

The Use of Collaborative Law In Medical Error Situations

By Kathleen Clark

In situations where a medical procedure goes awry (referred to herein as medical error), litigation is traditionally thought to be the only road to a satisfactory remedy.¹ In theory, the tort system compensates the injured person or her/his family while punishing the health care provider(s). However, in actuality, the likelihood of a verdict or settlement in favor of a plaintiff is quite small.² The cases that go to trial expend tremendous time, money and emotional resources. Many cases continue for years, thereby increasing the expenditure of these resources for involved parties, their insurers, and those close to them, as well as entire communities.

The medical malpractice litigation process is broken, as succinctly stated by Lawrence E. Smarr, President of Physician Insurers Association of America (PIAA)³, in his written testimony to the U.S. House of Representatives.⁴ Mr. Smarr stated: “Victims are left waiting for years to get just compensation. More than half of the damages awarded to victims of medical errors go to pay attorney fees and other legal costs rather than make these people whole. Doctors are forced to practice defensive medicine in an effort to prevent lawsuits. They are also faced with liability insurance premiums that are so high far too many providers are being forced to give up their practices or at least avoid ‘risky’ patients. *Incentives exist to cover up medical mistakes rather than acknowledge them and seek out ways to avoid them in the future....The only people benefiting from the current system are the attorneys who file lawsuits against doctors and their insurers.*”

¹ Mediation often falls within the litigation process. When it does, by the time the matter gets to mediation, the parties are generally entrenched in their adversarial positions, with little hope of interest based negotiations. In addition, the parties, having moved some way through the litigation arena, are more likely to look to the attorneys and the mediator to make decisions, rather than talking openly and making their own decisions, after consultation with their attorneys. Mediation, in addition, both inside the litigation process and as a stand alone process generally involves monetary settlements to the exclusion of other matters, such as disclosure, apology, and patient safety issues. In addition, the attorneys for the parties are looking toward continuing litigation and trial if the case doesn't settle in mediation, rather than focusing exclusively on resolution based on the interests of the parties. Although mediation can be structured in any number of ways, it is often structured like a settlement conference, i.e. the mediator going back and forth between the parties trying to agree on a number, which does not promote ANY exchanges between the parties, often frustrating the needs of the parties.

² Out of every one hundred medical malpractice cases filed nationally, one case results in a jury verdict in favor of plaintiff for damages; six cases result in defense verdicts; twenty two cases are settled for a payout by defendants; and seventy one cases are dismissed by courts or dropped by plaintiffs. Lewis L. Laska, Esq., Medical Malpractice Verdicts, Settlements and Experts Newsletter (www.mmvse.com), citing Journal of Vascular Surgery(2005) Vol 43, p. 635.

³ Physician Insurers Association of America (PIAA) is an association of fifty seven domestic professional liability insurance companies that are owned and/or operated by physicians and other health care providers.

⁴ Submitted Statement of Lawrence F. Smarr, President, Physician Insurers Association of America, July 13, 2006, U.S. House of Representatives Committee on Energy & Commerce, Subcommittee on Health “Innovative Solutions to Medical Liability”, page 2. (www.thepiaa.org/pdf-files/Statement_for_Health_Subcommittee_7_13_06.pdf).

To a great extent, medical malpractice cases often end in defense verdicts. In a recent dialogue, I learned that eighty five percent (85%) of medical malpractice cases that go to trial in Florida result in defense verdicts.⁵ The national statistics are quite similar: eighty percent (80%) of the medical malpractice cases that go to trial result in defense verdicts.⁶ The lengthy litigation process leaves all parties and the health care system depleted, having missed the opportunity to learn from each other and to improve the health care system. The purpose of this article is to explore an alternative to medical malpractice litigation--one that can benefit patients, families, health care professionals and their insurers, attorneys and communities. .

This alternative, which addresses all of the major issues mentioned by Mr. Smarr in his Congressional testimony, is already in place: a structured, voluntary, non-adversarial dispute resolution process, called collaborative law. Collaborative law involves a series of meetings with parties and attorneys in a structured process individualized to the case. In these meetings, all parties and attorneys work collaboratively toward a resolution unique to the facts of the case at issue and not limited by legal remedies. At the first meeting of the parties and attorneys, the participation agreement, explained herein, is discussed and signed. Collaborative law focuses more on finding solutions than on finding fault. It recognizes concepts of fairness. It is a process that has been used exclusively in family law matters for approximately fifteen years.⁷ This process is controlled by the parties and involves both total transparency and total respect for all involved. Collaborative law offers a “natural fit” in the medical error context, encouraging immediate participation of the parties, in consultation with their attorneys, once medical error has been alleged. The process encourages early discussions that can involve disclosure, apology (to the extent called for), proposed future patient safety solutions, and healing. Patient safety is a primary concern of collaborative law, bringing as it does the private interest of the injured person into alignment with the public interest in preventing injuries to the general public in the future. Unlike litigation, the collaborative process permits and encourages patient safety issues to be addressed immediately on a global, rather than an individual, basis.

The Collaborative Law Process

Collaborative law requires the parties and their attorneys to sign a Participation Agreement, which provides for: (1) full disclosure, (2) confidentiality, (3) retained experts, (4) consulting only experts, (5) outside legal opinion and (6) withdrawal of collaborative counsel, if the matter doesn't settle, requiring the parties then to each

⁵ Dialogue on Collaborative Law in Medical Error, Ft. Myers, Florida, January 23, 2007.

⁶ Statement of the Physician Insurers Association of America Presented by Lawrence E. Smarr, President, Physician Insurers Association of America before a joint hearing of the United States Senate Judiciary Committee and Health, Education, Labor and Pensions Committee Regarding: Patient Access Crisis: The Role of Medical Litigation, February 11, 2003 (www.thepiaa.org/pdf-files/February_11_testimony.pdf).

⁷ In the family law context, the structured meetings are known as “Four Ways” because the two parties and their attorneys, trained in collaborative law, meet to discuss the issues in the case. It is a team approach to resolution, which may involve forensic professionals, such as financial planners, working together in a respectful way, to bring resolution to the issues. The process could take several meetings over an extended period, but, in general, can move to resolution much faster and much more compassionately than litigation.

choose trial counsel. The Participation Agreement provides for collaborative/settlement counsel; if the matter doesn't resolve during the collaborative process, collaborative/settlement counsel withdraws and new counsel, trial counsel, is chosen by the parties.⁸

One much-quoted study indicates that injured persons and/or their families sue physicians because of the following reasons: they are advised to by third parties, often a health care provider, but rarely a lawyer (33%), they believe physicians are not honest or even lie (24%), they need money to care for their injured child (24%), they can't get answers to their questions about what happened (20%), or they decide to seek revenge or to protect others from harm (19%)⁹ Another often-cited reason for suing a physician is that the patient feels the physician does not listen to her/his experience, suggestions and questions, which often creates mistrust. But the tort system, as we have seen, fails to compensate the majority of patients injured by their medical care.¹⁰ Of all the people severely injured by medical error, only about ten to twelve percent actually file a claim.¹¹ One researcher found that evidence is almost completely lacking for the proposition that the tort liability system deters medical negligence.¹²

Collaborative law will be tremendously advantageous to injured parties with legitimate claims who otherwise will likely go unrepresented. There are specific reasons for the failure of some would-be plaintiffs to secure legal representation. It is often not economically feasible for an attorney to take the case; the claim is too small; the injured party is too angry or just seeking revenge; or the claim is too difficult or too complicated to prove. It is particularly difficult for young or elderly plaintiffs to find attorneys because it is difficult, if not impossible, to prove economic damages; this difficulty is compounded in states that have caps on non-economic damages.

In a situation in which an injured party sues and the process becomes too daunting, expensive or time and emotion consuming, the injured party (and her/his attorney) could move into a collaborative process, in the hope that an interest-based, face-to-face process would bring a reasonably speedy resolution to the matter. These situations require a case-by-case analysis by the attorney and client to determine if the collaborative law process is useful and appropriate.

⁸ This requirement, often referred to as the "collaborative commitment", is intended to ensure that the attorneys, as well as the parties, are fully committed to the collaborative process. In addition, it acts as additional protection for the confidentiality of the process. This collaborative commitment keeps the focus on interest-based negotiations.

⁹ Hickson et al, Factors That Prompted Families To File Medical Malpractice Claims Following Perinatal Injuries, JAMA, 1992 257:1359.

¹⁰ Harvard Medical Practice Study, report to the State of New York: Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York (Cambridge MA: President and Fellows of Harvard College, 1990).

¹¹ Edward Dauer and Leonard J. Marcus, Adapting Mediation To Link Resolution Of Medical Malpractice Disputes With Health Care Quality Improvement, 60 Law & Contemp. Probs. 185 (Winter 1997).

¹² Frank a. Sloan et al, Suing for Medical Malpractice, 15 n. 14 (1993).

Significant amounts of research support the proposition that poor physician communication with patients often leads to litigation. On the other hand, research shows that when physicians fully disclose and apologize, when appropriate, patients are more satisfied, more trusting, and less likely to change physicians than when the patient received evasive and/or incomplete information.¹³ In many circumstances, physicians are prohibited by their liability insurance carriers from speaking with patients after an adverse event. This prohibition seems to make litigation almost inevitable, when the intent of the carrier is just the opposite. Yet the Report of the Harvard Medical Practice Study to the State of New York concluded that only twenty-seven percent of adverse events that occur during hospitalization were due to actual negligence on the part of a healthcare provider.¹⁴ The study reports the incidence of adverse events for hospitalizations is 3.7% and, of these, 1.1% are due to negligence. Although it is generally envisioned as the logical next step after a medical error, as previously noted, the statistics regarding successful litigation in medical malpractice cases are abysmal.

Collaborative law in medical error has the potential to be very effective.¹⁵ It provides a container in which the stakeholders to any resolution of medical error can collaborate to provide a fair process to the injured party. The stakeholders include the patient, the patient's attorney, the physician, and the physician's attorney. From time to time, depending on the circumstances, others may be required, such as the physician's insurer, hospital administrators/risk managers, or counsel for the hospital. This process gives the injured party/family members the immediate support and advice of a collaborative attorney. It is particularly important because, unlike the traditional malpractice method, the collaborative support and advice offered by the attorneys takes place in a situation in which the injured party is less likely to be at a disadvantage. Most face-to-face meetings between an injured party and a physicians(s) and other health care providers are marked by inequality of bargaining power; lack of control over the process; difficulties insuring a full and fair opportunity to be heard, to ask questions and have them answered; and little chance for smaller claims, which wouldn't be taken on a contingency basis, to be heard and resolved.

The peace of mind that comes from taking a case out of the win-or-lose litigation process into a non-adversarial, compassionate process is empowering to all participants.

¹³ See Carol B. Liebman and Chris Sterns Hyman, *Medical Error Disclosure, Mediation Skills, and Malpractice Litigation: The Project on Medical Liability in Pennsylvania*, available at www.medliabilitypa.org. Copyright 2005 Carol B. Liebman & Chris Stern Hyman.

¹⁴ See Barry r. Furrow, Thomas I. Greeney, Sandra JH. Johnson, Timothy C. Jost and Robert L. Schwartz, *Health Law Cases, Materials and Problems*, 3rd Edition, West Publishing (1997) at p.32 (excerpt from *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York – the Report of the Harvard Medical Practice Study to the State of New York* (1990).

¹⁵ But see Jill Schachner Chanen, *A Warning To Collaborators*, ABA Journal.com, Tuesday, May 8, 2007 (from the May ABA Journal National Pulse), addressing the Colorado Bar Association's ethics committee's opinion regarding collaborative law. Colorado's bar association is the sixth state bar association to address the ethics of collaborative law and the only one to suggest that it is unethical. However, the Colorado opinion suggests that it is appropriate for the parties to sign a participation agreement and for the attorneys to limit the scope of their engagement to negotiation. The other state bar associations, including those of Kentucky, North Carolina, New Jersey, Pennsylvania and Minnesota, all approve of it.

Here, participants have the opportunity to share information and seek solutions with the physician(s) and, possibly, other health care providers in order to prevent future harm. In addition, there is more likelihood of receiving compensation quickly (and a greater percentage of it, since the attorney's fee is reduced, based on a speedy resolution). Parties have the chance to begin the healing process; to continue a relationship with their physicians; and to begin to repair/strengthen the trust in the patient/physician relationship. This process, serves the entire health care system, rather than one individual/family, while giving that individual/family a role in helping others (future patients) going forward. It takes the medical error out of the narrow realm of financial settlement in a private dispute. This process has the potential to bring the private interests of the patient/family into close alignment with the public interest of advancing patient safety to the benefit of the many, rather than the few.

To physicians, the process gives immediate access to a collaborative attorney who understands and is trained in the process and can advise on disclosure and other issues after an adverse event/medical error. It also provides¹⁶:

- confidentiality
- control of the process
- an early opportunity to offer an explanation and to answer questions
- a chance to offer an apology, if appropriate,¹⁷ (expression of sympathy, but not expression of fault,¹⁸ is protected from disclosure in California. A total of twenty-nine states protect apology, the large majority of which protects expressions of sympathy, but not expressions of fault.¹⁹ In states without apology statutes, expression of sympathy and fault are protected from disclosure by the Participation Agreement, which provides for confidentiality and is signed all parties and attorneys at the outset of the process)
- an early opportunity to strengthen the relationship with one's patient
- an atmosphere less inclined to blame
- an opportunity to begin healing
- a chance to examine, in collaboration with the injured party or the injured party's family, patient safety issues quickly, thereby providing opportunities for improvement in the health care process

¹⁶ Many of these benefits to the physicians also benefit their insurers. For instance, the opportunity to address patient safety issues quickly benefits the insurers because claims based on similar mistakes are lessened after open discussions and changes in policies and procedures.

¹⁷ See *Should Physicians Apologize For Medical Errors?*, Norman G. Tabler, Jr., Esq., *The Health Lawyer*, Volume 19, Number 3, January, 2007

¹⁸ California Evidence Code Section 1160 (a) provides: "The portion of statements, writings, or benevolent gestures expressing sympathy or a general sense of benevolence relating to the pain, suffering, or death of a person involved in an accident and made to that person or to the family of that person shall be inadmissible as evidence of an admission of liability in a civil action. *A statement of fault, however, which is part of, or in addition to, any of the above shall not be inadmissible pursuant to this section.*" (emphasis added)

¹⁹ Arizona, California, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Louisiana, Maine, Maryland, Missouri, Maryland, Massachusetts, New Hampshire, North Carolina, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, West Virginia and Wyoming.

- emotional/financial/energy savings because there is no lengthy, stressful, expensive and painful litigation process
- potential extensive cost savings
- peace of mind when issues are resolved quickly without a written claim having been filed (Although no reporting is required to National Patient Data Bank, absent a written claim or complaint²⁰, to the extent a practitioner might consider using this process to avoid the reporting requirement, all incidents can be subject to peer review, which can be included in the Participation Agreement.)

These opportunities can be compared with physician defendants in medical malpractice cases who experience:

- powerlessness in the process
- an inability to make any creative contribution to resolution
- a need to wait and worry, as litigation drags on and on
- a constant distraction
- no opportunity to influence future patient safety

In the collaborative law process, physicians and hospitals are not co-defendants in an adversarial process, pointing the finger at each other. In the collaborative law process, they can work together, along with patients, on solutions to patient safety issues.

Finally, this approach is much more conducive to looking at health care from a systemic point of view, rather than putting one individual plaintiff's case under the microscope. The collaborative law process encourages examination of the big picture. This is not to say that the physician(s) or hospitals are free of responsibility. Often, difficulties in the system play a significant role in the error and those difficulties, under typical modes of litigation, go unexamined or are examined only for purposes of negligence, rather than for purposes of protecting future patients.

The process gives attorneys the opportunity to take part in a non-adversarial, respectful interaction; to collaborate with the parties and other attorneys; to help create potential patient safety solutions; to handle more cases; to be paid on an hourly basis, without regard to winning or losing; and to cut down on stress. Hourly fees free attorneys from focusing exclusively on monetary damages (for their client's damages and their own contingency fees) giving them the opportunity to expand the process to address patient safety concerns.²¹ (Even if a medical error claim does not resolve and moves on

²⁰ See National Practitioner Data Bank Guidebook, Chapter E, page E-8.

²¹ See Fasler, K., *Combining Collaborative Law and Patient Safety Programs: A Proposal For the use of Parallel Processes to Facilitate Early Detection of Safety Issues and Early. Reparation for Injury Causing and Near Miss episodes*. Alternative Resolutions (State Bar of Texas Dispute Resolution Section), Vol 16, No. 1, Winter 2007, pages 13-20.

to litigation, changes in patient safety procedures not directly related to the medical error can still arise out of the CL process.²²⁾

For all involved, the process presents the opportunity for a learning experience and the potential for healing in a non-punitive setting. These words are not written lightly; the author does not mean to suggest, in a case in which the family is mourning the loss of a loved one or where there has been a life-threatening injury, that all agree to the collaborative process as a mere learning experience. The collaborative process, in terms of patient safety, can provide opportunities to focus on future patient safety, from which all can learn and help future patients, whether the case resolves in total or not, as determined on a case-by-case basis.

Dialogues on Collaborative Law

Before collaborative law in medical error can take hold, the stakeholders have to come together and see the benefits of the process. This clearly is no easy task. After attending two conferences at which it seemed there was much nay-saying, finger pointing, and negative assumptions about other stakeholders (i.e., insurance companies -- everyone's favorite bad guy -- won't ever agree to the process, defendants' attorneys won't turn over any records without court battles, plaintiffs' attorneys won't give up contingency fees, plaintiffs just want lots of money, physicians won't admit error, hospitals won't take responsibility),²³ a plan to structure a dialogue with all the stakeholders was devised. Central to the dialogue process was Appreciative Inquiry²⁴. Appreciative Inquiry focuses on possibilities, not problems; it focuses on what is working so we can do more of it. This method seemed a perfect choice for dialogue, bringing together as it would professionals who knew the possibilities of similar compassionate, non-adversarial processes and those who had no experiences with this process but who were willing to listen and consider, as well as propose, possible solutions. The professionals who had successfully used this type of process included attorneys, insurers, risk managers and patient advocates, among others. Although those processes were not formally known as collaborative law, they certainly fit within the spirit of collaborative law. The purpose of dialogue is to seek mutual understanding. It assumes that many people have pieces of the answer and that, together, they can craft solutions. The hope was to bring together a group of participants/stakeholders to think together and to understand each other's points of view, break through assumptions about each other, and begin to build community across disciplines, such that, as health care collaborators, all

²² Examples of changes in patient safety procedures not directly related to the medical error could include: changes in night security procedures at a hospital, changes in charting procedures, and changes in intern/resident/other hospital personnel's interactions with patients/families.

²³ One of these conferences involved an early morning session at an ABA Dispute Resolution conference, put together quickly, involving a small panel of practitioners of portions of the collaborative law process in medical error situations (non-adversarial), with an audience of medical malpractice attorneys, who questioned the possibilities suggested by the collaborative process.

²⁴ Cooperrider, David L., Whitney, Diana, *Appreciative Inquiry*, 1999, Berrett-Koehler Communications, Inc.; Clark, Kathleen, *Appreciative Inquiry: It's Not Easy, But It Is Simple*, www.abanet.org/lpm/lpt/mgt09041.html.

involved could begin to move forward together to offer a workable, legitimate, compassionate, patient safety-oriented option to medical malpractice litigation.

At the present time, two such dialogues have been designed and facilitated. One, in California in October, 2006, included a vice president of risk management for a physicians' insurer, an attorney and director of risk management for a group of forty-eight hospitals, a plaintiffs' medical malpractice attorney, a defendants' medical malpractice attorney, a medical ethicist, a ombuds/mediator for a multi-state health care provider, a patient advocate, and a associate general counsel for the Veterans Administration. The second dialogue, in Florida (convened in January, 2007 by Florida attorney Sheldon Fineman), included a plaintiffs' medical malpractice attorney, a defendants' medical malpractice attorney, a psychologist, a medical ethicist/hospital chaplain, two risk managers for a hospital (former nurses), in house counsel for a hospital, three physicians, a collaborative/cooperative family law attorney, and two long term care consultants.

The goal for these dialogues was to begin to build collaborative relationships among the various participants, based on trust, understanding of the perspectives of others, learning and respect. One of the physicians present spoke eloquently about the process. At the beginning of the dialogue, he said that there were a lot of participants on the fringes, but, by the end, all participants were moving toward the center. That comment brought to mind Bill Isaacs'²⁵ description of dialogue, "Dialogue is a conversation with a center, not sides." It is a process of taking the energy of our differences and channeling it toward something that has never been created before.

Through the dialogue process, using the framework of appreciative inquiry, participants already using portions of the collaborative process (a non-adversarial settlement process) to great success in their organizations were brought together. The hope was to expand the conversation from their experiences, i.e. how it works, how it was developed, how much money has been saved, how respectful it is, and both build on that and expand the dialogue to other stakeholders and other health care issues. Although not formally known as collaborative law/practice, these processes come from the same kind of compassionate thinking. For instance, the University of Michigan Health System in Ann Arbor, beginning in 2002 encouraged its physicians to apologize for mistakes. Richard C. Boothman, chief risk officer for the system, said that "this is not about making apologies, it's about being honest. Transparency, honest and open discussion all make sense to intercept patient claims that become litigation, because once they become litigation, they take on a life of their own."²⁶ Boothman testified before the U.S. Senate Committee on Health, Education, Labor and Pensions, stating that claims against the University of Michigan dropped every year since 2001, despite increased clinical activity over the same period. As a result, there has been a substantial drop in the number of medical malpractice lawsuits. In August, 2002, there were 220 total

²⁵ Isaacs, William, *Dialogue And The Art of Thinking Together*, 1999, Doubleday.

²⁶ SorryWorks; <http://www.sorryworks.net/media49.phtml>.

claims; 193 claims in August, 2003; 155 claims in August, 2004; 114 claims in August, 2005; and, since then, the total number of claims has fallen to fewer than 100.²⁷

Another example of a similar process at work is the Veterans Administration Hospital in Lexington, Kentucky, which began, in 1987, a process of disclosure and apology when a patient is injured through medical error or negligence. The VA fully discloses the facts to the injured party; by apologizing, accepting and stating full responsibility (including legal liability), and offering fair compensation. This process has been so successful that it is now mandated in all VA Hospitals in the United States. The statistics for the Lexington VA run counter to traditional legal thinking about disclosure and apology: between 1990 and 1996, compared to the thirty five other VA hospitals in the eastern portion of the U.S., the Lexington VA hospital was in the top quartile in the number of claims made and the bottom quartile in the amount of payments.²⁸

Areas For Further Consideration/Dialogue

The collaborative law process, as set forth above, has been successful in the family law arena for approximately fifteen years, in part because the only parties to the case are the divorcing individuals. In family law, the process is something of a one-size-fits-all concept. This is not to suggest that collaborative family law does not involve many substantive issues (such as pensions, social security, child support, child custody, and business valuations), but rather that there are only two parties/deciders, in consultation with their attorneys. In contrast, collaborative law in medical error situations may include half a dozen or more parties, including the patient or the surviving family members, the physician(s), the hospital, and other health care providers, in consultation with their attorneys. Behind the scenes are the several insurers for the physicians, hospital, and other health care providers, as well as risk managers in self-insured situations. With so many stakeholders/decision-makers in the medical error context, consisting of many overlapping and complex relationships, collaborative law in this arena becomes, at once, more challenging and potentially more rewarding. The dialogue process provides an opportunity to build relationships among those ordinarily mistrustful of each other in these situations, such as physicians and attorneys. It also encourages a closer look at the real possibilities associated with collaborative law.

The collaborative law process makes the experience of loss a more compassionate process, more compassionate primarily for the patient/family, but also for the physicians, the attorneys and the community outside the room. For this process to take hold, a shift in thinking will be necessary for attorneys (as well as physicians and other health care providers). The dialogue process creates the space for just that shift in thinking to take

²⁷ www.senate.gov/hearings/2006_06_22/boothman.

²⁸ Kraman, Steve S., M.D., Hamm, Ginny, J.D., “*Risk Management: Extreme Honesty may Be The Best Policy*”, 131 *Annals of Internal Medicine* 963 (1999); Taber, Norman, *Should Physicians Apologize For Medical Errors*, *The Health Lawyer*, January 2002, Volume 19, Number 3.

place. It is, of course, not the only approach, but it is a start.²⁹ Stakeholders and interested individuals and organizations need to keep talking about the significant issues to be addressed, including fair compensation, disclosure, patient safety, attorney fees, confidentiality, and the timing of and circumstances that indicate the need for withdrawal of collaborative attorneys.

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²⁹ Another dialogue will take place in October, 2007 as a workshop at the annual conference of the International Academy of Collaborative Professionals (IACP) in Toronto, which will include both U.S. and Canadian attorneys, law professors, and physicians. See www.collaborativepractice.com.