Mediation and Medical Malpractice: Why Plaintiffs, Hospitals and Physicians Should Be at the Table

By Chris Stern Hyman

While the national debate about how to improve health-care continues, hospitals and healthcare providers are under increasing pressure to improve patient safety and communicate more effectively with patients and families. They are also being asked to disclose adverse events and medical errors in the hopes that this will reduce the number of malpractice claims. For example, the University of Michigan Health System has a medical error disclosure program that includes a series of timely conversations with the patient after an adverse event or medical error, an apology, and an offer of fair compensation. This program has substantially reduced the number of claims against the university and its liability costs. The University of Illinois Medical Center at Chicago has a similar program through which it has been able to identify and implement system improvements and increase the reporting of adverse incidents.

Mediation is another vehicle for exchanging information about adverse events, giving an apology, and paying compensation. For the past nine years, my colleague, Carol Liebman, and I have been studying ways in which mediation and mediation skills can resolve healthcare disputes and at the same time improve patient safety and the quality of care.

The benefits of using mediation are well known to lawyers: a prompt, less expensive resolution; party control over decision making; and settlement agreements that are more nuanced than court decisions and can include non-monetary remedies in addition to monetary compensation, such as a promise to make health system improvements. In addition, because mediation communications are protected by confidentiality, the process encourages more candid and less strategic communications.

In the healthcare setting, the exchange of communications in mediation, as in error disclosure programs, provides additional benefits. Hospital representatives and healthcare provid-
ers may learn about missed or ignored information that contributed to the harm or about ways that established procedures were ignored, and then make improvements to the system. While they learn this information eventually in litigation, there is pressure not to change systems during litigation based on the thinking that a change may be an admission of liability.

Another benefit is that patients and family members can learn, often for the first time, exactly what happened to them or their loved ones and begin to understand the complexities and uncertainties of medical care. These are the kinds of communication that allow healing for both patients and physicians and can lead to a repaired relationship.

Litigation, by contrast, is often the result of poor communication between and/or among patients, physicians, and hospitals after a medical error. Physicians and hospitals rarely are open about what happened. Physicians and hospitals have been counseled by lawyers to believe that to say as little as possible is in their best interest when research suggests just the opposite: litigation is more likely if patients and their families feel they have not received answers to their questions.

My colleagues and I have conducted three research projects using mediation to resolve healthcare disputes. The first, a demonstration project in Pennsylvania in 2002 funded by the Pew Charitable Trusts (Pew Demonstration), was partly a response to the Institute of Medicine’s study suggesting that as many as 98,000 patients a year die in hospitals as a result of medical errors. The project focused on using mediation skills to enhance physician and hospital communication with patients and families after an adverse event. Interestingly, at the time this project took place, Pennsylvania had just enacted the first statute requiring hospitals to disclose adverse events to patients.

Two cases were mediated in the Pew Demonstration project. They differed from the cases mediated in the studies discussed below in that the chief of medicine participated in both mediations, along with other hospital representatives. Both cases involved claims for wrongful death. In one case, the patient, who had end-stage pulmonary disease, died after a resident inserted a subclavian central line and nicked the patient’s lung. At the mediation, the patient’s widow described to the hospital’s representatives, including the chief of medicine, how she had been treated after being told of her husband’s death. The doctor who related the terrible news abandoned her and left her standing alone in the hall outside her husband’s room. She also complained that no one had explained to her what had happened.

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The chief of medicine was particularly upset at how the widow had been treated. He appeared to feel she was owed an explanation and he proceeded to explain to her what the options were for putting in the central line and the risks of each, including a nicked lung. He apologized for the outcome and explained to the widow why the placement of the central line was not negligent, but a risk of the procedure. However, he acknowledged that, in her husband’s case, it might have been better to insert the central line in the patient’s neck, rather than the chest.

The case settled with the hospital’s agreement to pay monetary compensation to the widow, and a representation that it would train the medical staff how to respond to family members grieving as a result of the death of a loved one in the hospital.

As a result of this case, the chief of medicine implemented a new procedure for the Department of Medicine regarding the placement of central lines. The purpose was precisely to avoid harming other patients in the future.

In the second case, an elderly man on Coumadin, a blood thinner used to prevent and treat blood clots, was admitted to the emergency room the morning after a fall. The patient was initially misdiagnosed with an infection rather than internal bleeding. Then, contrary to hospital policy, the hospital did not allow the patient’s wife to be with him during his final hours.

At the mediation, the widow expressed her rage at the hospital for failing to give her husband proper treatment, ultimately leading to his death. The chief of medicine listened to her story, and when she was done, he apologized by acknowledging the hospital’s responsibility for the misdiagnosis. He also explained what treat-
m ents had been administered to him. During the course of the mediation, the widow moved from rage to sadness and she ultimately expressed gratitude for the apology.

In this case as well, the hospital changed one of its procedures after the medical malpractice mediation. It instituted a new policy requiring patients on Coumadin (or another blood thinner), who are admitted to the hospital through the emergency room as the result of a fall, be seen by a trauma surgeon.

Subsequently, we conducted two studies that evaluated interest-based mediation to see if it fosters problem solving and collaborative, candid communication to resolve medical malpractice cases. In both studies mediation services were provided at no charge.

The first study involved 29 lawsuits filed against municipal hospitals within the New York City Health and Hospitals Corporation (HHC study). The second study dealt with 67 lawsuits against private, non-profit hospitals in New York City (MeSH study). Given the central role that poor communication plays in the decision to file a malpractice lawsuit, we wanted to see if mediation could resolve more than just the individual case.

Findings

In both studies, 68% of the mediated cases settled. We co-mediated the cases with other expert mediators. We chose our co-mediators for their skill in facilitating discussions of both economic and non-economic interests. The mediators selected were comfortable with emotional conversations, knew how to encourage active participation of plaintiffs and defendants, and viewed the expression of emotions as contributing to settlement and healing.

We knew that most medical malpractice lawyers were likely to be less at ease with this style of mediator than with the evaluative mediator who focuses primarily on the economic value of the case, and spends relatively short amounts of time in joint sessions with all parties to the case and/or their counsel. The evaluative mediator also does not encourage the parties to actively participate in those sessions or in private meetings with the mediator.

Evaluative mediators tend to take a settlement conference approach notable for position-based negotiations over money. Litigators may prefer this approach because it is familiar. In addition, they need not be concerned about how well their clients present in mediation or their emotional outbursts. Although mediation courses teach the importance of the parties’ appearance at the mediation and the desirability of their participation, lawyers are the gatekeepers of the mediation and determine whether their clients attend and actively participate.

In the HHC study, the same lawyer from the New York City Law Department represented the City in all 19 cases and quickly became knowledgeable about mediation advocacy. In the MeSH study, the defense lawyers were primarily outside litigation counsel for the hospitals. In some instances, they appeared to be resistant to mediation; however, there may have been other factors that explain their apparent resistance, such as successful settlement negotiations already underway, not agreeing with their client that the case was a candidate for mediation, disagreeing about legal exposure, preferring other mediators, or maintaining billable hours out of self-interest.

**Time.** The mean amount of time spent in mediation in both studies was approximately two-and-a-half hours in the HHC study and three-and-three-quarter hours in the MeSH study. These results appear to confirm the efficiency of the process as compared to litigation, which is not known for completing a case in half a day or less.

**Discovery.** In both studies some cases were mediated and settled with minimal or no discovery. This seems to be an additional potential benefit of mediation that could translate into financial and emotional savings.

**Participation and Satisfaction.** The level of plaintiff participation was high in both studies: 84% in the HHC study and 80% in the MeSH study; there was no physician participation in either.

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<thead>
<tr>
<th>Two Empirical Studies Mediating Medical Malpractice Lawsuits</th>
<th>HHC Study</th>
<th>MeSH Study</th>
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<tr>
<td>Cases referred to mediation</td>
<td>29</td>
<td>67</td>
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<tr>
<td>Cases mediated</td>
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<tr>
<td>Cases settled</td>
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<td>Apologies in mediation</td>
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<tr>
<td>Plaintiff participation in mediation</td>
<td>16 (84%)</td>
<td>25 (80%)</td>
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<tr>
<td>Plaintiff satisfaction (mean) 1</td>
<td>2.2</td>
<td>1.98</td>
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<tr>
<td>Attorney satisfaction (mean) 1</td>
<td>1.95</td>
<td>1.9</td>
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<tr>
<td>Length of mediation (mean/hours)</td>
<td>2.34</td>
<td>3.7</td>
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1 On a scale of 1 (very satisfied) to 5 (very dissatisfied)
This may have limited the value of apologies offered by defendants in the eyes of the plaintiffs and reduced their expectations that anything would be done to improve patient safety.

Plaintiff satisfaction with the process was also measured and the rates were high: 2.2 in the HHC study and 1.98 in the MeSH study, measured on a scale of 1 to 5 with 1 being very satisfied and 5 being very dissatisfied.

Attorney satisfaction was also high: 1.95 in the HHC study and 1.9 in the MeSH study, measured on the same scale. Despite being the first exposure these attorneys may have had to interest-based mediation, most of them were satisfied with the process, although a few were critical of the mediators’ reluctance to value the cases.

Apologies: An apology can be exceedingly important to a plaintiff. Patients and their families expect an apology after a medical error or adverse event, and many physicians wish to apologize but feel constrained by fear that the apology will be interpreted as an admission of liability.11

Mediation addresses this dilemma because it is a confidential process. As a result, apologies can be given without fear of legal consequences. Even better, a mediator experienced in communication skills can coach both parties concerning the apology to ensure a productive dialogue.

In the HHC study, 11 apologies were made by defendants (out of 19 cases) and in the MeSH study, only 9 apologies were made (out of 31 cases). The reason for the greater percentage of apologies in the HHC study could be that the same attorney mediated all the cases for the defendants. She appeared to have become comfortable with offering apologies over the course of the study. By contrast, many of the defense attorneys in the MeSH study appeared less comfortable with giving apologies. As a result, they offered fewer apologies in that study. It is also possible that they felt that their apologies would not be very convincing. Litigators who are unfamiliar with apologizing for their clients to plaintiffs may inadvertently offer apologies that sound hollow and are not heard as genuine.

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**Observations**

Our studies show that mediation results in an earlier conclusion of medical malpractice disputes. These studies and the Pew demonstration project also show that the case for using mediation goes beyond the business case—it has a clear impact on patient safety. However, conventional ways of thinking, unjustified fear, and institutional and professional cultures are all barriers to realizing the full benefits of mediation. In order to overcome these barriers, hospital leaders and their lawyers need to rethink how they respond when a patient is harmed by medical care.

Mediation can have cathartic benefits for everyone involved in the process. To realize these benefits, attention should be given to bringing not just lawyers, but also patients, family members, and especially physicians to the mediation table.

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**ENDNOTES**


8 The doctors who were alleged to have committed medical malpractice did not participate in any of the mediations.

