g/o/cbl/pew/conference/AHRQFinalReport11/19

Conference on Medical Error Communication and Dispute Resolution

Carol B. Liebman, Principal Investigator
Chris Stern Hyman, Co-Principal Investigator
William Sage, Consultant/Advisor

Organization: Columbia Law School
Period: 9/30/03-9/29/04
Federal Project Officer: Kerm Henriksen
Acknowledgment of Agency Support: Agency for Healthcare Research and Quality
Grant Number: 1R13HS014389-01

Structured Abstract
Purpose: To convene a diverse group of individuals from various disciplines to share information about disclosure of medical errors and adverse events, use of alternative dispute resolution rather than litigation to resolve medical malpractice claims, and how both disclosure and mediation can improve patient safety.
Scope: Healthcare professionals, lawyers, insurers, patient safety advocates, mediators, and researchers discussed three areas: 1) communication between patients and their families following a medical error or adverse event; 2) alternative methods, including mediation, to resolve medical malpractice claims; and 3) the potential benefits to patient safety from disclosing a medical errors and adverse events and from the resolution of a medical malpractice claim through mediation.
Method: A 1-day conference was held on April 29, 2004, in Philadelphia, Pennsylvania. Attendance was by invitation.
Results: The participants learned about research and current initiatives in the field, which was new information for many. The differing perspectives and professions of the participants deepened their understanding about the complexity of communication with patients and their families after an adverse event or a medical error. Presenters explored the benefits and risks of apology and disclosure after an adverse event or medical error and considered the advantages of offering fair compensation to the patient and family as early as possible and of using mediation as an alternative to litigating medical malpractice claims.
Key Words: Apology, mediation, medical malpractice claims, patient safety, disclosure of medical error/adverse event, patient-physician communication.

Purpose (Objectives of the study)
The conference convened a group of individuals from a variety of disciplines who do not ordinarily meet together but who have shared interests in 1) improving communication between patients and their families following a medical error or adverse event, 2) resolving medical malpractice claims in a fair and efficient manner, and 3) improving patient safety.

Scope (Background, Context, Settings, Participants, Incidence, Prevalence)
The conference was held on April 29, 2004, at the Sheraton Rittenhouse Square Hotel in Philadelphia, PA. Physicians, nurses, risk managers, hospital and other healthcare facility administrators, defense and plaintiff's medical malpractice lawyers, insurers, patient safety advocates, members of the media, legislators and other government officials, academics, mediators, and others were introduced to new research about communication following a medical error or adverse event, the impact of various forms of apology, the value of early mediation following an error, and ways to help physicians and other healthcare providers handle their emotional reactions to errors and adverse events. The conference format mixed traditional plenary sessions with extensive opportunities for questions and discussion and interactive breakout sessions.

The initial plenary sessions featured keynote speaker, Lucian Leape, MD, whose prominence in the field of patient safety provided an engaging and inspiring introduction to the day. Leape's presentation was followed by an overview of findings of the Pew

Charitable Trusts-funded Demonstrative Mediation and ADR Project by principle investigators Carol B. Liebman and Chris Stern Hyman. They discussed their recommendations that hospitals develop a disclosure conversation consultant service composed of people who have excellent communication skills; that attention be given to the value of an apology after an adverse event or medical error; that institutions provide better emotional support for physicians and other healthcare providers after a medical error; and that hospitals and physicians offer, in appropriate cases, to participate in facilitative mediation soon after a medical malpractice claim is filed. Three plenary sessions explored these findings in depth.

The panel on the role of apology featured two researchers, Prof. Jennifer Robbenolt, from University of Missouri-Columbia School of Law, and Kathleen Mazor, from Meyers Primary Care Institute, University of Massachusetts Medical School, who are doing cutting-edge work on apology and disclosure of information. Although they are working on related topics, they had not known about each other's work before the conference.

During the second panel presentation, Tia Powell, MD, Executive Director, New York State Task Force on Life and the Law, and Jane Honoroff, MSW, and principal in The Mediation Group, spoke about helping physicians and other healthcare providers handle the grief and shame they experience after an adverse event or medical error. This important but often neglected aspect of the consequence of medical error interferes with effective communication with patients and families and impedes the sort of discussion that might help prevent similar errors in the future.

The third panel on mediating medical malpractice claims allowed the attendees to hear the actual experiences of a chief of medicine, risk manager, and plaintiff and defense counsel who have participated in mediations and to question them about its effectiveness. Plaintiff and defense counsel described the catharsis that occurred during the mediation and its importance for both sides. The risk manager discussed the importance of hearing the plaintiffs identify the factors at the hospital that had contributed to their pain and their decision to sue, factors that the hospital would not have known about if there had not been a mediation. The importance of offering an apology, taking the time to listen to the family, and explaining the event patiently were acknowledged by all the participants as benefits of mediation. They also noted the efficiency of avoiding protracted litigation.

At the end of the morning session, "spotlight speakers" - people from around the country who are working on cutting-edge communication, disclosure, and conflict resolution projects - were introduced and gave 3-minute descriptions of their work. During the working lunch, each spotlight speaker was assigned to a different table. Attendees selected a topic they wanted to discuss or learn more about, and during lunch participated in discussion of one of the spotlighted projects.

The spotlight speakers were:
Table 1- Gary Kalkut, MD, and Eran Bellin, MD, Montefiore Medical Center's Computerized System for residents to Report Errors (New York)

Table 2- Tobey Oxholm, Esq., Drexel University College of Medicine's Mediation Program. (Pennsylvania)
Table 3- Ed Porter, RN, Ombudsman/Mediator Program at Kaiser Permanente (California)
Table 4- Rick Kidwell, Esq., Johns Hopkins Health System's Mediation Program. (Maryland)
Table 5- Leslie Taylor, COPIC Insurance Co.'s 3Rs Program (Colorado)
Table 6- Kathryn Mariani, Montgomery County Mediation Center's Mediation Services for Seniors Program (Pennsylvania)
Table 7- Martin Hatlie, JD, and Carol Armenti, Consumer Advocates in the Patient Safety Movement (Illinois and New Jersey)
Table 8- Beverly Steinman, MD, Organizations Developing Healthcare Relationship Skills (Oregon)
Table 9- Patricia Reid Ponte, RN, Dana Farber Cancer Institute's Program for Patient as Safety Advocate in Practice Settings (Massachusetts)
Table 10- Kathleen Mazor, EdD, and Jennifer Robbennolt, JD, PhD, Role of Apology in Disclosure of Medical Error and Settlement (Massachusetts and Missouri)
Table 11- Tia Powell, MD, and Jane Honoroff, CSW, MSW, Emotional Support for Healthcare Providers after an Adverse Event or Medical Error (New York and Massachusetts)
Table 12- Stanton Smullens, MD, Communication Skills Training at Jefferson Health System (Pennsylvania)
Table 13- David Eskin, MD, Communications Skills Training at Abington Memorial Hospital (Pennsylvania)

After the last of the panel presentations, attendees were asked to suggest topics that they would like to discuss in the final breakout session. The topics included shaping an agenda for overcoming institutional barriers to change regarding disclosure of medical errors, mediation, Pennsylvania's particular issues regarding medical error and liability, possible legislative initiatives, changing the blame and shame culture within hospitals, the role of apology, and increasing the use of patient advocates to improve patient safety. In the final plenary session, each breakout group reported their key findings to the entire group.

Methods (Study Design, Data Sources/Collections, Interventions, Measures, Limitations)
N/A

Results (Principal Findings, Outcomes, Discussion, Conclusions, Significance, Implications)
Attendees indicated that they were delighted to know about the "spotlight" projects and initiatives and found the information instructive. In their emails and conversations with the organizers of the conference, they indicated appreciation for the amount of time allowed for discussion and questions following each of the panels. They also reported that they had learned a significant amount of new information from each of the panel presentations.

The differing perspectives and professions of the attendees deepened their understanding of how to communicate with patients and their families after an adverse event or a medical error. Interest was expressed in developing at a healthcare facility a consult service that would train staff to become expert in the communication skills necessary for an effective disclosure conversation after a medical error/adverse event and make them available to help plan, conduct, and debrief these conversations. The attendees explored the benefits and risks of apology and considered its powerful impact on patients and families and how to incorporate it into disclosure conversations as well as mediations. Interest was expressed in identifying cases in which mediation would be appropriate at an early stage of litigation or even before a claim is filed.

People have approached us from two cities about replicating the conference in their communities, if funding can be found.

List of Publications and Products (Bibliography of Outputs from the Study)
Speakers' PowerPoint presentations are available at www.medliabilitypa.org.