as a voice of empathy and instruct the hospital as to what a patient actually feels in the midst of CRP negotiations. In other words, the function of the liaison would be something like that of a translator – she would attempt to make clear to the hospital the confusion and pain which inform the patient's every act of engagement through CARe.

The paper concludes by identifying future areas of inquiry as well as potential areas for abuse in the CRP process that plaintiff's attorneys would not be well-suited to combat. Although we believe that the representation model outlined above maximizes patient protection while meeting the interests of other key stakeholders, hospitals must be cognizant of the fact that these recommendations are not infallible. The potential for abuse remains and could easily undermine both the mission and the credibility of CRPs. We hope that in alerting hospitals and other key stakeholders to these threats, they will be prepared to prevent them from coming to fruition.

# BACKGROUND

## WHAT TYPES OF CASES THIS PAPER COVERS

This paper's recommendations and discussion of Communication and Resolution Programs (CRPs) only covers serious medical adverse events, where hospital review determines that there is, or might be, liability through a violation of the standard of care that caused medical harm. This paper does not suggest that patients should hire an attorney for every minor dispute, many of which hospitals already handle through "service quality." However, this paper does cover cases where injury was severe, but not severe enough to merit hiring an attorney under the traditional medical malpractice model.[1] That is, this paper's recommendations cover medical injuries where damage awards may only be four or five figures, as well as those that cost into the hundreds of thousands of dollars or more. Of course, since not all parties will agree on every aspect in a case, any CRP must address a broad range of cases where the hospital and patient might be unsure whether the definition of medical error was met.

Outside the scope of this report are cases where the injury is too small to merit the response of a formal CRP and also those injuries not caused by any medical error.

## TRADITIONAL MEDICAL MALPRACTICE

Traditionally, the medical malpractice (MedMal) lawsuit has functioned as the primary mechanism for resolving disputes related to medical injury. If patients[2] suffer medical harm, they can receive compensation from the hospital only if they can satisfy a two-part legal test. First, they must demonstrate a violation by the provider of the legal standard of care. Second, they must demonstrate that this violation of the standard of care caused actual injury. Both causation and a violation of the standard of care are required for a successful claim.

Suppose a patient is injured following medical care and believes her doctor to be at fault for her injury. Under the traditional MedMal system, the patient would hire an attorney to represent her in litigation. That attorney would be paid on a contingency basis; that is, the attorney would be paid from a percentage of the damages recovered through trial or settlement. Because litigation is such a lengthy process, patients usually cannot afford the hourly rate that an experienced lawyer would charge. Additionally, the attorney would most likely need to hire expert witnesses if the case ultimately went to trial. These witnesses are extremely expensive. A contingency fee model cures these issues by requiring the patient only to pay when she has money and only from her damage award. These fees are scaled by statute in Massachusetts and depend on the total amount of the settlement or trial award.[3] In Massachusetts and in other states, the total fee is often around a third of the damage award. Because being paid on

[1] *See* Joanna Shepherd, *Uncovering the Silent Victims of the American Medical Liability System,* 67 Vand. L. Rev. 151, 151 (2014)("Indeed, over half of the attorneys responded that they will not accept a case unless expected damages are at least $250,000 – even for a case they are almost certain to win on the merits. For a case in which winning is less certain, most attorneys require minimum expected damages of $500,000").
[2] Throughout this paper, we refer to patients and their families collectively as "patients."
[3] Interview with Jeff Catalano.

contingency fee is so risky (if the case is lost, the attorney receives nothing), plaintiff's attorneys will generally only accept those cases for which the potential payoff is sufficiently high to compensate their labors.

In the traditional MedMal system, hospitals react by engaging in "deny-and-defend." Under threat of litigation, hospitals enlist the help of their insurers and dedicated MedMal defense firms. These parties then strategically withhold from the patient (and her lawyer) information about what actually happened during the patient's care in order to be in the best defensive position at trial. Thus, the hospitals' lawyers respond to litigation by zealously advocating for their position. Hospitals, insurers, and lawyers determine whether the care given is defensible, whether a colorable legal argument exists that either the standard of care was met, or that any inadequate care given did not cause the injury. As a result of focusing on the legal question of whether the care was defensible, hospitals do not evaluate the injury as a learning experience or look for ways to improve care in the future. Indeed, hospitals fear that changing their care would admit that they committed error and cause additional liability.

After litigation has commenced, the hospital may settle the case or take the case to trial. If the patient either settles the case or wins at trial, a report must be filed with the National Practitioner Databank, which records the case and places it in the public record.[4]

The traditional MedMal system has several flaws:

- Settlement or trial can take years. During that time, patients (and their families) will not receive compensation. Moreover, the trial process requires the patient to relive the traumatic experience of the adverse event over and over as the various stages of litigation unfold.
- Clinicians, too, feel a secondary trauma from seeing the injured patient and may suffer feelings of guilt or sadness from contributing to the injury – even in cases where the clinician satisfied the legal standard of care.
- Litigation often adversely impacts the relationship between patient and doctor.
- When hospitals deny and defend, they do not accurately evaluate whether preventable error occurred. Consequently, they do not consider how to avoid similar errors in the future.
- By adopting a deny and defend mentality, hospitals may inadvertently encourage lawsuits; a patient may need to sue simply to acquire access to information that would explain what happened in the course of her care.[5]
- Everyone pays more because of years of attorneys' fees.

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[4] *Health Care Organizations Reporting,* THE NATIONAL PRACTITIONER DATA BANK, http://www.npdb.hrsa/gov/hcorg/aboutReporting.jsp.

[5] Carole S. Houk & Lauren M. Edelstein, Beyond Apology to Early Non-Judicial Resolution: The MedicOm Program as a Patient Safety-Focused Alternative to Malpractice Litigation, 29 HAMLINE J. PUB. L. & POL'Y 411, 417-418 (2007-2008).

- There is widespread belief that trials do not provide fair outcomes and that damage awards are not correlated with the merits of a claim.[6]

- If the patient wins at trial, damage awards are highly variable. Concerns abound about the accuracy of jury awards, especially in cases with very high awards. The politically contentious issue of tort reform often focuses on what dollar awards juries are allowed to give.[7]

These flaws fall into four main categories: the amount of **time** spent in the litigation process, the **inaccuracy of compensation**, the **lack of emotional support and communication** between the patient and the provider, and the **absence of quality improvement** because deny and defend responses to litigation impede hospitals from taking actions to prevent the recurrence of past mistakes.

## COMMUNICATION AND RESOLUTION PROGRAMS (CRP)

Hospitals began to respond to these shortcomings in the traditional MedMal system by crafting alternative models of dispute resolution. The first large institution to implement such a system was the Veterans Affairs (VA) Hospital in Lexington, Kentucky. Dr. Steve Kraman, Chief of Staff in Risk Management at the hospital from 1987 to 2003, and Ginny Hamm, the hospital attorney, decided to pioneer a model different than deny and defend litigation. In Dr. Kraman's words, they chose to behave in a "straight up" way with patients.[8] If, after an internal review, the VA hospital thought that the standard of care had been violated and that significant harm had resulted to the patient (in other words, if the VA thought a legally cognizable medical error had occurred), then the VA would undertake the following course of action: It would notify the patient and explain exactly what happened to the patient and what mistake the provider had made. The hospital then would explain that the patient was entitled to compensation, tell the patient that she should retain an attorney, and offer to negotiate a settlement. The lawyers on both sides would then negotiate the terms of a settlement. Patients who went through the process appreciated what they saw as the forthright and honest behavior of the hospital.[9]

VA management enjoyed several structural advantages in implementing this system. First, the VA Hospital could offer small amounts of compensation (under $30,000) without needing any approval from the United States Attorney's office or any other authority. Second, Dr. Kraman and the VA Hospital attorney did not have to work with any insurance organization in order to set up this system. The VA and its doctors are "insured" by the U.S. Treasury. Third, the United States Attorney's office was willing to cooperate with the VA; it did not insist on defending those cases in which the VA admitted responsibility. Fourth, doctors at VA hospitals are not *automatically* reported to the National Databank after a settlement. A reviewing panel may decide to withhold the settlement from the Databank if, in its opinion, reporting the doctor is not

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[6] *See* David A. Hyman and Charles Silver, *Tort Reform: It's the Incentives, Stupid*, 59 VAND. L. REV. 1085, 1092-1100 (2006) (reviewing literature arguing the tort system is random).
[7] *See, e.g.*, Anne Underwood, *Would Tort Reform Lower Costs?,* THE NEW YORK TIMES, http://prescriptions.blogs.nytimes.com/2009/08/31/would-tort-reform-lower-health-care-costs/.
[8] Interview with Steve Kraman.
[9] Interview with Steve Kraman.

warranted. While doctors still wanted to avoid reporting, this process alleviated some opposition from healthcare providers.

This program was the first attempt at breaking the deny-and-defend model. Dr. Kraman and Ms. Hamm did not create a formalized description of their method. Nor did they seek to have the model implemented across the VA hospital system. And, although they did not design the program specifically to save money, the program turned out to cost no more than deny-and-defend. However, because the program was informal, it was not continued in the same way when Dr. Kraman left the VA.

In 2004, Rick Boothman, Chief Risk Officer at the University of Michigan, began implementing a fully developed CRP. Unlike Dr. Kraman's policies, the CRP at Michigan was more formal – the University of Michigan eventually published several studies of the results of the program[10] – and policies provided explicitly for apologies to patients. Michigan's experiment with the CRP process has greatly reduced its MedMal costs, even though more cases have received compensation.[11] The hospital also believes that the flexibility to admit, rather than deny, lapses in the standard of care helps improve patient safety.

Michigan was the first private hospital to adopt a CRP. Advocates of CRPs, such as Mr. Boothman, believe that the model has broad applicability throughout the world of private medical practice. However, the University of Michigan also enjoys structural advantages which facilitated the adoption of its CRP. In particular, the University of Michigan healthcare system has a single captive insurer for the hospital and all doctors. Some insurance risk managers believe that many private insurers would be hesitant to begin "giving away" potentially defensible cases.

While different states have different legal landscapes, the laws of a given state have much less of an effect on the success of a CRP than the culture of the hospitals, patients, lawyers, and insurers involved.[12] In some states, any apologies from a doctor are admissible in court as evidence during a MedMal suit; others hold that apologies become admissible after a certain time period. In Washington State, only apologies within 30 days after the adverse event are inadmissible in court; later apologies are admissible.[13] Massachusetts has legally robust protections for doctor apology and disclosure statements; they cannot be admitted into court except to impeach the doctor (i.e. if the doctor's later statement contradicts her earlier statement).[14] However, despite these differences in legal rules, hospitals in both Massachusetts

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[10] *See, e.g.*, Allen Kachalia, et al., *Liability Claims and Costs Before and After Implementation of a Medical Error Disclosure Program*, ANNALS OF INTERNAL MEDICINE, 17 August 2010; *see also* Richard C. Boothman et. al, *Nurturing a Culture of Patient Safety and Achieving Lower Malpractice Risk Through Disclosure: Lessons Learned and Future Directions*, 28:3 FRONTIERS OF HEALTH SERVICES MANAGEMENT 13, 23 (2012), *available at* http://www.med.umich.edu/news/newsroom/Boothman-ACHE-Frontiers.pdf.

[11] Richard Boothman et al., *Nurturing a Culture of Patient Safety and Achieving Lower Malpractice Risk Through Disclosure: Lessons Learned and Future Directions*, 28:3 FRONTIERS OF HEALTH MANAGEMENT 13 (2012).

[12] Interview with Jeff Catalano.

[13] Wash. Rev. Code § 5.64.010.

[14] Mass. Gen. Laws. ch. 233, § 79L(b).

and Washington are developing CRPs. Because the challenges that CRPs face are relationship focused, requiring the development of trust among doctors, patients, lawyers, and insurers, the success of a CRP does not turn on the admissibility of evidence in court. Rather the structure and working relationship among all the stakeholders is the key determinant of whether the program will succeed.

In a successful CRP, hospitals and clinicians will apologize not only because they are worried about legal liability, but because it is the right thing to do. The philosophy of a CRP is a full and frank admission of mistake and an acceptance of the consequences that flow from it. Apology laws at best encourage providers and hospitals to worry less about whether they are saying something legally the "wrong way" and care more about actually communicating with the patient.

## BETH ISRAEL DEACONESS MEDICAL CENTER (BIDMC)

Beth Israel Deaconess Medical Center (BIDMC) is a teaching hospital of Harvard Medical School based in Boston, Massachusetts. It is a nationally renowned academic medical center, focusing on clinical care as well as biomedical research and education.[15] BIDMC currently serves as one of six pilot sites of a program known as Communication, Apology, and Resolution (CARe).

Along with the other pilot hospitals, BIDMC is a member of the Massachusetts Alliance for Communication and Resolution following Medical Injury (MACRMI), which was formed in 2012 with the following goals:

- Provide pilot hospitals with help in CARe implementation
- Disseminate information related to CARe implementation, gathered throughout pilot sites, to facilitate wider implementation of CARe in the state
- Promote awareness of the CARe program to other concerned parties

Other members of MACRMI include: patient advocacy groups, teaching hospitals and their insurers, statewide provider organizations, the Massachusetts Bar Association, and the Massachusetts Medical Society.[16]

[15] *About BIDMC,* BETH ISRAEL DEACONESS MEDICAL CENTER, www.bidmc.org/About-BIDMC.aspx.
[16] *About* MACRMI, THE MASSACHUSETTS ALLIANCE FOR COMMUNICATION AND RESOLUTION FOLLOWING MEDICAL INJURY, www.macrmi.info/about-macrmi/#sthash.riE2GVt4.dpbs.

# PROJECT DESCRIPTION

## BACKGROUND OF HNMCP

This project was organized through the Harvard Negotiation and Mediation Clinical Program (HNMCP) at Harvard Law School. HNMCP provides students with an opportunity to work on a semester-long project in conflict management, negotiation, or mediation, in a team of 2-3 students and a clinical supervisor. HNMCP clients have included public agencies (both state and federal), for-profit companies (both start-up and multinational), educational institutions, and religious organizations.[17]

## OBJECTIVE OF THE PROJECT

Our task was to determine the optimal model for patient representation in CRPs. We reached our findings by speaking with relevant stakeholders and reviewing relevant literature. The final deliverables include this report as well as a presentation to BIDMC and MACRMI. Although many of the stakeholders to whom we spoke are based in Massachusetts and/or affiliated with BIDMC, we hope that our report is useful for CRPs across the country.

## METHODOLOGY

Our methodology consisted of a literature review of relevant materials on medical malpractice and CRPs. A bibliography can be found at the end of the report. The literature review focused primarily on scholarly articles from academics in law and public health. It also included journal articles from practicing lawyers and CRP administrators, as well as a review of news articles related to the topic of CRPs.

Furthermore, we interviewed twenty-one stakeholders from the following categories:

- Plaintiff's attorney
- Former and current administrators of CRPs
- Patient liaison
- Nonprofit support service group
- Former patient that went through adverse event
- Hospital social worker
- Hospital risk manager
- Defense attorney
- Public health academic
- Legal academic
- Insurance claims managers
- Disclosure consultant to CRP

[17] *Harvard Negotiation and Mediation Clinic,* HARVARD LAW SCHOOL OFFICE OF CLINICAL AND PRO BONO PROGRAMS, www.law.harvard.edu/academics/clinical/clinics/hnmcp.html.

We conducted sixteen of the interviews via telephone, and five of the interviews in person. At least two out of the three team members were present for each interview. Our client, BIDMC, referred us to many of the stakeholders we interviewed. We found others through referrals from previously interviewed stakeholders.

The interviews varied in structure (some were with one stakeholder at a time; others were with two stakeholders at a time), but they all involved discussion of the following issues:

- The stakeholder's role in CRPs (if any)
- The stakeholder's interests related to CRPs
- The stakeholder definition of the pros/cons of CRPs
- The stakeholder's view on the best form of patient representation
- The stakeholder's view of potential future challenges confronting CRPs

We also note that we did not interview any patients who have gone through a CRP. Reasons for this included confidentiality concerns (on behalf of both the hospital and the patient). However, we strove to capture patients' voices in two ways. First, we reviewed secondary sources that involved patient interviews. Second, we interviewed stakeholders who work directly with patients.

Our investigation also sheds light on the feasibility of various models of patient representation. While this report will address best practices and recommendations, rather than implementation, it would be of little use to provide recommendations if they were not likely to be implemented. Thus, we made our recommendations based in part on how achievable they would be, considering available resources and current attitudes among stakeholders.

## STAKEHOLDER INTERESTS

The following chart maps out some of the more significant interests of the relevant stakeholder categories. We explore in more depth the interests of stakeholders in the body of the report.

*Shared Interests*

Attorney with MedMal experience
Trust between parties
Faster resolution
Higher quality of care

*Non-Shared, Non-Conflicting Interests*

Ensuring agreements are binding
Insurance costs
Job satisfaction

*Potentially Conflicting Interests*

Reporting to the National Practitioner Databank
Financial liability
Reduced attorney fees
Profit motive

*Conflicting Interests*

Financial compensation

| | CONFLICTING INTERESTS | Hospitals<br>H | Insurers<br>I | Defense Attorneys<br>Δ | Plaintiff's Attorneys<br>π | Patients<br>P |
|---|---|---|---|---|---|---|
| ● | Reporting to the National Practitioner Databank | ↓ | | | | ↑ |
| ● | Legal liability | ↓ | ↓ | ↑ | ↑ | ↑ |
| ● | Reduced attorney fees | ↑ | ↑ | ↓ | ↓ | ↑ |
| ● | Profit motive | | ↑ | | | ↓ |
| ● | Financial compensation | ↓ | ↓ | | | ↑ |

MAJOR FINDINGS AND RECOMMENDATIONS

# MAJOR FINDING A: AN ATTORNEY CAN BEST FULFILL KEY STAKEHOLDERS' INTERESTS IN THE CONTEXT OF CRP NEGOTIATIONS

An attorney can effectively represent the patient's interests and in doing so, helps meet many of the shared interests of other key stakeholders. Attorneys can help patients receive adequate compensation and obtain and interpret important information concerning the adverse event. Concerns regarding the participation of an attorney in an alternate dispute resolution system can be mitigated so long as (1) the patient finds the right kind of attorney and (2) other stakeholders are prepared to deal with the patient's attorney. We suggest the "right" attorney is one that has experience with both MedMal and with representing plaintiffs. The presence of attorneys is also critical for building the public perception of CRPs as fair, which is a key interest for hospitals.

We note that some stakeholders discussed the possibility of using neutral parties in some capacity (e.g. an expert panel composed of a defense attorney, plaintiff's attorney and medical expert) to review compensation offers made to patients. However, there are too many uncertainties surrounding the efficacy of a neutral party to express patient's needs and too many difficulties regarding how such a neutral party would be compensated, retained, and comprised. By contrast, the use of experienced MedMal plaintiff's attorneys presents far fewer uncertainties of effectively advocating for patients and fewer difficulties in terms of finding and paying for their services.

## AN ATTORNEY CAN HELP FULFILL MANY PATIENT INTERESTS IN CRP

### PATIENT INTEREST: RECEIVING COMPENSATION

Patients have an interest in receiving fair and adequate compensation after an adverse event. Stakeholders varied in their views on how important this desire for compensation would be for the typical patient. For instance, Mary McDonough, a social worker, stated: "Patients resort to monetary compensation when they feel as though people aren't listening to them."[18] Ms. McDonough's statement implies that the desire for compensation is secondary to the desire to be heard. On the other hand, Dr. Michelle Mello, professor at the Harvard School of Public Health, opined that while "not all patients want money, most of them do."[19]

[18] Interview with Mary McDonough.
[19] Interview with Michelle Mello.

Patients often struggle to procure adequate compensation on their own. Patients' requests for compensation, when made without the advice of counsel, tend to be modest or insufficient.[20] There are several reasons for this phenomenon.

One potential reason that the unrepresented may not receive adequate compensation is that such patients would not know the appropriate amount to ask for. The full physical and emotional impacts of an adverse event may remain unknown for many months or even years after its occurrence. With the effects of the adverse event unknown, the patient may not appreciate how much compensation she will actually need. For instance, patients that suffer adverse events do not always recover as their physicians predict. In some cases, the impact of an adverse event may grow worse over time. If the patient is an infant, it may take years to tell whether the adverse event has had any developmental impacts;[21] it may take even longer to determine whether the child will be permanently disabled. [22]

A patient cannot properly evaluate the amount of monetary compensation she will need unless she has a strong understanding of her long-term prognosis. As plaintiff's lawyer Jeff Catalano remarked, "What seems minor may not be minor."[23] While this difficulty in assessing the actual damages caused by an adverse event suggests that uncertainty could result in both over-compensation *and* under-compensation, stakeholders were much more concerned that uncertainties would lead to under-compensation.[24] Because patients generally lack medical or legal expertise, they rarely have a sense of potential future damages; they only understand their immediate needs. If the patient were willing to settle in satisfaction of those immediate needs alone, the patient would never be over-compensated, as a patient's total damages will never be less than her immediate needs.

Additionally, patients feel uncomfortable asking for compensation. One stakeholder commented on how rare it was for patients to "negotiate on their own for anything," unless what they were looking for was "absolutely clear," such as missed wages from a week of work or a certain dollar amount for discrete medical expenses.[25] A likely reason for this behavior is that patients do not know how to value the "worth" of their pain and suffering. This ignorance may cause them to feel less comfortable or less able to ask for compensation for these seemingly unquantifiable items.

Patients also fear that asking for compensation will sour their relationships with care providers or cause them to receive worse care. A patient may refuse compensation because of concerns that accepting it would interfere with other interests. One such interest is preserving the patient's relationship with her provider. Dr. Kraman, the former manager of the CRP at the VA hospital in Lexington, KY, told us that, in his experience, some patients felt that "to accept compensation would destroy the good feelings" that developed between the patient and the hospital after the disclosure and apology conversation. Patients refused compensation "even though they

[20] Interview with Doug Wojcieszak; Interview with Rick Boothman; Interview with Steve Kraman.
[21] Interview with Jeff Catalano.
[22] Interview with Beth Cushing.
[23] (Interview with Jeff Catalano.
[24] E.g., interview with Lynn Tenerowicz.
[25] Interview with Beth Cushing.

clearly deserved it." The hospital then had to convince the patient to take the money; it also had to assure the patient that her relationship with the hospital would not change.[26]

For other patients, the decision to accept little or no compensation may stem from a desire to avoid the conversation about compensation in the first place. Some family members of patients that pass away due to adverse events may find discussions about money "disgusting."[27] Other patients may feel that if the hospital approaches them with a conversation about compensation, the hospital is just trying to buy them off.[28]

## HOW AN ATTORNEY CAN FULFILL A PATIENT'S COMPENSATION INTEREST

***An attorney knows what to ask for.***

Experienced medical malpractice attorneys can help patients receive fair and adequate compensation.

Unlike patients, these attorneys "know how to ask the right questions" throughout the process.[29] Thus, the right attorney can help the patient navigate the uncertainties surrounding the effects of an adverse event – both long-term and short-term. The attorney can also assess how much compensation the patient will need to be made whole and make that request of the hospital.

In addition to assessing how much the patient needs to cover quantifiable expenses such as future medical costs and missed wages, an experienced medical malpractice attorney can also assess how much the patient should receive for pain and suffering. The attorney possesses this expertise because she would be familiar with the value of settlements or jury awards in similar cases.

Attorneys can therefore anticipate patients' needs and also plan for unexpected changes in those needs. Thus, the needs of a patient should be adequately reflected in any resolution reached with attorney assistance.

***An attorney knows how to ask for it.***

Unlike some patients, attorneys will not experience discomfort related to conversations about compensation. As Jeff Driver, Chief Risk Officer at Stanford University, put it, the attorney can "separate the money from the emotion."[30] Attorneys can also help patients receive adequate compensation because they know how to overcome certain structural factors of the existing medical malpractice and insurance frameworks. For example, some insurers may require the submission of a written claim before any compensation can be paid.[31] As one stakeholder from an insurance company told us, in order for patients to be compensated through her company,

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[26] Interview with Steve Kraman.
[27] Interview with Rick Boothman.
[28] Interview with Winnie Tobin. On the other hand, proactively talking about compensation could make the patient feel like the hospital really is taking the adverse event seriously. *Id.*
[29] Interview with Winnie Tobin.
[30] Interview with Jeff Driver.
[31] Insurers do not always have this requirement of written claims for compensation. We note that the CARe program at BIDMC has compensated patients without a written claim.

"the patient or patient's representative needs to be the one to say, 'There is a problem and I want compensation.'"[32]

In addition, some CRPs may not operate on the presumption that patients want compensation.

> "There should be a presumption that patients do want compensation; the money is not just [expressive] of the hospital's apology. People really do need money." – Professor Michelle Mello, public health academic

We note that many hospitals with a CRP, including BIDMC, have made great strides in adopting the presumption that patients in fact require monetary assistance after an adverse event, even if they do not ask for it. However, our stakeholder interviews suggested that there is still room for improvement on this issue. For instance, Leilani Schweitzer, patient liaison at Stanford University Medical Center, stated there is a need to move past the notion of "if a patient doesn't ask for it, why bother?" Ms. Schweitzer agreed with Professor Mello that it would be more accurate to presume that a patient always needs help.[33]

Unless hospitals adopt this presumption, the burden will fall on the patient to affirmatively request what she believes to be fair and adequate recompense. An attorney can help with making these requests explicit and formalized. For instance, if the insurer requires a written claim, an attorney who understands the formalities of such a claim will make sure it is submitted properly.

### SHARED INTEREST: HOSPITALS ALSO HAVE AN INTEREST IN PATIENTS RECEIVING FAIR COMPENSATION

Every hospital has an interest in promoting the credibility of its CRP. A hospital can satisfy this interest most readily if it builds a reputation of offering fair settlements to CRP participants. As disclosure-training consultant Doug Wojcieszak put it, a hospital does not want to be "known as a rip-off shop."[34] Several stakeholders articulated the importance of maintaining "integrity" in CRP settlement offers. Each offer must seem fair to an outside observer and pass the proverbial "smell test."[35] Thus, if attorneys can help patients receive fair compensation, both the patient and the hospital will benefit from ensuring that patients have access to attorney representation.

### PATIENT INTEREST: UNDERSTANDING THE ADVERSE EVENT

A patient who has suffered an adverse event wants access to information concerning how and why the event occurred. The patient will also want to understand the possible future consequences that may arise as a result of an adverse event.

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[32] Interview with insurance claims manager.
[33] Interview with Leilani Schweitzer.
[34] Interview with Doug Wojcieszak.
[35] *Id.*

Yet patients are often unable to process the information that they receive from the hospital. Many stakeholders commented on patients' emotional vulnerability and expressed concern that potential trauma resulting from the adverse event could impede the ability to integrate information from the hospital.[36]

Furthermore, as Linda Kenney, director of the nonprofit support group Medically Induced Trauma Support Services (MITSS), pointed out: "the patient doesn't know what the patient doesn't know."[37] This statement suggests that patients are not even aware of the information to which they should want access.

Another barrier to patient understanding is unclear communication from the hospital. According to Mary McDonough, social worker at BIDMC, a frequent complaint from patients concerns ineffective communication on the part of the hospital. As Ms. McDonough explained, patients may feel there are "too many doctors" telling the patients "too many things."

## HOW A LAWYER CAN HELP THE PATIENT UNDERSTAND THE ADVERSE EVENT

Almost every stakeholder commented on the emotional trauma that the patient suffers as a result of experiencing an adverse event. This trauma, in turn, can negatively impact a patient's ability to integrate information from the hospital.

While an attorney is not the *only* resource that would help a patient to better understand the nature of her adverse event, an attorney can be instrumental in helping the patient to access and interpret information from the hospital. The attorney can process information from the hospital and insurance companies and respond to them in a way that the patient may be unable or unprepared to do, as the patient is likely to struggle with the medical, emotional, and financial impact of the injury.[38] Furthermore, an experienced medical malpractice attorney knows what questions to ask if she believes information is missing. In addition, while the patient may be overwhelmed by "too many doctors," the attorney is likely to be experienced in conversing with several providers at once. The attorney should be able to process such conversations effectively.

Another way an attorney could help the patient understand the adverse event is by providing the patient with the attorney's own substantive medical knowledge. An experienced MedMal attorney is likely to have encountered similar adverse events in her career and could serve as another source of information for the patient.

## PATIENT INTEREST: UNDERSTANDING THE RESOLUTION

A patient has an interest in understanding the terms of the resolution reached with the hospital, just as she has an interest in understanding the facts surrounding her adverse event.

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[36] Interview with Winnie Tobin; Interview with Jeff Catalano.
[37] Interview with Linda Kenney.
[38] Interview with Jeff Catalano.

Many of the same barriers that impede patients from understanding information about adverse events also prevent patients from understanding the nature of the resolution. First, the patient is still likely to be struggling with the various personal issues that follow in the wake of an adverse event. Thus, the patient may not be well prepared to negotiate an enduring agreement. Furthermore, the resolution may contain legal terms that the patient would not understand, even if the patient were not in an emotionally vulnerable state. Finally, even if patients know the literal meaning of certain terms in an agreement (e.g. confidentiality clauses), many patients may not understand what they must do in order to comply.

## HOW A LAWYER CAN HELP: EXPLAINING THE RESOLUTION AND ENSURING FAIRNESS

The attorney can review the terms of any potential resolution. This review would entail an assessment as to whether the offer proposed is adequate to meet the patient's long-term, as well as short-term, monetary needs.[39] Attorneys can also review the substantive legal provisions of a resolution. These include things like confidentiality and lien clauses which impose legal obligations on the patient after settlement and which the patient will be asked to sign upon receiving any offer of compensation.[40]

In addition, if the agreement is vague or unclear, an attorney is able to ask clarifying questions on behalf of the patient. Thus, the attorney helps to ensure that the patient understands the agreement.

## SHARED INTEREST: REACHING A DEAL THAT "STICKS"

The hospital and insurer have an interest in reaching a resolution that "sticks" – i.e. a resolution that prevents patients from claiming that they received insufficient compensation.[41] This interest encompasses both legal and business concerns. A hospital does not want to risk having settlements thrown out by judges who believe that the hospital created unfair power imbalances by not encouraging traumatized patients to retain an attorney.[42] Furthermore, every hospital wants to develop a reputation for excellence in patient relations. It would not reflect well on the hospital to reach settlements with unrepresented patients if those patients later complained that the settlement offers which they signed were somehow unfair or inappropriate.

Patients that fully understand the legal consequences of a resolution are less likely to return to the hospital with complaints that they are dissatisfied.[43] Since attorneys help to ensure that patients in fact understand the settlement terms that are offered to them, both the hospital and the patient stand to benefit if the patient is represented by an attorney during the CRP process.

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[39] Interview with Jeff Catalano.
[40] Interview with Jeff Catalano.
[41] *E.g.*, interview with Rick Boothman.
[42] *See supra*, note [38]; *see also* interview with Jeff Driver (raising concern of making binding agreements).
[43] Patients are unlikely to accept offers that they in fact understand unless they find such offers reasonable.

## ENSURING PATIENTS HAVE COMPETENT LEGAL REPRESENTATION IS IN THE INTEREST OF HOSPITALS AS WELL

### SHARED INTEREST: AVOIDING CONFLICTS OF INTEREST

While hospitals and insurers want patients to be fairly compensated, the fact remains that there is a potential conflict of interest between the patient and the hospital after an adverse event. This conflict of interest stems from the fact that the parties – the provider and the patient – can become adversaries in a lawsuit if CRP negotiations prove unsuccessful.

Indeed, even if the negotiations are going well, the hospital cannot "play both sides of the fence."[44] That is, as much as all parties want to reach a resolution that is fair to the patient, at the end of the day, the insurer and lawyers for the hospital have obligations to the providers and to the hospital, not to the patient.[45]

Negotiating with a patient directly, i.e. without an attorney, is a barrier to hospitals avoiding a conflict of interest. As one stakeholder put it, because patients are "not acquainted with what they should be getting, or what their needs are," the insurer and hospital end up educating the patient about these issues. [46] This situation is less than ideal, because educating the patient is not the proper role of the hospital or insurer, and because of the potential conflict of interest.

### HOW AN ATTORNEY CAN HELP: ADVOCACY FOR A SINGLE PARTY

An attorney is well equipped to represent the patient in the potentially adversarial CRP negotiations. The patient's retention of an attorney avoids implicating either the hospital or the insurer in a conflict of interest because, unlike the hospital or the insurer, the attorney has an affirmative obligation to act in the patient's best interest. Furthermore, if the attorney is experienced in medical malpractice, the attorney will have a better sense of what the patient's needs are and what the patient should ask for, relieving the hospital and insurer of the burden of educating the patient on those issues.

### HOSPITAL INTEREST: AVOID OVERWHELMING PATIENT

Hospitals also have an interest in making sure that they do not overwhelm patients during CRP negotiations.

The existing power imbalance between patients and hospitals does not usually result from hospitals intentionally trying to overwhelm the patient during CRP negotiations. In many CRPs, hospitals work in good faith to compensate the patient fairly, even if the patient lacks an

[44] Interview with Rick Boothman.
[45] Interview with Beth Cushing.
[46] Interview with Beth Cushing.

attorney. However, as patient liaison Leilani Schweitzer put it: "Goodwill does not always translate into fair outcomes."[47]

Thus, while hospitals may well act in good faith during CRP negotiations, they still may end up overwhelming the average patient. Matt Connors, a defense attorney based in Boston, stated that without a lawyer, the average person "would feel somewhat overwhelmed by that process, sitting in a room with a risk manager, a couple of physicians, [and a] defense lawyer." Despite the fact that Mr. Connors himself is an experienced defense attorney, he remarked that he, too "would feel overwhelmed."[48]

Further complicating the issue of power imbalance is the fact that hospitals may not be aware of just how overwhelming CRP meetings can be for unrepresented patients. Diann Seigle, executive director of Carolina Dispute Settlement Services, a non-profit that works on implementing a CRP in North Carolina, pointed out that hospitals may be unaware that CRP meetings can further traumatize patients.[49]

## HOW AN ATTORNEY CAN HELP: COUNTERING THE PRESENCE OF HOSPITALS' AND INSURERS' ATTORNEYS

Attorneys may not have an explicit objective to ensure that patients avoid feeling overwhelmed in CRP negotiations. However, their very presence may help to balance the fact that the hospital and its insurers are represented by their own attorneys. This, in turn, may help patients feel less overwhelmed (and thus less traumatized) by the CRP process.

## HOSPITAL INTEREST: MAINTAINING PERCEPTION AND PRACTICE OF FAIRNESS

Hospitals with CRPs have an interest in reaching substantively fair agreements. They also have an interest in *seeming* fair, both to patients and to the public more generally. Appearing fair helps to promote the credibility and legitimacy of the CRP process, which, in turn, strengthens trust and public confidence in the CRP.

## HOW AN ATTORNEY CAN HELP: PUBLIC PERCEPTION

One way to avoid becoming known as a "rip-off shop" would be for the hospital to make efforts to ensure patients have adequate representation. As Matt Connors commented, if a patient did *not* have an attorney or "someone looking out for [her]," one might have reason to be suspect of any resolution reached.[50] Leilani Schweitzer of Stanford stated that adequate patient representation would increase the legitimacy of the CRP process.[51] Ensuring that patients have access to a good attorney not only brings credibility but also "respect," according to Diann Seigle.[52] Stakeholders interviewed for a previous assessment identified "ensuring legal

[47] Interview with Leilani Schweitzer.
[48] Interview with Matt Connors.
[49] Interview with Diann Seigle.
[50] Interview with Matt Connors.
[51] Interview with Leilani Schweitzer.
[52] Interview with Diann Seigle.

representation" as a strategy to overcome the barrier of perceived fairness and accountability.[53]

## HOSPITAL INTEREST: REACHING RESOLUTIONS

Hospitals have an interest in reaching resolutions through CRPs. Yet hospitals' good intentions to reach a resolution are often not sufficient to arrive at satisfactory settlement agreements; some degree of patient cooperation is also required.

> "Folks think that by altruistically doing the right thing, a resolution will be reached, but that's not the case." – Lynn Tenerowicz, chief risk officer at BIDMC pilot site Baystate

One potential barrier to reaching a resolution is the unwillingness of some patients to participate in a CRP. In addition, some patients may be unreasonable or unrealistic in their demands for compensation. Several CRPs have identified the "challenge to keep families from having unrealistically high expectations for compensation."[54] Furthermore, if it is determined that the standard of care was met, patients may still expect to receive compensation simply because intended results were not achieved.

## HOW AN ATTORNEY CAN HELP: HELPING PATIENTS BECOME COMFORTABLE WITH THE PROCESS AND SUBSTANCE OF CRP

With an attorney guiding them through the process and providing them with the relevant medical and legal information, patients may be more willing to settle for reasonable offers. One study found that in some CRPs, attorneys were "welcomed" for their ability to "manage patients' expectations about the value of the case." The involvement of attorneys "frequently facilitated resolution."[55]

Attorneys could actually educate patients regarding the CRP process[56] and encourage families that may have previously been unwilling to engage in conversations to come to the table. In addition to getting patients to try to reach a resolution through the CRP process, attorneys can help calibrate the patient's expectations about alternatives to CRP – that is, about the risks of traditional medical malpractice litigation.[57] Some patients may have unrealistic views on how much their cases are worth and may want to go to trial instead of trying to reach a resolution through a CRP.

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[53] Beth Israel Deaconess Medical Center & Massachusetts Medical Society, *A Roadmap for Removing Barriers to Disclosure, Apology and Offer in Massachusetts*, May 2011 (provided by client).
[54] Michelle Mello et al., *Communication and Resolution Programs: The Challenges and Lessons Learned from Six Early Adopters* 33(1) HEALTH AFFAIRS 20 (2014).
[55] *Id.* at 24.
[56] Interview with Lynn Tenerowicz.
[57] Interview with Peg Metzger.

It is important to note that an attorney's ability to facilitate the CRP process and to reach a resolution is highly dependent on the attorney's experience and expertise. We discuss the characteristics that an ideal attorney in a CRP below.

## THE ADEQUATENESS OF PATIENT REPRESENTATION DEPENDS ON THE ATTORNEY'S SUBSTANTIVE EXPERTISE AND EXPERIENCE

As Sarah Armstrong, administrator of the CRP at the University of Washington, told us: once you bring a bad lawyer into the mix, "you're asking for chaos."[58] Bad lawyers are a cause for concern because these lawyers do not know how to support a patient through an alternative dispute resolution procedure or how to adequately value the case before them. For a CRP to succeed, both parties to the negotiation must arrive at the table with similar background knowledge. Both parties must have a deep understanding of both legal and medical concerns.[59] In order to prevent patients from getting a *bad* lawyer, we outline what makes a *good* lawyer in this section.

### THE ATTORNEY SHOULD HAVE A BACKGROUND IN MEDICAL MALPRACTICE

An experienced medical malpractice attorney will be realistic about the risks of going to trial. As we discussed earlier, medical malpractice attorneys understand how much cases are worth, based on what the patient's injury is, what the patient will require to be made whole, and what the expected value of going to trial would be. This understanding of the complexities and risks of medical malpractice litigation means that a medical malpractice attorney will not be unduly bullish about going to trial. The attorney can therefore also help the patient understand the risks of going to trial based on a number of factors, such as the complexity of the case, demographics, the location of the trial, etc.[60]

### THE ATTORNEY SHOULD BE EXPERIENCED

Many stakeholders also emphasized the importance of having *experienced* attorneys represent patients. Rick Boothman, head of the CRP at Michigan, stated his preference for working with

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[58] Interview with Sarah Armstrong.

[59] Stone et al. provide a useful framework for understanding substantive disagreements, the Ladder of Inferences. According to the Ladder of Inferences theory, our conclusions are drawn from a combination of what we see mixed with our mental processing. If people evaluating a situation either "see" different information or experience different mental processes, then they will disagree on their assessment. A lawyer without the proper substantive legal and medical experience will frequently disagree with the hospital's attorneys because the inadequate plaintiff's attorney will often observe and/or process factual information differently than the defense teams. This problem can only be resolved by if the patient retains an experienced and competent representative. *See* DOUGLAS STONE ET AL., *Stop Arguing About Who's Right: Explore Each Other's Stories*, DIFFICULT CONVERSATIONS 27, 30 (2nd ed. 2010).

[60] Interview with Jeff Catalano.

experienced attorneys.

> "I am benefited by dealing with someone who knows what they're doing." – Rick Boothman, Chief Risk Officer, UMHS at University of Michigan Health System

Matt Connors, a defense attorney, similarly opined that dealing with inexperienced plaintiff's attorneys is "where the problems are." One problem Mr. Connors described was when "[plaintiff's attorneys] tell you they want $750,000 for something that is worth $15,000."[61]

### IF POSSIBLE, THE ATTORNEY SHOULD HAVE EXPERIENCE REPRESENTING PLAINTIFFS

The most important aspect of an adequate attorney for patients in CRPs is experience with medical malpractice cases. We further recommend that, if possible, the attorney should have experience representing plaintiffs. As Norm Tucker, a plaintiff's attorney in Ann Arbor, Michigan, told us, issues that would "jump out at a plaintiff's attorney" would not necessarily be obvious to another attorney with medical malpractice experience, such as a defense attorney or a judge.[62] That is, plaintiff's attorneys might already be in the habit of looking for certain issues that are important to protect patient interests.[63]

## THE CONCERNS ABOUT BRINGING ATTORNEYS INTO THE CRP PROCESS SHOULD BE MITIGATED BY OUR RECOMMENDATIONS

We recognize that our recommendation that most patients should retain an attorney may sound like a threat to the collaborative spirit of CRPs, particularly given many popular perceptions of attorneys as hostile and litigious. We explore some of these concerns below, followed by reasons why they are either overstated or should be mitigated by the recommendations in this report.

### CONCERN: ATTORNEYS INEVITABLY MAKE DISCUSSIONS ADVERSARIAL

Several stakeholders suggested that the tenor of the conversation between the patient and the hospital may change with the introduction of an attorney. Specifically, they worried that the conversation could become adversarial.[64]

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[61] Interview with Matt Connors.
[62] Interview with Norm Tucker.
[63] For similar reasons, we recommend that patients in hospitals with unique settings should get an attorney that has experience working in that system. For instance, patients at the VA hospital should have an attorney who has experience working in the federal system.
[64] E.g., interview with Winnie Tobin.

Indeed, part of the reason that some CRPs do not encourage legal representation is because of the belief that attorney participation makes "resolution discussions adversarial" and "hinder[s] administrators' attempts to develop a positive relationship with patients."[65]

We note that an adversarial process need not be a hostile one. Rather, an adversarial process ensures just and fair resolutions by providing strong advocacy to both sides of a dispute. There is nothing normatively wrong with an adversarial discussion; what is important is that proper safeguards exist to prevent the adversarial process from becoming antagonistic. As we discuss later in this report, we do not believe that all attorneys possess the skills, demeanor, or experience necessary to facilitate collaborative CRP negotiations.

## CONCERN: ATTORNEYS WILL PROTRACT NEGOTIATIONS

Another potential concern with involving attorneys in the CRP process is the fear that attorneys may engage in hard-bargaining techniques such as making misleading statements or obscuring whether they can commit to proposed settlements.[66]

We believe that this concern is likely overstated. Most of the stakeholders we interviewed believed that the bulk of plaintiff's attorneys would negotiate in good faith. For example, Beth Cushing, vice president of claims at CRICO, stated that in her experience, both plaintiff's and defense attorneys in Massachusetts are "cordial." Ms. Cushing described a few instances where the patient's attorney "took complete advantage of the situation… and entered into harsh negotiations to increase the amount of money [offered]." However, Ms. Cushing further pointed out that these instances are "rare." Lynn Tenerowicz, chief risk officer at BIDMC pilot site Baystate, echoed this sentiment when she stated, "There are a few unreasonable plaintiff's attorneys out there, but overall, the folks who do the majority of med mal are reasonable."

## CONCERN: ATTORNEYS ARE OVERLY LITIGIOUS

One might worry that attorney involvement in the CRP process would lead to situations in which the collaborative spirit of the CRP was undermined by the attorney threatening to go to trial. Yet plaintiff's attorneys understand the uncertainties and risks attending the decision to take a case to trial. In the words of Jeff Catalano (who is himself a plaintiff's attorney), there are simply "too many risks of going to trial." Thus, we would not expect an attorney to act bullishly and end negotiations unless the attorney truly thought that such a course of action was necessary.

[65] Mello, *supra* note [58], at 20.
[66] *See generally* ROGER FISHER ET AL., *What If They Use Dirty Tricks? (Taming the Hard Bargainer)*, GETTING TO YES, 131, 131-45 (3rd ed. 2011).

## IMPEDIMENTS TO ENSURING ATTORNEY REPRESENTATION OF PATIENTS IN CRP

Below we discuss how stakeholders affected by CRPs can work together to achieve the goal of adequate patient representation.

**Impediment: Resistance from the plaintiff's bars.**

As we mentioned earlier, a successful model of patient representation requires patients to have access to competent and experienced attorneys. We suggest a few ways that the plaintiff's bar can, through shifting its beliefs and perceptions about its own role in CRP and its own business model, improve patient representation.

CRPs offer a more expansive view of the role of both plaintiff's and defense attorneys. Although the CRP process may seem intuitive, it actually presents a dramatic shift from the traditional medical malpractice system. In light of this shift, it is not surprising that several stakeholders commented on visualizing the role of the attorney – on both sides of the CRP process – as broader than before.

Rick Boothman, director of the CRP at the University of Michigan, described a conversation he had with a plaintiff's attorney who represented a patient in a CRP settlement. After the process, the patient's attorney said he saw his role change, "from advocate and warrior" to "counselor" and "architect" – "more of a builder than a salvager."[67]

**Attorneys should have some training or education in CRP.**

Because most plaintiff's attorneys do not at present have experience with CRP negotiations, some training in the CRP process may be necessary.[68] The attorney must provide "vigorous representation" for the patient while remaining "open to settlement,"[69] even through new mechanisms like a CRP process.

Similarly, defense attorneys must also rethink their goals in light of the collaborative aspirations of a CRP. The mark of an effective defense attorney in a CRP setting is not, "Can I defend any conduct?" but rather, "Can I work to ensure that the patient is adequately compensated?"

Educating the attorneys for both sides in the CRP process can improve outcomes for all involved.

**Plaintiff's attorneys should embrace the new model of compensation.**

As we discuss later in Major Finding B, patients' attorneys should probably not be compensated in the same manner as they are for traditional medical malpractice lawsuits – that is, through a contingency fee. Instead we recommend that patients' attorneys be paid hourly. However, this recommendation is likely to face some opposition from members of the plaintiff's bar, who will likely represent most patients in CRP. Plaintiff's attorneys may feel that this model will reduce their overall income. Thus, in order for our recommendation to take hold, there may need to be some

[67] Interview with Rick Boothman.
[68] Interview with Jessica Scott and Diann Seigle; Interview with Leilani Schweitzer.
[69] Interview with Michelle Mello.

education of the plaintiff's bar and encouragement to embrace the new model of compensation.

Hospitals will need to show plaintiff's attorneys that this new model of hourly pay will benefit them in the long run. Many stakeholders commented on the need for plaintiff's attorneys to take a long-term view of CRPs and trust that they will "pay off" in the future.[70] While the typical contingency fee pay from a successful lawsuit may be much higher for an attorney than hourly pay, hourly pay is significantly more consistent and comes with far fewer risks and incentives. Overall, plaintiff's lawyers should support the switch.

**Hospitals can play a role in this shift in attitudes among the plaintiff's bar.**

Hospitals with CRPs can take steps to proactively engage and educate the plaintiff's bar about their disclosure programs. Doug Wojcieszak encourages hospitals to explain to plaintiff's lawyers that the hospitals will "remain engaged with patients and families post-event, welcome the participation of plaintiff's counsel during the process, attempt to understand what happened during the adverse event in a collaborative fashion, and, finally, resolve all situations in a fair and expedited fashion." Hospitals have the power to bring the plaintiff's bar on board with the new system.

**Impediment: Stakeholder groups are uncomfortable with speaking to plaintiff's attorneys.**

We discuss how patients may be uncomfortable speaking to attorneys in the section of this report entitled "Informing Patients About Attorneys." Stakeholders also told us that other individuals in the CRP process might not be comfortable speaking with plaintiff's attorneys[71] and suggested reasons for this discomfort.

One group that might be reluctant to engage with plaintiff's attorneys is lawyers for the hospital and insurers. Rick Boothman pointed out that before occupying his current position, he had years of experience as a trial attorney. This experience meant that he was accustomed to working with plaintiff's attorneys on a regular basis. By contrast, many in-house counsel at hospitals and insurance companies lack this trial experience and by extension, are not accustomed to dealing with plaintiff's attorneys. This lack of familiarity may prime in-house counsel to be less willing to engage with plaintiff's attorneys.

Hospitals can help their lawyers (and the lawyers of their insurers) overcome any discomfort in dealing with plaintiff's attorneys by educating the defense-side legal team as to as to what exactly it should expect in its conversations with plaintiff's attorneys during CRP negotiations. Hospitals can devise different ways to provide this education; depending on the individual personalities of the attorneys on the defense side.

Other groups that may have an ingrained fear of dealing with plaintiff's attorneys are clinicians and practitioners. Many stakeholders commented on how clinicians may feel vulnerable and fearful of the consequences of an adverse event. These negative feelings on behalf of the

[70] Interview with Michelle Mello; Interview with Larry Smith.
[71] Although our report specifically addresses stakeholder reactions to plaintiff's attorneys, we note that stakeholders who feel uncomfortable with plaintiff's attorneys may well feel similarly uncomfortable and resistant to any type of attorney representing patients in a CRP process.

clinicians after an adverse event can be so severe that some call clinicians the "second victim" of an adverse event.[72] There are many reasons why physicians are fearful after an adverse event. For one, there is the chance that they will be reported to the National Practitioner Data Bank, which can affect a clinician's reputation and career. In addition, stakeholders suggested that among the community of clinicians, there is a certain shame in admitting mistakes.[73] So physicians may be uncomfortable with communicating about an adverse event – and the prospect of adding a plaintiff's attorney to the mix may inspire even more feelings of dread.

> "It is radical to tell the truth; it is even more radical to embrace the plaintiff's bar." – Leilani Schweitzer, patient liaison

Clinicians, in addition to patients, are in need of emotional support after an adverse event.[74] It has been recommended in the past that providing emotional support for clinicians can help with disclosure and reporting, because clinicians will feel safer reporting.[75] We suggest that providing emotional support to clinicians can also serve the purpose of making clinicians more comfortable when working with the attorneys representing patients in the CRP process.

For instance, the Roadmap for Removing Barriers to Disclosure, Apology and Offer in Massachusetts (Roadmap)[76] identified physician discomfort with disclosure as a barrier to CRP implementation and suggested preparing physicians for "challenging bedside conversations." Similarly, we suggest preparing physicians for bringing lawyers into the mix. If physicians feel safe and supported before they interact with attorneys, they may become more open to the idea of patient representation.[77]

## ATTORNEY INVOLVEMENT AS AN ANSWER TO CRITICS OF CRP

Critics of the CRP process worry that patients will confuse the hospital's willingness to apologize and pursue corrective action with impartiality in the valuation of damages. Furthermore, because some CRPs discourage – or in the case of COPIC in Colorado, prohibit[78] – patient communication with a lawyer, these programs leave open the possibility that traumatized

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[72] Interview with Steve Kraman.
[73] Interview with Winnie Tobin; Interview with Gabriel Teninbaum.
[74] Interview with Linda Kenney.
[75] How exactly to provide this kind of emotional support, however, is not always clear, even to experienced professionals. Steve Kraman, who had 17 years of experience leading a CRP, stated that although he recognized the need of providing emotional support for clinicians, he was not completely sure on how to go about this. As he stated, "Referring doctors to psychologists does not go very well."
[76] Beth Israel Deaconess Medical Center & Massachusetts Medical Society, *A Roadmap for Removing Barriers to Disclosure, Apology and Offer in Massachusetts*, May 2011.
[77] *Id.*
[78] Interview with Gabriel Teninbaum.

patients, uneducated as to their legal rights, might accept "less compensation than the law entitles them."[79]

Professor Gabriel Teninbaum of Suffolk Law School has argued that the primary problem with CRPs today is that "patients are not aware of the inherent conflict of interest the risk managers have." This may result in patients confusing the "willingness of a provider to communicate with the willingness of a provider to compensate them fully."[80] Teninbaum concludes that "the first and most important step is to require apology programs to allow their patients a real opportunity to educate themselves on their rights before being influenced to settle."[81] Joanne Doroshow, at the Center for Justice and Democracy at New York Law School, has also been openly critical of CRPs, arguing that they shortchange patients and do not provide the safety benefits promised.[82] Her critiques focus on the difficulties which confront patients who seek to navigate the complex elements of any hospital-proposed settlement.[83] Robust patient representation through a lawyer would alleviate these major concerns.

As of 2003, only four percent of hospitals with disclosure programs provided information about legal representation to participant patients.[84] Thus, by adopting a patient-representation paradigm that strongly encourages patients to retain legal representation in the wake of an adverse event, CRPs would confront the concerns expressed by Teninbaum. In order to prevent patients from the possibility of "manipulation," the hospital must make clear to any CRP participant that its legal interests are adverse to those of the patient in regard to settlement. Of course, the hospital should affirm to the patient that it wants to do its best to compensate the patient fairly, but it must also state from the outset that only a lawyer with extensive experience in medical malpractice litigation is sufficiently skilled and sufficiently impartial to determine whether a proposed settlement is in fact "fair." In the words of the apology and disclosure advocacy group *Sorry Works!*: "Patients and families should never feel like the hospital/insurer is trying to pull a fast one on them, and by encouraging involvement of [personal injury] attorneys you remove those fears and make your disclosure program more credible."[85]

In order to respond to these concerns, the hospital must at once communicate honestly and in good faith with injured patients while making abundantly clear – both in its explanation as to why a patient should consult a lawyer and in its encouragement for the patient to retain said lawyer – that "the willingness of a provider to communicate" should *not* be confused by patients with "the willingness of a provider to compensate them fully."

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[79] Gabriel Teninbaum, *How Medical Apology Programs Harm Patients*, 15 CHAP. L. REV. 307, 309 (2011).
[80] *Id.* at 332.
[81] *Id.* at 332.
[82] Joanne Doroshow, *Patient Safety Takes a Back Seat Once Again*, THE HUFFINGTON POST, January 20, 2014, http://www.huffingtonpost.com/joanne-doroshow/patient-safety-takes-a-ba_b_4598745.html.
[83] *Id.*
[84] Teninbaum, *supra* note [79],. at 333 (citing Rae M. Lamb et al., *Hospital Disclosure Practices: Results of a National Survey*, 22 HEALTH AFF. 73, 77 (2003)).
[85] *Id.* at 333 (citing *September 13, 2006 Newsletter*, Sorry Works!).

## INFORMING PATIENTS ABOUT ATTORNEYS

Success in the context of a CRP requires more than the conclusion of a settlement between the hospital and the patient; it also requires that any final agreement fulfill the numerous patient interests discussed above. Lawyers are uniquely situated to protect a significant portion of the most important patient interests. As such, successful implementation of a CRP depends in large part on patients having the right lawyer. As we have noted, hospitals also have an interest in ensuring that patients find competent and experienced attorneys. This next section discusses ways that hospitals can help patients find and engage a capable attorney.

### THE HOSPITAL SHOULD PROACTIVELY TELL THE PATIENT TO GET AN ATTORNEY

**Patients are unlikely to find attorneys themselves**

Although patients often *should* hire an attorney, it is not inevitable that patients *will* hire one. Securing legal representation is a serious step, and there are several considerations that might lead a patient away from hiring a lawyer. We discuss some of these considerations below.

Patients fear that hiring an attorney will disrupt the patient-provider relationship. Patients and their doctors often have a strong emotional bond. When an adverse event occurs, patients may feel that bringing in a lawyer will threaten or disrupt that relationship.

Peg Metzger, a former patient who experienced a medical injury, pointed out how vulnerable patients feel while under the care of medical professionals; their lives are often quite literally in the hands of their providers. This vulnerability can contribute to and exacerbate fears of being disliked by providers.[86] Matt Connors, a defense attorney, also acknowledged that one of the reasons people *do not* seek lawyers is that they fear ruining the relationships they have with their physicians.[87]

A patient who expects to receive care again at the same hospital may be concerned that her future care will be impacted by the negotiations surrounding the present adverse event. For instance, the state of Kentucky only has two veterans' hospitals. A patient that visits one hospital is unlikely to be able to travel to the other hospital, even if she experiences an adverse event in the first. Dr. Kraman, the former CRP manager at the VA Hospital in Lexington, KY, described having to convince patients that engaging in a CRP conversation with the hospital would not affect the patient's future health care.[88]

In sum, patients want their doctors to like them, in part because they think being liked by their providers will ensure adequate care, and in part because they fear that their doctors will provide inferior care if a lawyer enters the picture. This latter concern, however, is not realistic.

Once a patient retains a lawyer, the interaction between patient and provider drastically changes. It is no longer just about providing treatment, but about figuring out what went wrong and how much should be paid. The lawyer monetizes what is an inherently unquantifiable relationship. Furthermore, the lawyer himself might act as an intermediary between the provider

[86] Interview with Peg Metzger.
[87] Interview with Matt Connors.
[88] Interview with Steve Kraman.

and the patient. Sometimes states even require a change in communication structure once a patient hires an attorney. For example, California law stipulates that once a patient retains legal representation, the patient's lawyer must be present for all conversations with the hospital. Partly for this reason, Stanford's CRP does not use its non-attorney patient liaison with represented patients.[89]

**Patients lack awareness on how to find and pay for an attorney**

Another reason patients may not seek attorneys is because of a lack of awareness on how to find one. Patients rarely have pre-existing relationships with attorneys, and therefore, when an adverse event occurs, a patient must not only *search* for an attorney, but must also form a relationship with one.

Even when patients feel comfortable searching for an attorney, they still may be deterred from doing so because of the perceived costs of retaining an attorney. In particular, patients may believe that retaining a lawyer will require them to incur upfront costs they cannot afford when, in reality, most attorneys offer free consultations and contingency fee compensation arrangements with no upfront costs.

**Patients often receive ambivalent advice from hospitals**

When a patient asks advice from the hospital, as to whether she should hire a lawyer, many hospitals will say "we cannot give you legal advice, so we cannot advise you any which way; you are, however, entitled to hire an attorney." This kind of statement is often useless to the patient because the patient is in no better position to decide whether or not to get a lawyer than she was before asking the hospital. At worst, these statements can prove harmful to the patient, because the patient may be deterred, without an affirmative push, from getting a lawyer when she really needs one.

Thus, without some sort of "push," not every patient who suffers an adverse event and needs a lawyer will hire one. As the only institution with any knowledge of what the patient is going through, the hospital should be the entity to give that push. That is, at the appropriate time, the hospital should advise the patient to consider retaining a lawyer.

## THE HOSPITAL SHOULD BE THOUGHTFUL ABOUT HOW IT TELLS THE PATIENT TO GET AN ATTORNEY

We encountered several different methods of how a patient might find an attorney, all with varying levels of hospital involvement in the process. What is clear, however, is that the hospital should be careful with its wording in advising patients to get an attorney.

The conversation in which the hospital tells a patient that she should retain an attorney is a difficult one, and not all of the stakeholders we interviewed agreed on what the conversation should sound like or when it should happen.

[89] Interview with Jeff Driver.

Many stakeholders discussed the concerns of not offending or scaring the patient with the suggestion of hiring an attorney.[90] Being told one needs a lawyer adds to the stress and discomfort that patients feel immediately after an adverse event.[91] In addition, being advised to retain an attorney might make the patient lose trust in the CRP system. The patient might think, "Why do I need an attorney? Isn't the hospital going to take care of me?" So instead of building the relationship between the patient and hospital, the wrong delivery might actually create a wedge between patient and provider, especially if the patient feels that she is not being told about her care. [92]

Many stakeholders were concerned about the hospital telling patients, "You *can* get a lawyer, but know that a lawyer will take a percentage of the settlement."[93] Such wording does not encourage patients to obtain counsel; rather, it might well discourage them from doing so.[94]

Some stakeholders offered suggestions as to what they thought the conversation on getting an attorney should include.

- Doug Wojcieszak: "You have a right to legal counsel; you can find your own attorney or we can make some suggestions."
- Gabe Teninbaum: "You have legal rights and, as a representative of a party with an adverse legal interest, you should get independent advice because it would be unethical and unfair for me to claim to represent your interests."
- Matt Connors: "You have the right to have an attorney."
- Sarah Armstrong: "We want to meet your needs, but I feel it is fair to disclose to you that I also have a duty to the hospital/provider, so we encourage you to get an attorney to be certain you feel you are making a free and informed decision."

The hospital need not require the patient to retain an attorney, but it must at least explain *why* a lawyer is necessary. By making clear to the patient the power imbalance between the well-represented hospital and the unrepresented patient, the hospital builds trust with the patient. Due to the many inertial factors discussed above which might lead a patient to hesitate and not hire a lawyer, the supposedly "neutral" statement "it is your right to get a lawyer" is actually not neutral at all. In the context of an adverse event, it discourages the patient from hiring a lawyer because it provides no positive reason to overcome the many considerations that discourage patients from seeking legal counsel. To illustrate, here are several very short statements about getting a lawyer that we have ordered roughly from most pro-lawyer to most anti-lawyer:

- You must get a lawyer
- If I were you, I would get a lawyer; it would be foolish not to

[90] *E.g.*, interview with Matt Connors.
[91] Interview with Sarah Armstrong.
[92] Interview with Sarah Armstrong.
[93] Interview with Jeff Catalano; Interview with Diann Seigle and Jessica Scott; Interview with Winnie Tobin.
[94] Interview with Jeff Catalano.

- You should get a lawyer
- You probably should get a lawyer
- Maybe you should consider getting a lawyer
- You can get a lawyer to help you
- You are entitled to hire a lawyer
- We cannot advise you on whether or not to get a lawyer
- You don't need to get a lawyer
- You probably shouldn't get a lawyer
- You shouldn't get a lawyer
- If I were you, I wouldn't get a lawyer
- You cannot get a lawyer

Stakeholders on the hospital and insurance side indicated that as the CRP process progressed, if the case were serious enough, the defense would help "nudge" patients towards getting a lawyer. But if retaining a lawyer earlier is better for the patient (see below, "When the attorney should be present"), this "nudge" should be made sooner and more openly.

It is interesting to note that in the first CRP at the VA hospital in Lexington the conversation was not thought through too much. According to Dr. Kraman, the process was simple – "If there was harm: notify patient, give them the entire story, notify them they were due compensation, and tell them they should hire an attorney to represent them in these discussions."[95]

There is no single way to tell a patient she most likely needs a lawyer. But, the hospital should be aware of how different each patient's reaction could be and how individual needs could vary. Thus, we recommend that the social worker (or other secondary representative) assigned to a patient (see Major Finding C) help the hospital tailor the conversation to the individual disposition of that patient.

### THERE MAY BE SOME CASES WHERE AN ATTORNEY IS NOT ABSOLUTELY NECESSARY

Even though attorneys are often necessary, there are certain cases where they may be less useful. Many stakeholders discussed "tiers" of cases.[96] Within this tiered framework of cases is a threshold level of value, below which having an attorney probably would not help, and may even hurt. Stakeholders disagreed on when exactly this threshold value was reached, but it would be somewhere around $100,000. Even settlements of far lower value than the traditional MedMal lawsuit could have powerful impacts on patients' financial well-being, and patients' should have that interest protected by an attorney.

[95] Interview with Steve Kraman.
[96] *E.g.* interview with Larry Smith; interview Michelle Mello.

Generally, in cases valued at larger dollar amounts, stakeholders stated a preference for the hospital to work with an attorney.[97] In smaller cases, however, an attorney is less necessary, as the resolution of such cases will probably prove quicker and simpler.

For these cases of lower value, it is "worthwhile to see if the case [can] be resolved without an attorney."[98] Nonetheless, the patient should still be informed of her freedom to hire an attorney. The conversation about the lawyer might be slightly different in such cases. For instance, the hospital would not have to provide the affirmative "push" to hire a lawyer that it might need to provide in cases of higher value.

## WHEN THE ATTORNEY SHOULD BE PRESENT

When exactly the attorney should be present during the course of CRP negotiations depends on the facts of the case and the patient's emotional status. Hospitals should consult with the patient's secondary representatives (see Major Finding C) to assess when the best time to recommend attorney representation would be. Below, we discuss some of the considerations surrounding the issue of when an attorney should be present.

### THERE ARE SEVERAL POINTS IN THE CRP PROCESS AT WHICH AN ATTORNEY COULD ENTER

According to disclosure-training consultant Doug Wojcieszak, one can view the CRP process as consisting of three stages.[99] The first stage is empathy and customer service; at this point, no patient representation is necessary. The conversation should not be about law or the standard of care, but just about empathy; Mr. Wojcieszak called it a "grief counseling situation." In the second stage, the hospital should investigate the adverse event and interview the patient and her family. It is not until the third stage, when the hospital and patient have a conversation about compensation, that there is any need for patient representation.[100]

**An attorney could be brought in right away.**

Only one stakeholder believed that the patient should have an attorney from the very beginning of the process – i.e. shortly after the adverse event. Professor Teninbaum of Suffolk University Law School expressed concern that a patient might be lulled into thinking that she does not need compensation if a large amount of time passes between the occurrence of the adverse event and her retention of an attorney. Professor Teninbaum called this phenomenon "cooling the mark out."[101]

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[97] interview with Jeff Driver.
[98] Interview with Matt Connors.
[99] We emphasize that this three-stage process is a conceptual framework with which to think through the conversation, and not actually a required protocol or guideline. In reality, these steps may occur in tandem or in a different order. In addition, not all stakeholders agreed with the applicability of this framework to the CRP process.
[100] Interview with Doug Wojcieszak.
[101] Teninbaum, *supra* note [73], at 308.

According to Professor Teninbaum, a patient should be encouraged to hire an attorney before engaging in communication with risk management.[102]

> "It is scary to be told, 'You need a lawyer.' That's a hard conversation. But this isn't a reason NOT to advise patients that they should get advice from a lawyer." – Prof. Gabriel Teninbaum, professor at Suffolk University Law School

**When an attorney is brought in depends on the specifics of the case**

Not every stakeholder agreed with Professor Teninbaum's position. Indeed, most expressed some uncertainty as to when exactly the attorney should be brought in.

Peg Metzger, a former patient who experienced an adverse event, stated that she was not sure if an attorney needed to be brought in "on day one" in most cases. She did note, however, that in cases of "clear negligence," the attorney should be brought in right away.[103] Winnie Tobin, communications director at MITSS, also remarked that she was not sure about the best timing for talking about an attorney. Linda Kenney, executive director of MITSS, suggested having the conversation about getting an attorney *after* sharing the findings from the hospital's investigation of the adverse event. Doug Wojcieszak said that, depending on the circumstances, patients may need legal counsel during this stage (stage 3 in his framework), or that representation could begin at some later time.

Leilani Schweitzer, the patient liaison at Stanford, stressed the importance of developing a trusting relationship between the hospital and the patient before adding the component of a lawyer. As the process of building such a trusting relationship is time-intensive, Ms. Schweitzer's perspective suggests that patients might be benefited from some amount of delay between the occurrence of the adverse event and the hiring of an attorney. Ms. Schweitzer's recommendations entail a process in which the hospital would meet with the patient, explain the workings of the CRP, let some time pass, and only then introduce to the patient the idea of hiring a lawyer.[104]

## STAKEHOLDER GROUPS SHOULD ACKNOWLEDGE BOTH THE "EVOLUTIONARY" NATURE OF CRP AND THAT THERE ARE UNKNOWNS IN THE PROCESS

Although the ideas behind the CRP process make intuitive sense, they remain revolutionary when compared with the status quo of medical malpractice litigation.

Dr. Kraman, former manager of the CRP at the VA Hospital in Lexington, KY, noted that it may take decades for the entities involved in CRPs – providers, patients, attorneys and insurers – to change their practices and traditions in dealing with adverse events. Larry Smith also told

[102] Interview with Gabriel Teninbaum.
[103] Interview with Peg Metzger.
[104] Interview with Leilani Schweitzer.

remarked that the implementation of CRPs "is an evolutionary process; we're trying to move into a new world."

Stakeholders also commented that no one purported to know the "right" way to execute a CRP. As Larry Smith put it, "I don't know that any of us have a complete answer as to how this should work."

**"Everyone wants change, but what that change should look like is a struggle." –Diann Seigle, Executive Director, Carolina Dispute Settlement Services**

# MAJOR FINDING B: FINDING THE RIGHT ATTORNEY AT THE RIGHT PRICE

## METHODS OF FINDING AN ATTORNEY

Even if the patient knows that she needs a lawyer, she still has to go out and find one. There are several different ways this could happen. First, the hospital could curate a list of approved plaintiff's lawyers. Second, the relevant local bar association could instead maintain a list. Third, the patient could go out on her own to find a lawyer – for instance, on the Internet or through word of mouth. We spoke with stakeholders about each of these possibilities. Each carries benefits and disadvantages. We conclude that both the hospital and the patient would be best served if the hospital maintained a list of experienced MedMal lawyers. We analyze each possibility in turn. This chart also summarizes our findings and shows why we recommend a hospital-curated list.

**Patient Interests by Method of Finding an Attorney:**

| Who Curates the List? | Hospital | Group of Hospitals | Bar Association | No One |
|---|---|---|---|---|
| **Interests** | **H** | **G** | **B** | **N/A** |
| Lowest Actual Foul Play, Going Easy on Hospital | ● | ● | ● | ● |
| Lowest Perception of Foul Play | ◑ | ◕ | ● | ● |
| Easy for Patients to Use | ● | ● | ◕ | ◔ |
| Most Skilled MedMal Attorneys | ● | ● | ◕ | ◔ |
| Geographically Close Attorneys | ● | ◕ | ● | ◔ |
| Builds Trust with the Patient | ● | ● | ◑ | ○ |

Key: ● - interest fully satisfied, ◕ - mostly satisfied, ◔ - partially satisfied, ○ - not at all satisfied

## HOSPITAL-CURATED LIST

The hospital could curate a list of lawyers with expertise in both medical malpractice and CRPs. Stakeholders on all sides – plaintiff's attorneys, doctors, risk managers, and defense attorneys – all stressed that the CRP process would operate best if the hospital were dealing with a competent and experienced MedMal plaintiff's attorney. Not only is the patient better represented by someone who has a clear substantive grasp of the law, but the hospital's

attorneys and the experienced lawyer will both agree on how the substantive law works. Experience and knowledge of the substantive law matters more than negotiation style or perhaps any other factor. No statement was more unanimous across stakeholders than that the involvement of an experienced MedMal plaintiffs' attorney as the patient's counsel would be better for CRP than the involvement of any other kind of lawyer. Between the hospital and the patient, the hospital clearly knows better who the most experienced and competent MedMal plaintiff's attorneys are, and a hospital-curated list ensures that all sides benefit from the patient retaining the best lawyer.

Various stakeholders, such as hospital defense attorneys and insurers expressed concerns regarding this idea.[105] They were worried that any list of lawyers curated by the hospital would give the impression that the plaintiff's lawyers on the list would exhibit a pro-hospital bias in order to remain on the list. However, even these stakeholders doubted that such a conflict of interest would actually arise, but they worried about the optics of such a list. Still, some stakeholders, including hospital risk managers, endorsed this method.[106] We believe that so long as the hospital makes clear that the patient can still retain a lawyer who is not on the list, patients will trust that the hospital does not have an improper motive. This would be especially true if the hospital affirmatively tells the patient that she should get a lawyer. The hospital has more expertise with the local legal community than the average patient. Thus, if the hospital curates the list, the patient is likely to receive a better lawyer. Rick Boothman described a case in which he found a lawyer for a particularly vulnerable patient, who, because of personal issues, would have been unable to find adequate counsel herself. He picked out a tough plaintiff's lawyer, one who had a reputation for hard bargaining at the settlement table and was willing to take cases to trial, and together they worked to create a favorable settlement package that adequately compensated the patient.

One minor adjustment to the idea of a hospital-curated list would be a list curated by a group of hospitals. By placing an additional degree of separation between the hospital and the lawyers it recommends, impropriety should be less likely to occur. Any one hospital would only have so much authority over the list; it could not strike a particular attorney if the other hospitals disagreed. Stakeholders who expressed concerns regarding a hospital-curated list remained wary of a group-of-hospitals-curated list. Still, we believe that both the likelihood and the appearance of impropriety would decrease if the list were curated by an alliance of hospitals and other stakeholders rather than just by one hospital.

An additional critique of the group-of-hospitals approach is geographic scope. Even within a state, hospitals may fall into different regional legal markets.[107] As such, a group of hospitals that desired to compile a list of recommended attorneys would need to either stick to one complete legal market or make clear which attorneys cover which areas and which hospitals.

## BAR ASSOCIATION REFERRAL SYSTEM

[105] Interview with Matthew Connors.
[106] Interview with Lynn Tenerowicz.
[107] Interview with Lynn Tenerowicz.

An alternative means for patients to find competent attorneys would be for the relevant Bar Association to curate a list of recommended lawyers. Hospitals could refer patients to that list for finding a lawyer. Of course, nothing would stop the patient from hiring a lawyer whose name did not appear on the list, but the list would help direct the patient to a lawyer with the experience necessary to bargain effectively with the hospital in a CRP system. A list curated by the Bar Association should avoid the potential conflicts of interest which might arise if the hospital – as the adverse party to the patient – curated its own list.

The downside to this method is two-fold. First, this method still requires the patient to engage an intermediary before retaining a lawyer. The process is neither as simple nor as efficient as it might be if the hospital gave out the list. After leaving the hospital, the patient will need to call the Bar Association or visit its website. This additional step makes it that much more unlikely that the patient will actually retain a lawyer. Second, because the Bar Association is removed from the experience on the ground in the hospital, it may not know as well as the hospital which attorneys are truly the most competent at CRP negotiations. Rather, it is more likely that a Bar Association list would become something of a directory for any lawyer that wanted to be on the list. At the very least some curation mechanism would be required.[108] The hospital already knows which lawyers work well in its CRP and which do not. Adding in the Bar Association as an intermediary for that information at best obscures the hospital's role.

### NO LIST: PATIENTS FIND ATTORNEYS BY THEMSELVES

This method is the least preferable of the three ways a patient could find a lawyer. The benefit of a patient finding her own lawyer is that the hospital does not have any conflict of interest concerns. Likewise, the hospital need not worry that a patient felt as if a particular lawyer were being forced upon her. The hospital can rest easy knowing that the patient has chosen the lawyer that she wanted. A patient also has no reason to think that her chosen attorney has any conflict of interest with the hospital. However, these theoretical benefits are outweighed by the vast downsides of the patient hiring the wrong lawyer.

The primary downside to this approach is that most patients do not know what to look for in a lawyer. When they search on the internet for "MedMal attorney," the patient may find a list of reputable attorneys who have handled similar cases before. But the patient also runs the risk of hiring a lawyer with little MedMal or alternative dispute resolution experience.

The risk that a patient does not find an experienced lawyer harms both the patient and the entire CRP process. Here, the hospital's interests and the patient's interests are aligned. The patient should receive an advocate who understands the medicine as well as the law. The patient will undoubtedly get a better settlement from a more informed attorney. Moreover, the CRP system will improve from having lawyers on both sides that fully understand the legal and medical situation in front of them. Then, the lawyers can, in the words of Dr. Kraman, negotiate a settlement in the "usual way."[109] Hospitals will not have to waste time explaining to a novice MedMal attorney why her case is not the "home run" she thinks it is. Instead, everyone will

[108] Interview with Jeff Catalano.
[109] Interview with Steve Kraman.

approach the case through the lens of significant experience. As such, the various parties will be more likely to reach agreement.

## HOURLY FEE IS THE BEST FORM OF COMPENSATION FOR CRP

Attorney compensation is perhaps the most difficult problem related to the issue of patient representation. Patients who have been injured by an adverse event often do not have the financial resources to pay for an attorney on an hourly basis. These patients are dealing with severe medical problems and many are already strained to the financial breaking point. Yet the traditional contingency model makes little sense if the lawyer is merely reviewing a more-or-less fair settlement deal that the hospital has willingly offered. The success of CRPs requires a viable method for all patients to receive and pay for legal representation. We believe that hourly-rate compensation can be effective in CRPs if it is coupled with some financial help for patients, whether in the form of delayed-payment options, hospital stipends, or something similar.

### HOURLY RATE

Many of the same stakeholders who expressed skepticism with contingency fee arrangements advocated for the possibility of plaintiff's attorneys being paid with an hourly rate. Jeff Catalano, a member of the Plaintiff's Bar in Massachusetts, felt that in some cases lawyers who represent patients through CRPs could be compensated on an hourly basis. The legal review in CRPs is much simpler and less risky than the legal review of a traditional MedMal case, and hourly compensation is a conventional form of compensation in the legal world that aligns closely with the less risky work involved in CRPs. However, many people injured by medical errors cannot afford to pay a lawyer. Mr. Catalano also felt that plaintiff's lawyers might be willing to take an hourly pay rate in some cases, but defer payment until after the settlement. If there is no settlement pre-suit, the lawyer can revert to a traditional contingent fee structure. This method of compensation is a hybrid of hourly pay and contingency fee. Since the hospital has offered the plaintiff some award, she has a floor for compensation, and any lawyer she retains will know that she will have the money from the award to pay an hourly rate. While this method of compensation seems significantly fairer than a contingency fee for CRP, it is a substantial change from the contingency fee norm. As such, it may be difficult to win the support of the entire plaintiff's bar.

One additional difficulty with hourly fee is the problem of referrals. Under the traditional contingency fee system, if a lawyer who is not an expert at medical malpractice refers a case to another plaintiff's attorney, she usually receives a third of the attorney's fee as compensation.[110] That is, the contingency fee model already has a referral system built in, but the hourly system does not.

Hourly compensation is probably the best form of compensation for attorneys in a CRP system. It satisfies the concerns that contingency fee compensation is unfair given the low risk of CRP cases. Moreover, lawyers generally understand how to bill hourly, so implementation should not prove difficult. Deferred payment would mean that patients are not afraid to get the representation they need at a time of extreme physical, mental, and financial vulnerability.

[110] Interview with Jeff Catalano.

Other forms of compensation, including contingency fee, could still be utilized within the CRP context. We simply believe that hourly payment should be the default method.

## HOSPITAL PAYS (FROM COLLABORATIVE LAW)

Another possibility for compensation is that the hospital could pay all or a part of the patient's fees. This idea comes from a unique implementation of a CRP-like system in North Carolina, where Carolina Dispute Settlement Services (CDSS) is working on a collaborative law model to reach settlements. CDSS is an independent, neutral organization that provides lawyers to patients in addition to providing mediators/coaches who facilitate discussions between hospitals and patients in MedMal disputes. Discovery is extremely limited, and the process is significantly less formal than litigation. The hospital pays a flat fee to resolve a dispute using CDSS, and CDSS pays a flat fee to the patient's lawyer. All lawyers involved have gone through a special collaborative training program as a prerequisite to working with CDSS.

This model would require adaptation to work with a typical CRP. We envision something like a voucher system: If a patient experiences an adverse event which the hospital believes will require compensation, the hospital could offer the patient a voucher, or a stipend of money, for the purpose of retaining a lawyer. Depending on how the program is run, hospitals could offer the stipend to a broad range of patients, even those the hospital believes should not receive compensation. Such a gesture would not only help build trust, it would also ensure that patients receive fair representation and that their representatives dispose of claims quickly. Possibly, the hospital would find that if it explained the cause of the adverse event, patients would not use the stipend to hire a lawyer, even if doing so would be free.

Obviously, this model of pay is a radical departure from traditional systems. Additionally, those stakeholders who are most concerned with conflict-of-interest (see hospital-curated list above) would likely be equally concerned that a patient's lawyer is being paid for by the hospital, regardless of the mechanism. For now, hourly fees appear to be the better choice. Once CARe takes hold, it may be worth reevaluating whether a voucher system should be introduced.

## TRADITIONAL CONTINGENCY FEE

Under a traditional contingency fee arrangement, plaintiff's attorneys receive a percentage of the damage award, usually around 30%. The benefit of this compensation method is that there are no upfront costs to the patient. Whether indigent or not, the patient can find an attorney if the payout from her case is promising. The large percentage award also makes sense in the context of litigation. The attorney is taking a risk with the case, as it may not pay out at all. Additionally, the attorney will need to hire experts, engage in discovery, and pay her staff, all while she waits to see whether the case actually pays. The percentage-of-damages compensation structure allows the attorney to cover all of these large costs. A major downside of this model is that cases need to have very large potential damages in order for attorneys to accept them. The potential damages often need to be at least in the six figures, often larger than $250,000, in order to be large enough for a plaintiff's attorney to even consider the case.[111]

[111] Interview with Michelle Mello; *see* Shepard, *supra* note [1], at 151.

Some patients, for whatever reason, may feel more comfortable with this payment scheme, and there is no reason why a CRP should specifically prohibit patients from contracting with their lawyers however they so choose.

Much of the underlying rationale for the contingency fee structure does not exist in the CRP context. Ideally, the hospital would approach the patient with a settlement offer and a fair description of what actually happened. While a plaintiff's lawyer certainly needs expertise and negotiation skill to obtain for her client the best possible compensation, a CRP settlement is significantly less risky than a traditional trial. Additionally, the attorney will not need to engage in the same level of discovery and expert review. Costs to the lawyer should drop dramatically, but the actual compensation to the victim may not drop as dramatically. As such, many stakeholders, including plaintiff's attorneys,[112] directors of CRPs,[113] and academics,[114] expressed concerns that a traditional contingency fee model, with the attorney taking 30% of the settlement, would be inappropriate in some cases given the vastly reduced amount of risk the lawyer would be required to bear.

However, the classic contingency fee model does offer several benefits. Contingency fees allow lawyers to take cases that may require medical experts and sometimes damages experts such as neuropsychologists, physiologists, life care planners, and economists. Because these costs are borne by the plaintiff's attorney unless and until there is a settlement, the attorney can represent a patient in these tricky cases regardless of the patient's wealth.[115]

A contingency fee is not inherently incompatible with CRPs. Dr. Kraman explained that while the Lexington VA hospital engaged in its CRP, plaintiff's lawyers were paid on contingency fee. Because the VA is run and insured by the federal government, the Federal Tort Claims Act provides explicitly for a twenty percent contingency fee,[116] so there was no opportunity to change the structure of compensation. The program was successful nonetheless.

While it may be possible to run a CRP with a lower contingency fee rate than the statutory maximum, there are two difficulties. First, because the law so clearly spells out contingency fee requirements, lawyers charge the statutory rate as a matter of course. Indeed, Dr. Kraman did not attempt to change the fee rate at the VA hospital.[117] Convincing lawyers to lower the rate would be difficult, particularly in light of the fact that there exists no statutory guidance as to the appropriate contingency rate for a CRP setting. Second, with the risk removed, pay by the hour fits better with CRPs than contingency fee, regardless of the rate. With an offer on the table, patients will be able to afford representation, and contingency fee is not required to ensure that representation.

[112] Interview with Jeff Catalano.
[113] Interview with Rick Boothman.
[114] Interview with Michelle Mello.
[115] Interview with Jeff Catalano.
[116] 28 U.S.C. § 2678.
[117] Interview with Steve Kraman.

# MAJOR FINDING C: SECONDARY REPRESENTATION AND THE VALUE OF EMOTIONAL SUPPORT

In addition to legal representation, patients should have access to a professionally trained specialist who can provide them with the case management and emotional support needed to cope with the trauma of having experienced an adverse medical event. We anticipate that this role will generally be filled by social workers.[118]

We believe that a non-professional "patient liaison" (like Leilani Schweitzer of Stanford's PEARL program) would offer additional protections to patient interests. Although a liaison should be included if feasible, we do not believe that such a liaison is absolutely necessary in order to ensure that patients receive high-quality representation.

According to Winnie Tobin of MITSS, patients are often emotionally distraught and vulnerable following an adverse medical event. Ms. Tobin worried that if the hospital instructed patients to retain a lawyer without also providing adequate resources for emotional support, the patient would see the hospital's instruction as confrontational. Such a perception would undermine the collaborative tone that CRPs intend to foster. Ms. Tobin believed legal counsel was a necessary component of a patient representation scheme; she feared, however, that counsel in itself could, in some cases, prove insufficient.[119]

Some medical apology programs prioritize emotional support over legal representation. For example, Stanford's PEARL program networks patients who have experienced an adverse medical event with a "patient liaison." This patient liaison, Leilani Schweitzer, was the mother of a child who passed away as a result of an adverse medical event that occurred at Stanford Hospital. Ms. Schweitzer provides patients with support and mentorship as they engage Stanford Hospital in negotiations through the PEARL program. She also communicates with claims managers and PEARL program administrators in order to act as a bridge between the hospital and PEARL program participants. Ms. Schweitzer has no professional training in social work or legal advocacy. Her primary qualification to serve as a patient liaison is her own personal experience. Ms. Schweitzer became involved as a patient liaison because she supported the

[118] Kaiser Permanente uses omsbuds/mediators who "act as coaches for physicians… to aid them in strategizing what and how they will communicate to families." These ombudsmen then act as "go-betweens to check in with patients and families to see that their needs and questions are being taken care of appropriately." Houk & Edelstein, *supra* note [5], at 420. . We do not propose such a method because we do not believe that ombudsmen possess comparable training to social workers in the fields of emotional support and case management.
[119] Interview with Winnie Tobin.

concept of CRPs and wanted to help make such a program successful at Stanford. She works as an independent consultant.

At present, the PEARL program does not encourage or prohibit participants from retaining legal counsel. If a patient hires a lawyer, all subsequent discussions must take place between the lawyer and Stanford's PEARL administrators – in other words, discussions between Ms. Schweitzer and the patient must end. Ms. Schweitzer was critical of this aspect of PEARL. She believed that the program would operate more efficiently – and that it would be seen as more legitimate by patient participants – if the patient were encouraged to access a lawyer. When patients do not have lawyers, patients must either "take the hospital's word" or "be savvy enough" to navigate the settlement process on their own – and that expectation of knowledge, according to Ms. Schweitzer, is "unrealistic" (see Major Finding A above for a detailed description of the power imbalances and informational asymmetries that make it extremely difficult for a patient to negotiate directly with a hospital without legal representation).

Yet Ms. Schweitzer also believed that legal representation could not, in itself, resolve all the problems confronting patient representation in apology and disclosure programs. Ms. Schweitzer informed us that she spends much of her discussion time with PEARL participants listening to their sorrows and validating their frustrations. In her words: "often, patients are just looking for someone to listen."[120] According to Ms. Schweitzer, "the chasm" between the patients and the hospital administrators "is just really big." Emotional needs," Ms. Schweitzer affirmed, "are distinct from legal needs."[121]

To this end, Ms. Schweitzer proposed that a lawyer, a social worker, and a non-professional patient liaison could all serve independent but important functions in her ideal model of patient representation. The lawyer would provide the patient with the legal knowhow required to evaluate settlement proposals and navigate the various complexities of the settlement process. The social worker would attend to the patient's emotional trauma – and, wherever possible, direct the patient to resources or programs within the hospital to help address such emotional needs. As a staff member of the hospital, the social worker would be more knowledgeable than a lawyer or patient liaison about the available resources within the hospital. Lastly, the patient liaison would remain as an intermediary to facilitate communication between the patient and social worker, on the one hand, and the hospital administrators, on the other.[122]

As a consultant to the hospital, the patient liaison would be familiar with the perspectives and concerns of the hospital. Further, if the patient liaison were someone like Ms. Schweitzer, whose family had suffered the effects of an adverse medical event, the liaison would also possess an intimate familiarity with the emotional difficulties confronting participants in a CRP. The liaison would thus be positioned to make comprehensible the concerns of each side to the other. The patient liaison would not attend to the emotional or legal needs of the patient directly, but

[120] For theoretical literature concerning the importance of active listening in alternative dispute resolution, *see* ROBERT H. MNOOKIN ET AL., BEYOND WINNING 49 (2000); *see also* MICHAEL P. NICHOLS, THE LOST ART OF LISTENING (1995).
[121] Interview with Leilani Schweitzer.
[122] *Id*.

would serve as a bridge by which to span the communicative "chasm" separating hospital from patient.[123]

Mary McDonough, the manager of social work at BIDMC, concurred with Ms. Schweitzer's assessment that a lawyer was not best situated to address the emotional needs of one who has experienced an adverse medical event. Lawyers, according to Ms. McDonough, make sure to ask the right questions. But lawyers lack the training necessary to make ongoing assessments of the psycho-social status of their clients. Patients and families are often in shock when they commence a CRP. They rarely have had the time to sort out what the incident will mean to their long-term well-being, and many are not in a state of mind in which they are prepared to "integrate" their conversations with the hospital "into the rest of their world." [124]

Ms. McDonough suggested that a social worker could do more than just interface with the patient or family. Ideally, the social worker could also help coordinate communication between the hospital and the patient and between the patient and her lawyer. The role of the social worker would be ongoing throughout the CRP process. The social worker would "listen and watch" while the other parties talked. Thus, the social worker would be poised to make a continual assessment – and to coordinate continual adjustments in communication between the parties as necessary.[125]

Ms. McDonough expressed the fear that CRPs might fail to make a "holistic assessment" of patient needs if participant patients were not offered emotional support to supplement legal representation. Like Ms. Schweitzer, Ms. McDonough believed that the wants of an injured patient often extend beyond monetary compensation. Patients want "to be heard." They want transparency from the hospital, and they want to know that learning will occur in direct response to the adverse event experienced by the patient. Thus, Ms. McDonough worried that an exclusive focus on compensation and legal rights might stop the hospital from "listening effectively" – and might prevent the CRP from realizing its full potential to serve as an instrument which improves the hospital's quality of care.[126]

Ms. McDonough took the position that a social worker would be better suited to interface with a patient or family member than a patient liaison without professional training. Such a patient liaison would lack the clinical skills of a social worker, and thus would be unable to attend to the needs of the patient with the same professional expertise as a social worker. A further danger in using patient liaisons is that a patient liaison might encounter emotional conflicts if a patient's case triggered a flare-up of the liaison's past trauma. Ms. McDonough stressed that dealing with patients could re-trigger the trauma of the patient liaison, even if the liaison believed that she had overcome said trauma. Without professional training in social work, a patient liaison might be unable to handle such a situation effectively.[127] It should be noted that Jeff Driver, the director of the PEARL program at Stanford, believed that if PEARL were extended to other

[123] *Id*.
[124] Interview with Mary McDonough.
[125] *Id*.
[126] *Id.*
[127] *Id*.

hospitals, the substantive job performed by Leilani Schweitzer as a patient liaison would be taken up by hospital social workers.[128]

If CARe seeks to "do right" by those patients and family members that participate in it, the program must be responsive to the very real emotional trauma that often follows in the wake of an adverse medical event. Thus, we recommend a patient-representation model much like that proposed by Leilani Schweitzer. In summary: A social worker should be assigned to patients participating in CARe. The task of the social worker would be three fold:

- 1) The social worker would help the patient confront any trauma suffered as a consequence of the adverse medical event.
- 2) The social worker would help network the patient with any programs available within the hospital that the social worker believed beneficial to the patient's emotional recovery.
- 3) The social worker would, where requested by the patient, sit in on patient meetings with the patient's lawyer, the CARe administrators, or the patient liaison. The task of the social worker in this setting would be to help facilitate communication.

If feasible, a patient liaison would be added to the patient safety department of the hospital. This liaison should be a former CRP participant (ideally, a former CARe participant). The task of the liaison would be to make sure the emotional needs of the patient are being communicated to the CARe administrators -- and that the CARe administrators are fully cognizant of the trauma being experienced by the patient.

- The liaison would essentially be an empathetic, "pro-patient" check on the hospital's internal negotiating team. The presence of this "check" would hopefully facilitate additional trust between the hospital and the patient, especially if the patient is at all wary of participating in CARe.
- The liaison would serve the purpose of continually reinforcing the idea that doing the best for the patient at hand (as opposed to trying to get a cheap deal) is the right thing to do – and that it is in the long-term best interest of the healthcare system at large.

[128] Interview with Jeff Driver.

# CONCLUSION

Our research gave rise to (1) a number of observations outside the immediate scope of our inquiry and (2) other alternatives to the model of patient representation, besides using an attorney.

We conclude this report by briefly discussing both, in turn.

## OTHER MODELS FOR PATIENT REPRESENTATION

In the future, hospitals may also want to experiment with other models of patient representation. Since the background law pertinent to CRPs is that of a MedMal tort suit, any large change to patient representation would require buy-in from the plaintiff's bar in order to effectively implement it. Without all stakeholders on board, trust in the CRP process would dissolve and the traditional MedMal system would take hold again. As a result, we concluded that any model of patient representation other than that of a MedMal plaintiff's attorney would be exceedingly difficult to implement – at least for now. Yet alternative models exist, each of which carries its own strengths and weaknesses.

For example, a hospital could try assigning one of its attorneys to represent patients in CRP negotiations. However, this approach would likely create too many conflicts of interest. Indeed, at least one court has stated that a case in which an attorney represented both hospital and patient was "all too likely to end poorly" because of the obvious conflict.[129]

Yet another alternative is using a trained mediator in CRP negotiations. This mediator would function as a neutral between the provider and the patient. If the mediator felt that the case could not be resolved without an attorney, the mediator would then recommend that the patient get an attorney and assist with finding an attorney for the patient.[130] A major problem with this model is that the presence of a neutral mediator does not help the patient compensate for the power and knowledge imbalance between the hospital (which has access to myriad lawyers, all of whom owe the hospital a fiduciary duty to pursue the hospital's best interests) and the patient (who, under this model, has no direct representation).

Another form of alternative patient representation would be to create an expert panel, composed of a defense attorney, a medical expert, and a plaintiff's attorney. This panel would review resolutions reached in CRP meetings and evaluate them for fairness.[131] However, this panel may not provide the level of advocacy necessary for a court to uphold a settlement agreement. Several stakeholders expressed an interest in having an agreement that would not be overturned by a court, including an insurance claims manager and the directors of other

[129] *Allen v. Gaus*, No. 313307, LN No. 09-007428-NM (Mich. Ct. App. Feb. 27, 2014), *available at* http://law.justia.com/cases/michigan/court-of-appeals-unpublished/2014/313307.html.
[130] Interview with Larry Smith.
[131] Interview with Sarah Armstrong.

CRPs. While not directly on point, at least one court was willing to overturn an alternative dispute resolution agreement when it would have denied the patient access to trial.[132]

Carolina Dispute Settlement Services offers an example of collaborative law in the medical malpractice context. Both the patient and the provider would have attorney representation, but these attorneys would be trained in collaborative law; in other words, both the patient and the provider would have attorneys specially trained in resolving disputes without going to court. Under the collaborative law model, the hospital would fund the attorney's fees for the patient, and if the resolution involves money, the fees would be deducted from the ultimate settlement.

We note that implementing either an outside panel of experts or a collaborative law process would be difficult and time-consuming. In practice, plaintiff's attorneys would dominate both processes, as no one possesses the same degree of substantive knowledge (and experience) in both legal and medical issues as a MedMal attorney.[133]

**Considerations for other models**

There are a number of outstanding questions raised by these ideas. How would these individuals be compensated for their time? Who would assign them to a patient? How would they be recruited? Nonetheless, these alternative representation models provide an interesting starting point in thinking about how patients can be provided with legal expertise outside the framework of the traditional lawyer-client relationship.

As we stated at the outset of this section, we believe that a traditional medical malpractice plaintiff's attorney is required in most circumstances. Yet in those cases where negotiations might prove especially difficult (or in those cases where damages might prove especially small), these suggested alternatives could work well.

## TOPIC FOR FUTURE INQUIRY: THE ROLE OF INSURERS

Almost every stakeholder to whom we spoke suggested that insurance companies can pose significant obstacles to the success of a CRP, as insurance companies may hold interests adverse to those of the hospitals they insure.

In certain critical regards, the business realities of a hospital resemble those of a conventional service provider. Satisfied patients will not only be "repeat customers," but, by spreading word about their positive experiences to friends and family, will help build the hospital's reputation for excellence as well as its "customer base." No hospital wants a reputation for mistreating or ignoring patients in the wake of an adverse event – especially if competitor hospitals are known

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[132] *See Medical Malpractice Binding ADR Agreement Invalidated by Pennsylvania Trial Judge,* THE LEGAL EXAMINER, http://harrisburg.legalexaminer.com/medical-malpractice/medical-malpractice-binding-adr-agreement-invalidated-by-pennsylvania-trial-judge/ (invalidating ADR agreement on power of attorney grounds); *see also Arbitration Agreement Voided in Medical Malpractice Case,* SALTER HEALY LLC, http://www.salterhealy.com/blog/arbitration-agreement-voided-in-medical-malpractice-case/#top (invalidating arbitration clause because it did not follow every element of the relevant Florida arbitration law).

[133] For example, North Carolina's collaborative law model uses plaintiff's attorneys to represent patients. Interview with Diann Seigle.

for operating CRPs that the community views as transparent, fair, timely, and responsive to emotional needs. Once the difference in patient experience between a hospital with a CRP and a hospital practicing deny and defend becomes better known to the general public, one would expect competitive pressures to eventually push more and more hospitals to adopt CRPs.[134]

Unlike hospitals, the primary interest of a for-profit insurer is to make money. Consequently, one would only expect for-profit insurers to support a CRP if doing so led to an increase in profits. Yet CRPs are designed to offer settlements in cases that would be too small to go to trial under the traditional deny-and-defend system. Stakeholders expressed doubt that for-profit insurers would want to start paying on those cases. As Jessica Scott, former director of healthcare ADR innovations at Carolina Dispute Settlement Services, observed: some insurers may take the position that "we weren't compensating those cases in the beginning; we're not going to start compensating now."[135] In hospitals that are not self-insured, the hospital implementing a CRP must obtain the support of its insurer. When that insurer is a for-profit entity, the hospital must demonstrate that CRP will redound to the insurer's bottom line in order to win that support. In the words of one stakeholder from an insurance company concerning the difficulty of convincing her colleagues to support CRP: "[It is a] tough road getting their buy in."

Some critical questions for future inquiry include:

- Can CRPs be structured so that they increase the profits of insurance companies while still protecting patient interests thoroughly?
- Does the public in fact value the idea of CRPs enough that the implementation of CRPs by some hospitals will create a competitive pressure for other hospitals to develop CRPs? If so, how can hospitals best raise public awareness concerning the benefits of CRPs?
- Is it possible to reconcile the various interests that motivate hospitals to implement CRPs with the mandate (often imposed by agency law) of private insurers to seek profits?

## FINAL THOUGHTS

By abandoning the traditional "deny and defend" mentality in favor of apology and disclosure, hospitals can much more quickly – and much more transparently – mobilize to improve shortcomings in care. The potential benefits to future patient safety from programs such as CARe are real, and they carry real value in the eyes of many participant patients. As Carole Houk and Lauren Edelstein note in their article *Beyond Apology:*

"After many years of handling literally thousands of cases, the evidence now clearly supports that patients and families who are harmed by unanticipated outcomes have the same basic trio of needs: honesty and information in real time, close to the event rather than after a lengthy investigation; an acknowledgment of their pain and suffering and an apology if warranted; and an assurance that what happened to them won't happen to someone else [.]"[136]

[134] Interview with Doug Wojcieszac.
[135] Interview with Jessica Scott.
[136] Houk & Edelstein, *supra* note [5,] at 421.

Nevertheless, promises of corrective action cannot be used, in the words of Professor Teninbaum, for the "manipulation of injured patients."[137] Improved future safety must be understood as a favorable side-effect of apology and disclosure, not as a bartering chip with which to induce patients to accept "less compensation than the law entitles them."

Unfortunately, the involvement of a patient's attorney in the CARe process cannot in itself eliminate all possibilities of exploitation. Due to the expense and risk of litigation, few MedMal lawyers will accept cases in which the patient's damages do not exceed $250,000.[138] By vastly reducing the costs and risks associated with pressing a negligence claim, CRPs offer the promise of compensation for patients whose damages are insufficient to justify litigation. Yet this promise might well remain unrealized – particularly if insurers decide to offer insufficient settlements for those smaller cases that would never make it to court.

Apology programs need to be about more than saving money. Of course, saving money is not inherently bad. By reducing the risk and expense of pressing a medical malpractice claim, CRPs also result in a reduction in the size of settlements ultimately paid to CRP participants.[139] Still, these savings must be offset, at least in part, by the provider assuming responsibility for compensating those smaller claims that would not, under the traditional system of litigation, end up in court. If the hospital or its insurers attempted to "double dip" by simultaneously saving money (in the form of reduced payouts and avoided legal fees) on large cases while skimping on smaller ones, patients might well lose confidence in the hospital's commitment to treat them fairly. This result would not only undermine the willingness of patients with larger claims to participate in the CRP (and thereby save the hospital money), but would also undercut the hospital's efforts to use disclosure and apology as a means of improving its quality of care.

One potential means of addressing such concerns would be to disclose to each participant in the CRP more information concerning the insurer's assessment of the value of her case. At present, CRICO does not disclose to patients any information concerning its internal process of case assessment.[140] Claims managers determine a "value" range for each case, but both this range and the method of its derivation remain unknown to the patient throughout the negotiation process.[141] Thus, when the insurer makes an offer, it gives little or no information to assure the patient that it has actually given its "fairest" offer (let alone an offer within its own internally assessed value range). Insurance providers respond that the law obligates them to evaluate all cases and to seek expert input during the evaluation process. According to CRICO, whenever the expert believes harm has occurred as a result of negligent care, the insurer faces a legal obligation to make a settlement offer. Yet the expert reports prepared on behalf of the claims managers remain privileged, and the patient has little means of assessing the reasonableness of the insurer's settlement offer. The only protection available to a patient is

[137] Interview with Gabriel Teninbaum; Teninbaum, *supra* note [71,] at 308.
[138] Interview with Norm Tucker; *see also* Shepherd, *supra* note [1], at 151.
[139] Although settlements paid through CRPs should involve fewer total dollars than court verdicts, the actual value of CRP settlements should more or less equal the value of a court verdict once adjusted for risk and time.
[140] Anonymous stakeholders have suggested that CRICO's approach is standard throughout the insurance industry.
[141] Interview with stakeholder from CRICO.

legal representation – and such representation offers little protection when the potential award is small and lacks the bite of a trial.

Despite these possibilities for abuse, CRPs such as CARe offer hospitals the ability to promptly identify lapses in the standard of care and to take quick corrective action to investigate such lapses and make sure that they do not recur. As *Sorry Works!* and MITSS have noted, patients who have experienced adverse medical events do not want to feel as if they have suffered in vain.[142] They want their stories to motivate change and improvement in the quality of care received by future patients. In the words of Rick Boothman: "the most important party in an apology and disclosure program is neither the patient who was injured nor the hospital – it is the patient who has yet to be injured."[143]

## SUMMING UP: A BRIEF RESTATEMENT OF OUR RECOMMENDATIONS

In summary, we believe that a system of "best practices" regarding patient representation in BIDMC's CARe program would require BIDMC to implement a model in which each patient:

- Is represented by an attorney with extensive experience in MedMal litigation.
- Is presented with a list of recommended attorneys by the hospital.
- Is free to retain any attorney she may choose, whether or not that attorney is present on the hospital-curated list.
- Is provided a professionally trained specialist, such as a social worker, who would (1) help the patient to confront any emotional trauma resulting from the adverse medical event and (2) network the patient with other resources within the hospital that would facilitate emotional recovery.

We also believe that the patient representation model would be further optimized if:

- Attorneys representing patients in CARe accepted compensation on an hourly basis.
- A former CRP participant in the capacity of a non-professional "patient liaison" was included on the hospital's Patient Safety board.

[142] Interview with Winnie Tobin; Interview with Doug Wojcieszac.
[143] Interview with Rick Boothman.

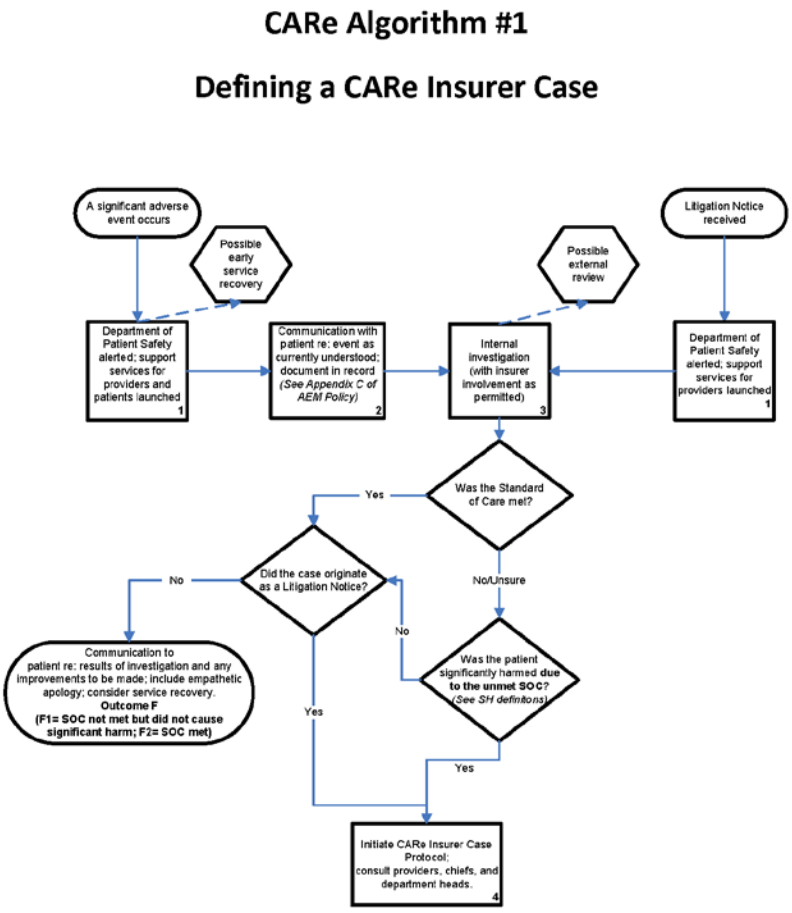
## APPENDIX A: WHAT MAKES BIDMC UNIQUE (AND WHAT MAY NOT BE REPLICABLE)

Although many of the stakeholders we spoke to are based in Massachusetts and/or affiliated with BIDMC, we hope that our report is useful for CRPs across the country. There are many aspects of the health law system in Massachusetts that do not exist in other jurisdictions. For instance, Massachusetts has an apology law that was designed to bar the admission of any liability information in a hospital or doctor apology. Other states generally have different rules governing the admissibility of an apology.

In addition, there may be features of BIDMC that do not exist in other health care systems. For instance, BIDMC has a shared-captive insurer. BIDMC's insurance model differs from the insurance model at the University of Michigan because BIDMC's insurer covers all Harvard teaching hospitals, not just BIDMC. CRICO, the insurer of BIDMC, is also a for-profit entity. At least in theory, the implementation of a CRP at BIDMC should be more difficult than at a hospital such as the University of Michigan because BIDMC does not control its insurer.

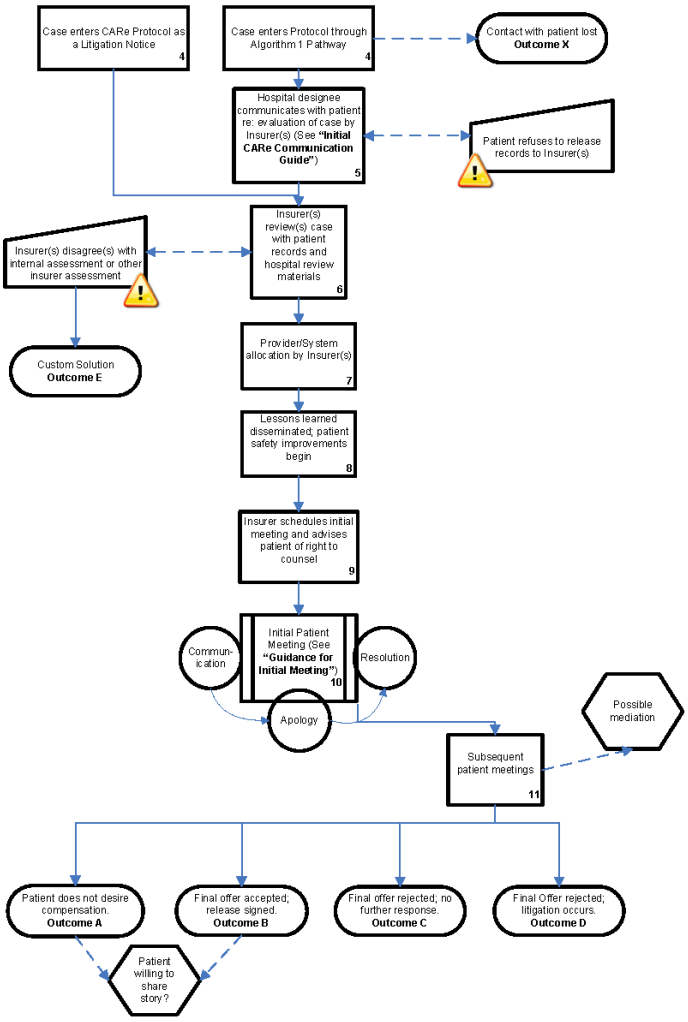
## APPENDIX B: CARE PROTOCOLS

Below we provide the protocols from CARe, to illustrate what the process might look like for a case going through a CRP.



# CARe Algorithm #2

## CARe Insurer Case Protocol



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