MED-MAL MEDIATION OFFERS PROMISE, BUT SYSTEMIC OBSTACLES REMAIN

Can mediation work to resolve medical malpractice cases? The question is not farfetched, as the pilot program discussed in this article shows. Mediation resolved a number of cases that went through the pilot program, but as author Amy London tells us, mediation is not a panacea because many systemic issues need to be addressed.

BY AMY G. LONDON

Amy London graduated from Brown University (1980) and the University of Pennsylvania Law School (1983). She has worked in the Tort Division of the New York City Law Department since graduating from law school, currently holding the position of Senior Counsel in the Medical Malpractice Unit. She has also served as a Continuing Legal Education instructor on the topic of defending cases brought against Emergency Medical Services.

An abbreviated version of this article first appeared in the February 16, 2006 edition of the New York Law Journal. *Reprinted with permission.*

As a seasoned litigator, I am rarely at a loss for words. Court reporters often chastise me for rattling off deposition questions too rapidly; judges occasionally glare at me when I fail to wait patiently for my adversary to finish speaking before I chime in with my point of view. Yet there I was, facing my opponents in mediation—a far less pressured setting—unsure of what to say.

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There was no court reporter recording each word, and no judge trying to speed the participants along to get to the end of a long court calendar. Instead, the proceedings were led by two soft-spoken attorneys (yes, there are a few of those out there) who suggested that we all address each other by first names. They explained that they simply wanted to "facilitate" (a new term in my litigator's lexicon) a free discussion of our concerns, which might lead to consideration, in part, of "non-monetary remedies" for our dispute.

After over 20 years of defending lawsuits brought against the City of New York and other municipal agencies—most of my career has been devoted to medical malpractice cases involving public hospitals like Bellevue—I was participating in my first mediation. This came about when I was given the opportunity to take part in a pilot program run under the auspices of Columbia University Law School, in which a number of our medical malpractice cases would be mediated and then studied to see if it could be shown that mediation was an effective way of resolving these kinds of matters.

As a veteran of 19 completed mediations—13 of which concluded in settlements—I am in a position to offer a favorable opinion as to the viability of this form of dispute resolution.

I entered into this experiment skeptical but open-minded, for I had developed my own strong viewpoint that the current system of medical malpractice litigation fails in almost all respects. By forcing jurors to choose between absolutes (i.e., whether the defendant did or did not deviate from the standard of care), the judicial system deprives them of the opportunity to examine medicine in all of its nuances. Unfortunately, there is no difference in the eyes of the law between a competent physician who makes a rare, slightly careless error, and a consistently sub-par doctor who commits an egregious act of malpractice. Accordingly, the value of a case does not take into account the nature of the error but only the damages suffered by the plaintiff. And this determination is usually ruled by such vagaries as how much the decedent earned (i.e., was he or she a highly paid executive or a low-level employee?), or how much sympathy would be elicited for the patient's pain and suffering.

Over time, I became even more convinced that the critical determination made at medical malpractice trials—whether or not the defendant had departed from the standard of care—is artificial. In the majority of cases, treating physicians have a hard time putting their fingers on exactly what, if anything, they did wrong. Yet sure enough, years later at trial, hired "experts" who were nowhere near the place where the treatment was rendered will affirm with "a reasonable degree of medical certainty" that malpractice was (or was not) committed, merely from reviewing the entries made in the medical record. But so much of medical care is based on impressions of the patient's condition that can never be recreated. For example, an expert will never know how sick that patient looked to the treating physician in the Emergency Room or what was in the surgeon's field of vision during that laparoscopic procedure.

Moreover, in malpractice cases, plaintiffs' attorneys work on a contingency fee basis. As a result of the contingent payment arrangement, they are not rewarded in proportion to the time and effort they put into a case—or for using the litigation process to determine what actually happened. Rather, their goal is to spin the facts so that their experts can plausibly testify that there was a deviation from the standard of care.

Add to this deeply flawed scenario another option: a process called facilitative mediation. I came to understand that it is completely different from arbitration. No decision, non-binding or otherwise, is imposed on the parties. The mediator (or co-mediators) are there simply to help the parties reach a mutually acceptable resolution.

For me, the key question was what mediators could do that my highly skilled colleague who runs an early settlement program in my office couldn't accomplish during much quicker telephonic negotiations. I got a hint of how mediation could be helpful—and even how the risk of lawsuits can be minimized—when I attended a day-long seminar on medical errors and alternative dispute resolution (ADR) as preparation for my participation in the mediation program. The morning program on medical errors was dominated by doctors, not lawyers. The gist of their presentation was that doctors are trained and encouraged by "attendings" and senior physicians to be mortified and guilt-ridden when a patient has a bad outcome, rather than to consider what may have contributed to the outcome and how it might have been avoided. The potential for a

malpractice suit further elicits feelings of guilt and fear and discourages any effort to examine what happened because any inquiry in this direction could lead to damning information falling into the hands of plaintiff's counsel. The result is a lost opportunity to learn how to improve the quality of care.

The seminar speakers asserted that it was far better for a physician to come clean when something goes wrong—to speak freely not only with colleagues and superiors, but also with the patient, offering as much information as possible about what occurred. To illustrate how this would work, a videotape was played in which actors, in the roles of physician and patient, demonstrated what an open encounter about a bad outcome would look like. The setting was a hospital room of a patient who suffered a severe allergic reaction after her doctor prescribed a penicillin-based antibiotic without first checking her earlier records (which clearly indicated a penicillin allergy) or asking her about any drug sensitivities. The doctor apologized profusely to the patient, acknowledging that she had made a serious error. Then she told the patient something like, "But fortunately you received immediate medical attention and should suffer no permanent harm."

After the film ended, one of the mediators made the tantalizing claim that most patients who seek legal advice after an adverse medical outcome are not primarily after money. What they really want is an apology and full disclosure. Once I got over the initial shock, I began to think that, if this were true, physicians and patients could both benefit from full disclosure after unfortunate outcomes. Then doctors could put their energy into helping their patients deal with the consequences, as well as trying to sort out what happened. Patients would appreciate the doctor's openness and willingness to take responsibility for his or her actions, and could focus on getting better rather than getting revenge. So patients would sue less often, alleviating the malpractice crisis. Even if they did sue, the parties could mediate and perhaps resolve the dispute more quickly and more satisfactorily. What I heard at the seminar seemed to offer the possibility of a seamless continuum of conflict management and dispute resolution options.

The Mediations

Following the seminar, my task was to select a group of malpractice cases that we considered appropriate for mediation. My colleagues and I identified files that contained sufficient information to conclude that we had some legal exposure, and to place a value on the file. Surprisingly, the vast majority of plaintiffs' attorneys wanted to mediate. Finally, after months of preparation, what had been an abstract concept became a reality—I participated in my first mediation. And so it was that I found myself in the unusual position of being unsure of what to say. I had learned from the seminar and from journal articles (I referred to this as "mediation school") about the importance of being open, the role that an apology could play, and the need to be compassionate and empathize with the plaintiff.

But I had problems with the mediators' encouragement of openness because of my litigator's instincts. Didn't an apology amount to a concession of liability? Why should I show compassion to plaintiffs I felt were less than honest in reporting the events at issue? I also worried about confidentiality. Both sides had to sign forms promising to keep the proceedings confidential. But could I trust my adversary to respect this agreement if we ended up back in court? I pondered these questions and others as our scheduled mediations—there would ultimately be 19—began.

By far the most significant factor in the success of the mediations was the presence of the plaintiffs, who had the opportunity to express anger and other emotions, reveal their concerns, and generally participate in a meaningful way. In this regard, mediation was eye-opening in one personal respect: I pride myself on treating plaintiffs in a courteous and respectful manner. Yet I am ashamed to say that until I participated in mediation, I never gave any real thought to what litigation must be like from the plaintiff''s point of view. Plaintiffs appear for depositions, during which their answers are narrowly circumscribed by a question and answer format; if they attempt to offer an open-ended narrative expressing their feelings, defense counsel cuts off the monologue as "non-responsive."

Moreover, plaintiffs rarely play any role in settlement negotiations—arguably another missed opportunity for meaningful participation in their lawsuits. Yet mediation encourages just those expressions of feelings, which are offered not only to convince the defendant of the worthiness of the suit, but also to allow the parties to vent their emotions and speak freely about what happened.

Not unexpectedly, the plaintiffs focused on their experiences in the hospital and after when they had to cope with their injuries and limitations. Many plaintiffs said they often felt as if the doctors were unavailable or uncommunicative. A plaintiff whose IV had infiltrated expressed frustration that no one explained to her what hap-

pened to her arm and why. In another case, the family of a young man with sickle cell disease who was admitted to the hospital on the eve of a holiday expressed anger that the staffing was inadequate.

I found it easy to offer what mediators call an "apology of sympathy"—telling the woman with the IV infiltrate that she deserved a full explanation as to why such complications occur, and expressing sympathy to the plaintiffs who felt ignored by the medical staff. When the medical record indicated to me that there was clearly malpractice, I learned to acknowledge this by giving an "apology of responsibility." This was difficult at first, but it got easier. In fact, it was a relief not to take the defensive posture that litigation demands. I could simply offer an apology of sympathy or responsibility, as appropriate. When the facts warranted, I could say to a patient that the medical care he or she received did not measure up to the quality that we seek to provide, and I was truly sorry for that.

The sickle cell mediation epitomized for me what the process could accomplish. Not only did the family have their grief acknowledged by my client; both parties agreed as part of the settlement (which included a large monetary component) that the decedent's mother would write a letter to the hospital president outlining what was troubling her about the care her son received. I think everyone left the mediation room feeling that something meaningful had been accomplished, apart from reaching a financial settlement.

I must add, however, that in an ideal world, we would not have settled this case because a top expert in sickle cell disease had advised us that the hospital care was excellent and he strongly believed that the plaintiff's medical theory was simply wrong. We settled not because of any conviction that the hospital committed malpractice—but because we worried that we could not rely on a jury to untangle the highly complicated medicine and ignore feelings of sympathy for the family. Nevertheless, I was satisfied with the process; we had an open dialogue and the young man's mother and brother were able to play an active role in the proceedings.

Venting also played an important part in a mediation involving an elderly patient who had fallen and broken his hip at one of our nursing homes and sued for negligent supervision. We had considerable leverage in this case because the man died leaving a Medicaid lien of nearly half a million dollars in favor of the City. The initial stages of the mediation were tremendously satisfying. I felt a rapport with the man's daughter (the substitute plaintiff in the lawsuit) and genuine empathy for her and her son. Even though the City's lien would have wiped out any verdict in their favor, we made a small offer in order to give them something. The daughter understood when I explained the reason for our offer, but her son did not. He became very emotional, accused the City's lien department of being uncaring, and shouted that to accept our rather meager offer would dishonor his grandfather's memory. I tried to explain that the people he called inhumane bureaucrats were simply fulfilling their commitment to protect the public fisc within the limits of the law. But he left the room in tears. His mother said she did not feel comfortable accepting the offer when her son felt so strongly against doing so and asked for more time to think about it. I left this mediation feeling that it was a failure because of the communication breakdown. What I hoped to accomplish by speaking compassionately to the grandson vanished because the vagaries of the legal system transformed his grandfather's life-altering injury into a case with little value. A few weeks after the mediation session, however, the daughter accepted our offer. I hope her son came to terms with it too.

Mediation gives plaintiffs a real role in settlement negotiations, and it may, as in another mediation I participated in, allow the plaintiff's will to trump her lawyer's. This case involved breast reduction surgery. The 21-year-old plaintiff, who was 19 at the time of the operation, was unhappy with her scars. As soon as she was given the chance to speak at the mediation, she broke down. It became apparent that she was anxious to put this all behind her and that the last thing she wanted was to face a jury and discuss her experience. I made an offer that reflected my feeling that, notwithstanding the suboptimal outcome, the case could be plausibly defended because we had informed the plaintiff that unsightly scarring was possible. Then I left the room so that the plaintiff and her attorney could discuss the offer in a private "caucus" with the mediators. Quite a while later, the mediators emerged, looking visibly shaken. Even before they said anything, I sensed that the plaintiff's lawyer was very angry. When I learned that our offer had been accepted, I surmised that the plaintiff wanted immediate closure even if it meant sacrificing some cash, while her lawyer wanted to refuse the offer because he thought that sometime down the line, maybe not until the eve of trial, we'd offer a higher amount. He may have been right about this, illustrating that the interests of a plaintiff and a lawyer paid on a contingency fee basis may not be the same—a conflict much more evident in the context of mediation.

While the plaintiff described above overruled her attorney, there were other cases in which the plaintiffs seemed uninterested in the process and resisted all efforts to engage in a dialogue. Instead, they looked solely to counsel to tell them whether the offer should be accepted. Regardless of whether these mediations settled, they were not particularly satisfying.

Conclusion

Now, as a veteran of 19 completed mediations —13 of which concluded in settlements—I am in a position to offer a favorable opinion as to the viability of this form of dispute resolution. I hope that my office will pursue the possibility of setting up a permanent mediation program so that appropriate cases can be identified and mediated on a regular basis. I believe that mediation is a far more efficient, dignified and compassionate method of resolving lawsuits than protracted litigation. I also find the concept of non-monetary remedies, which are usually available only in mediation, intriguing, although they are problematic because, as noted above, attorneys paid on a contingency fee basis have no incentive to recommend them to their clients. While fee issues are not supposed to influence counsel's advice, they do. This is unfortunate, because there could be many types of non-monetary compensation that might interest a plaintiff—for example, establishing a series of medical seminars to honor a deceased's memory, providing corrective surgery free of charge, or arranging, as we did, to give the plaintiff a means of informing the head of the hospital of her concerns about the quality of care.

Even more interesting to me than using mediation as just another means of settling cases is the possibility of an open approach to medical errors. I have no doubt that this approach, as demonstrated in the seminar videotape, would allow physicians to learn more from their mistakes. But I am skeptical about the claim that fewer patients would sue if this did change. Our hospitals, large teaching facilities with limited budgets, face a daunting task in that they must provide medical care to every patient, whether insured or not. Unfortunately, whether by reason of their size or their government ownership, their patients often see an uncaring bureaucracy rather than a compassionate caretaker, even when hospital physicians do their best to communicate openly with them.

Nevertheless, I believe that having more open and honest communication between doctor and patient is a worthwhile goal; only by doing so can we learn whether or not it reduces lawsuits. In those cases in which the patient opts to sue, there is always mediation. The caveat to this, however, is my conviction that it would take nothing less than a revolution to reorganize our system so as to make this model the norm rather than the exception. But revolutions can occur, so it is my great hope that I will see, at some point in my career, changes made in our system of judicial dispute resolution that will move us closer to a process that is dignified and equitable for all participants. ■

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