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

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(Note from the Chair of the Newsletter Editorial Board: This article continues a series whose purpose is to expose our readers to perspectives on Collaborative Law. If you would like to contribute an article about Collaborative Law, please contact Sherrie Abney at SAbney913@aol.com or Walter A. Wright at ww05@txstate.edu.)

Too often, an adverse medical event will be followed by evasion, secrecy and blame-shifting as healthcare personnel attempt to avoid entanglement in litigation proceedings or individual losses to reputation. Healthcare providers may act on the advice of counsel or otherwise adhere to limitations in insurance policies that ultimately restrict the flow of information provided to injured patients. The ensuing "safeguard shuffle" interferes with communications and has led to instances of patients or families entering litigation simply to find out what happened.[1] Explanations offered by healthcare personnel are sometimes so guarded and stilted that patients feel providers are acting dishonestly or even attempting to cover up facts. Patients may also assume there is undisclosed fault when an occurrence is followed by non-engagement and delay.[2]

Further adding to dysfunctional communication styles are existing processes tending to interfere with the acquisition and use of safety-enhancing information. For example, adverse-event investigations are sometimes conducted only when litigation is actively pursued. Even if routine assessments are performed, the accumulated information may be filed away, never to be looked at again unless a lawsuit is filed. Once filed, important information may be withheld for several years as cases wind their way through the litigation system. As a result, information that could have (and should have) been used immediately to improve safety processes becomes so dated it is of little use in improving patient safety.[3] This system further wastes valuable healthcare resources as personnel assess and re-assess cases over a period of years before a final disposition occurs.

This paper investigates whether Collaborative Law[4] and Patient Safety Programs can be run simultaneously as parallel processes and whether this combination can act to facilitate the following: early detection and response to safety issues; early reparation for injury-causing events; and preservation of provider / patient relationships through understanding and effective communication.

ELEMENTS NECESSARY TO SUPPORT AN EFFECTIVE SAFETY PROGRAM

1. Access to Information

Information is critical to the provision of safe health care.[5] Experts believe multiple warnings signs, or near-misses, happen prior to the occurrence of many serious adverse events.[6] Unfortunately, most Patient Safety Programs focus only on after-the-fact detection and analysis.[7] Few efforts are made to identify trends that could circumvent potential injury-causing practices.[8] The result of this one-sided focus is that many patient safety systems remain reactive in nature and lose out on the potential for proactive error avoidance. An effective Patient Safety Program must be able to access information from all available sources, including both adverse events and near-miss episodes.

2. Open discussion of near-miss and injury causing events

Open discussion is necessary to get to the root cause of events that have resulted or may eventually result in injury. In order for parties to feel safe enough to engage in open discussion about such events, they must believe their good-faith efforts to resolve issues will not come back to haunt them at a later date.

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They must be assured they can fully discuss events and they are free to express anger, grief and even remorse. Providers must be assured they can offer apologies without the fear of later repercussions. Similarly, patients must believe their own contributory actions or omissions will not be used against them if the case does not achieve resolution.

3. Quick response to safety issues

Providers and institutions must be able to respond quickly to events that have caused or that have the potential to cause injury. Safety cannot be enhanced if one waits years before taking steps to correct dangerous situations. Injured patients want assurances they will not be re-harmed and want to be sure that other patients will not be exposed to similar dangers. A safety program must have the ability to access, analyze and utilize all available information if it is to respond to safety issues in a timely manner.

COLLABORATIVE LAW CAN FACILITATE THESE ELEMENTS

1. Access to Information

An effective Patient Safety Program must examine all adverse events and near-miss episodes. A near-miss incident can be defined as an act of commission or omission that could have injured the patient but did not do so as the result of chance, prevention or mitigation.[9] An adverse event can be defined as an unintended harm to the patient by an act rather than a harm that is the result of the underlying disease or condition of the patient.[10] Adverse events can be further subdivided into those that are the result of negligence and those that are not.

Access to information is sporadic at best. Currently, very few safety programs examine near-miss episodes. As a result, this potential wealth of information remains largely untapped. On the legal front, statistics reveal that lawsuits are filed only in a very small percentage of cases involving medical negligence.[11] Attempts to study these cases limit the pool to only those acts falling below a set standard of care and resulting in actual harm to a patient. Further limiting the number of cases that could provide information is the fact that, as a practical matter, only those cases with the potential for sufficient dollar recovery are taken on contingency. These factors all tend to compartmentalize and limit the amount of valuable information ultimately available for use in improving patient safety.

The collaborative process has the potential to extend beyond these limited boundaries and is capable of addressing cases involving both near-misses and adverse incidents.[12] This ability to span almost the full spectrum of possible incidents gives Collaborative Law a distinct advantage over other processes.

The combined parallel programs have the potential to intersect at the following points **in the table below**:

2. Open discussion of near-miss and injury causing events

Collaborative Law can provide the safe environment necessary to promote open discussion of events. Collaborative Law sessions provide the following:

a) face-to-face communications

An environment allowing face-to-face communications is essential for open discussion of injury-causing events and near-miss episodes. The participants must feel safe enough to talk about events and to express remorse, anger, grief, and even forgiveness.[15] Detailed information is essential when performing root-cause analysis of factors that may have precipitated injury.

Collaborative Law provides an excellent venue for this exchange process, as communications are all face-to-face. In typical litigation proceedings, initial communications come in the form of dueling onslaughts of paperwork as the process of discovery begins. Answers are crafted to give only what is immediately demanded and nothing more. The atmosphere is often one of evasion rather than solution, and parties may never see each other until they arrive in court. Other legal alternatives also have the potential to interfere with direct communications. Although mediation may help open communication channels,

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NEAR-MISS -episode avoided due to **chance** ie: contraindicated drug given but patient has no reaction[13]	**NEAR-MISS** -episode avoided due to **prevention** ie: incorrect medication recognized and never given	**NEAR-MISS** -episode avoided due to **mitigation** ie: overdose given but countered with antidote	**ADVERSE INCIDENT without negligence** ie: inadvertent bowel perforation during surgery	**ADVERSE INCIDENT with negligence** ie: clamp left in patient's abdomen during surgery
Collaborative Law may be appropriate	Collaborative Law is not required[14]	Collaborative Law may be appropriate	Collaborative Law may be appropriate	Collaborative Law may be appropriate

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sometimes the process amounts to nothing more than a mission of "shuttle diplomacy" comprised of back-and-forth settlement offers.[16]

b) confidentiality

Confidentiality concerns may surface in a few different ways. Concerns typically arise in the healthcare setting as physicians worry whether their apologies and other efforts towards disclosure will subsequently be used against them in court as admissions of wrongdoing.[17] In response to these concerns, a few states have enacted statutes protecting certain types of apologies made by healthcare providers.[18] Although these statutes may protect some physicians, most healthcare providers remain concerned they will say too much and may even lose insurance coverage if they somehow manage to "admit" liability. As a result, they clam up, avoid contact, and for years play the waiting game with the hope that a lawsuit will never be filed.

Collaborative Law offers a safe place to talk and provides a level of confidentiality that can facilitate open discussion of issues. The confidentiality of settlement conferences is protected by statute.[19] Provisions for confidentiality are also made part of Collaborative Law participation agreements.[20] Since Collaborative Law proceedings are voluntary and can be entered very soon after an incident, healthcare workers have a safe venue to tender the apologies and explanations they might otherwise be reluctant to offer. Because mediation and arbitration proceedings are often entered very late in the game, the opportunity for apology and forgiveness may have passed by the time such proceedings begin.

Confidentiality concerns also surface in other ways. For example, court proceedings are a matter of public record, and many jurisdictions now have documents posted on-line. This level of publicity has caused concern for parties who are reluctant to have private information readily accessible to friends and neighbors. Collaborative Law can help alleviate this problem, as its proceedings are not open to public scrutiny. As a result, participants may be more willing to participate in open discussions.

c) mandatory attorney withdrawal

The mandatory withdrawal provisions for Collaborative Law attorneys may also facilitate the willingness of parties to engage in open discussions. The separation of collaborative attorneys from the litigation process provides just one more layer of protection for parties and therefore is more conducive to open communication. One of the limitations of mediation has always been the fear that divulging too much information would provide opposing counsel with more ammunition in court. Because parties undergoing mediation usually keep the same attorneys if the case continues to court, there is always the feeling that the "cat is out of the bag," even if confidentiality agreements are signed. Collaborative Law attorneys must withdraw if resolution is not achieved, and parties may be more apt to speak out if they do not feel that opposing counsel is ready to pounce on each tidbit of information revealed.

3. Quick response to safety issues

Collaborative Law has a distinct advantage over other proceedings in that it can be voluntarily entered upon the request of any party. There is no need to wait for legal machinations to grind on at a snail's pace. Better yet, if the process is offered routinely as part of a safety resolution program, valuable information can be quickly gathered, assessed, and utilized as a means to address safety concerns.

As an added bonus, Collaborative Law offers an excellent venue to obtain permission to use confidential patient information for safety studies, thereby alleviating some potential concerns associated with HIPAA requirements.[21] Patients can be informed that both the institution and provider are deeply committed to providing safe patient care and that information obtained in these proceedings will be useful in avoiding future problems. Patients can also be informed of any state and federal reporting requirements, as appropriate.

One may well ask why patient disclosure of near-miss episodes should even be considered in cases where there is no resultant injury. Many physicians take a "no harm, no foul" approach and consider it unnecessary to inform patients of these types of occurrences. Patients, on the other hand, want acknowledgment of even the simplest of errors.[22]

The obligations regarding disclosure to patients are not the same as the obligations to report incidents to various institutional or governmental agencies. Physicians have an obligation to inform patients of complications, including all facts necessary for understanding and to make informed decisions regarding future medical care.[23] Near-miss episodes may fall under this umbrella because even when there is no apparent injury at the time, harmful effects might develop at a later date (i.e., Rh-female becomes sensitized following the inadvertent administration of Rh+ blood and may have complications in later pregnancies). Sometimes follow-up testing is all that is necessary to ensure there truly will be no future complications (i.e., serial testing for HIV and hepatitis following the inadvertent use of a contaminated needle). Patients have the right to know about anything materially affecting their care and welfare and should not have to bear the financial responsibility for these additional procedures.[24]

Disclosure of near-miss episodes is also important because patients and families may possess vital information about points of contact that may have altered the course of events or points where danger might ultimately have been averted.[25] The amassed information from these events can be invaluable for improving safety operations and preventing future injuries. Patients may also reap the benefits of near-miss disclosure if incidents are used as teaching opportunities to help them prevent future injuries (i.e., the importance of reporting medication allergies to providers).[26]

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Healthcare personnel are extremely fortunate when their near-miss actions fail to result in injury to a patient. However, future patients encountering the same set of circumstances may not be so lucky.

Disclosure of near-miss episodes is probably discretionary,[27] as may be the case where there has been no injury and there is absolutely no chance the non-disclosure will affect future healthcare decisions.

Whether patient disclosure is deemed necessary or not, each near-miss episode should be evaluated with the goal of overall improvement in patient safety. The circumstances surrounding all the near-miss episodes likely hold valuable information that can be used to prevent similar scenarios from eventually resulting in harm.

4. Why address adverse incidents that do not rise to the level of negligence?

Physicians are sometimes reluctant to discuss the particulars of an incident when they believe they have delivered an appropriate level of patient care. They feel they have "done nothing wrong" and therefore should not have to justify their actions. However, patients often believe healthcare providers must have acted negligently if they suffer harm while undergoing treatment. When faced with unanswered questions, patients sometimes seek redress through litigation until their concerns are addressed.

The general consensus is that physicians and healthcare organizations are obliged to disclose errors that cause harm.[28] Even if physicians would like to distinguish injury or harm-causing events that do not amount to negligence, the bottom line is that repercussions on the health of injured patients are not dependent upon whether the care was delivered in a negligent fashion (i.e., even if a surgeon performs in a competent manner, the inadvertent perforation of a bowel during surgery will likely add time to a patient's hospitalization as well as increase the overall costs associated with care).

5. Other reasons to distinguish negligent vs. non-negligent incidents

a. patients may need the information

Patients are consumers of healthcare services and often have long-term, ongoing relationships with healthcare providers. When something goes wrong, patients and families often express an intense need to know exactly what happened (including whether something could have or should have been done differently that might have prevented the ensuing harm). Some need this information in order to forgive, and others need it to make decisions about whether they wish to continue a particular physician-patient relationship. The level of "fault" or "responsibility" they attach to the incident can sometimes affect their ultimate decisions.

b. physicians have a right to safeguard their reputations

Much of the harm patients suffer is not due to negligence. When competent care has been provided, physicians want their patients to know they acted appropriately and they did everything within their power to prevent injury. For many, the perception that their personal reputation is at stake is a significant factor in any decision whether to defend a lawsuit. Physicians are often held responsible for bad outcomes even in the absence of error, particularly if the injuries are significant. This result can cause great angst to physicians who feel doubly wronged when their names are subsequently reported to state and federal data banks.

Studies of closed cases have shown that many adverse events occur even when there is no evidence of error on the part of practitioners. Patients often receive compensation under these circumstances; sometimes even when there is no verifiable injury. Jury awards do not correlate strongly with actual negligence or even iatrogenic injury.[29]

The Collaborative Law process offers an opportunity for healthcare providers to explain the circumstances of an incident, to demonstrate that appropriate care was bestowed, and possibly to avoid the stigma associated with a lawsuit. The process allows for the use of a neutral expert to assess the situation and provide an opinion to all parties involved. The use of an expert whose sole purpose is to come to an unbiased conclusion may increase confidence in overall results.

The Collaborative Law process also offers a solid "reality check" for both patients and providers regarding the medical care in question. Attorney representation should help clarify to patients the potential consequences of pursuing litigation if it appears the injury is not based upon negligence. Similarly, providers should understand the potential consequences of a "deny and defend" stance if liability is probable.

c. the information may be necessary for patient safety improvement

To improve patient safety, one must know what, if anything, could or should be done differently in the future to help prevent the occurrence of similar injuries. To make these determinations, one must know the existing standards of care and whether these standards have been met. If deviations have occurred, training programs can be developed to educate all who will benefit from the information. If the standard has been met and injuries have still resulted, the standard itself must be re-evaluated and changes made accordingly.[30] Discussion of issues related to standard of care and the determination of fault do not require that parties engage in accusatory tactics or finger-pointing. Discussions of responsibility similarly do not have to include long and drawn-out or overly detailed narratives of each element of negligence. However, they must include enough information to determine what happened.

Many incidents are due to systems failures rather than individual incompetence. These errors are the result of badly designed systems in which multiple factors combine to produce ideal conditions for error.[31] Systems failures must be analyzed along

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with individual failures as the potential bases for near-miss episodes as well as negligent and non-negligent injuries. In a complex environment, there are numerous opportunities for error as multiple interactions occur between physicians, nurses, laboratory personnel, and others who come into contact with patients and their families. Instead of focusing on a few bad actors, the focus should be on errors of individuals working in systems where mistakes can and do occur.[32]

A totally blame-free environment probably cannot exist, however, and may even be irresponsible.[33] Whether individual or systems factors are responsible for injury, patients expect and deserve accountability.[34] Many providers appear to recognize this fact and seem willing to accept reasonable consequences to their own actions.[35] Other caregivers also seem to recognize this fact and are not willing to shelter co-workers who fail to disclose injuries to patients. In fact, the numbers of lawsuits initiated upon the advice of other healthcare workers[36] supports the penchant for accountability and the refusal to cover up negligent incidents at the expense of patients.

Disclosure in a blame-free environment involves two prongs, the first being the truthful and ethical disclosure to a patient or family after which the injured party has the option to consider absolution.[37] The second prong looks at blameworthy acts from the point of view of the organization. On one hand, an organization will want to facilitate reporting by creating a non-punitive environment, but on the other hand it might be irresponsible for an organization not to punish terrible and egregious errors.[38]

The organizational culture within an institution will play a major role in how individuals respond to incidents.[39] A progressive increase in self-reporting by doctors and nurses was experienced at the VA Medical Center in Lexington, Kentucky that is believed due to the general air of openness and the fact that management does not punish honest errors.[40] Errors are inevitable and expected within complex systems. Latent failures, those embedded in the design of complex systems, are "accidents waiting to happen" and can be the most dangerous because they often remain unrecognized.[41] Organizations must endeavor to treat healthcare workers fairly and with respect when incidents occur if they wish to develop the trusting relationship necessary to facilitate self-reporting of all potentially harmful situations.

It simply makes sense to use a parallel program to promote resolution of safety issues. Organizational responsibility and individual responsibility can be assessed together while seeking solutions and facilitating reparations.

THE COMPETING INTERESTS

Patients typically want at least three things when faced with an unanticipated medical outcome. They want to know why or how an incident happened; they want to know what has been done to see that it will not happen again; and they want an apology.[42] The more serious the injury, the more detailed an explanation is desired.[43] Additionally, some may want financial recovery, while others may want to preserve ongoing relationships with their physicians.[44]

Many physicians would like to provide sincere apologies, but are reluctant to do so because of they fear any statements they make will be construed as admissions of liability. Physicians do not want to see their patients faced with added medical expenses, but do not feel monetary recovery should come out of their insurance if they believe they "have done nothing wrong." They vigorously defend actions because of the stigma attached to being labeled a "bad doctor" and the fear of being reported to various state and federal data banks. When no negligence is involved, they want their patients to know they acted appropriately even though there has been a bad result.

Some insurance companies and healthcare organizations worry their costs will explode if they fail to defend all but the most blatant of negligent actions. Others look to new solutions involving apology and disclosure and recognize such actions can result in significant cost savings. Institutions recognize they must respond to many new requirements for reporting adverse incidents and near-misses.

A Collaborative Law program run in a parallel process with a Patient Safety Program has the ability to address many of these competing interests.

SAMPLE PARALLEL PROGRAM SET-UP

A parallel program could be set up in the following manner:

A Parallel Team is formed to investigate all adverse incidents and near-miss episodes. The team includes a medical doctor (capable of determining whether disclosure is required) and a report officer (capable of determining whether reporting is required). All members of the healthcare team (including affiliated physicians) are educated about the benefits, purposes and requirements of the program. Members are informed of reporting mechanisms and provided with contact information.

The Parallel Team is notified immediately following all incidents.[45] The facts are then reviewed with the healthcare provider to determine whether disclosure is necessary, and if so, whether disclosure has already occurred. If disclosure is not necessary, the information is routed to the Patient Safety Program for in-house evaluation, statistical use, and to ensure necessary safety revisions are made to existing processes.

If a provider desires assistance with disclosure or otherwise prefers the use of Collaborative Law (perhaps for added confidentiality), the Parallel Team explains the program to the patient and requests participation in the process.

If disclosure has already occurred, the Parallel Team should contact the patient for the following reasons:

- to see if he or she has any further questions or concerns, and if so, whether the patient would prefer to have the issues addressed within the Collaborative Law process;

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- to explain the overall commitment of both the institution and provider to patient safety and how information gained from each incident could be used to foster change;
- to request patient consent for the use of confidential information for safety improvement purposes.[46]
- to inform patients of the opportunity for independent attorney representation within the Collaborative Law process that can help to ensure protection of their interests.

The Collaborative Law process can be initiated by either the patient or the healthcare provider with the assistance of the Parallel Team. Since all incidents in the parallel process are evaluated by the Parallel Team and since entering the process is not dependent upon whether or not error has occurred, the stigma of participation can be far less than that associated with litigation.

Once the process is completed, the Parallel Team follows through to ensure that any mandatory state and federal reporting requirements have been met. The Team also takes whatever steps are necessary to see that the appropriate safety changes are made to existing processes, protocols and policies.

WHY ADD ATTORNEYS TO THE MIX?

Some early resolution programs seek solutions without the active participation of attorneys. Although this approach may work well for some parties, attorneys can offer some assistance for others facing healthcare issues. Lawyers can help equalize some of the power imbalances that often occur in physician-patient relationships, especially when the physician and healthcare institution have legal backup. Some injured parties may avoid early resolution attempts because they feel they are easy prey for sophisticated organizational representatives. On the other hand, some institutions find it helpful for patients to have attorney representation because counsel can help clarify standard-of-care and accountability issues.[47] Some facilities advise patients of the right to retain counsel, and some encourage them to seek representation if they have not already done so.[48]

Many institutions have successfully relied upon in-house counsel to resolve issues related to medical injury. However, there are some advantages to outsourcing the entire process to Collaborative Law professionals.[49] First and foremost is the opportunity to focus 100% of efforts solely upon settlement and resolution. Outside collaborative professionals do not have to face the impossible tasks of trying to settle a case while also preparting for trial. Collaborative attorneys are also trained in seeking solutions through interest-based negotiations and will not be focused solely on monetary recovery. Additionally, some in-house attorneys might find it impossible to turn over detrimental information even though all parties have agreed in advance to full disclosure.[50]

Further, even if firewall protections are instituted, the potential for inadvertent release of information between co-workers exists. Even when there is no impropriety, a certain level of mistrust and the appearance of the impropriety may cloud some efforts at solution. The mandatory attorney withdrawal provisions of the Collaborative Law process can help alleviate concerns that information and apologies will be used against the parties if resolution is not achieved. Outsourcing leaves in-house counsel available to take over if the case proceeds to litigation.[51]

COST / BENEFIT ANALYSIS – WHY SUPPORT A PARALLEL PROCESS?

Although it may seem counterintuitive for open disclosure of mistakes to result in overall cost savings, the savings do occur.[52] The cost-saving potential associated with the utilization of parallel processes actually comes from a variety of sources. For starters, unwarranted and outrageous jury awards are avoided because settlements are made only upon agreement of all parties.

A Parallel Team has the ability to coordinate efforts and avoid the costs associated with multiple reviews of the same set of facts by multiple departments. For example, an institution may have separate Risk Management and Safety Review processes operating independently to analyze the same set of circumstances. Then, if the case goes on to litigation, more reviews follow. Through a Parallel Program, it is possible to combine some of these elements. By addressing issues as they arise, the team can potentially avoid costs to dismiss or to otherwise defend unwarranted lawsuits. Additional savings are realized as systems and safety improvements prevent the recurrence of similar patient injuries.

Recently, several programs promoting early disclosure and apology have been developed and studied. Early results are impressive. Programs have been successfully adopted at the following institutions: the Veterans Administration Medical Center in Lexington, Kentucky;[53] the University of Michigan Health System;[54] COPIC Insurance Company in Colorado;[55] and Catholic Healthcare West.[56] The financial results have been very positive.

The Parallel Program combines Collaborative Law and patient safety processes in an attempt to provide reparation for medically injured patients. The program is able to meet patient needs for early answers, apology and prevention of further harm. The program is also able to meet physician needs for assistance with disclosure and apology, protection of reputation, and prevention of unwarranted reporting or accessing of individual insurance for non-negligent injuries. The program is able to meet organizational needs for identification of near-miss and injury-causing events for reporting and safety improvement purposes. The program also meets the needs of medical institutions and insurance companies by providing a cost-effective process for resolution of medically related issues.

Parallel Programs combine elements of no-fault, enterprise, and professional-negligence theories of liability, and they have the

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potential to provide reparation for both negligent and non-negligent injury while maintaining the cost-saving benefits and potential for increased satisfaction among all participants.

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ENDNOTES

[1] Carol B. Liebman & Chris Stern Hyman, *Medical Error Disclosure, Mediation Skills, and Malpractice Litigation, in* THE PROJECT ON MEDICAL LIABILITY IN PENNSYLVANIA, at 22-23 (2005), *available at* http://www.pewtrusts.org/pdf/LiebmanReport.pdf (citing Hickson et. al., *Factors that Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries,* 267 J. AM. MED. ASS'N 1359 (1992)). Hickson's study of the reasons parents sued after the occurrence of perinatal injury reported, "33% sued because they were advised to do so by a third party, often another health care provider; 24% felt the doctor was not completely honest or had lied to them; 24% needed money for the child's future care; 20% couldn't get anyone to tell them what had happened; and 19% wanted revenge or to protect others from harm." *Id.*

[2] Dale C. Hetzler, *Superordinate Claims Management: Resolution Focus From Day One, 21 GA. ST. U. L. REV. 891,* 897-98 (2005).

[3] Liebman & Hyman, *supra* note 1, at 76 (dated information is of little use in improving patient safety).

[4] Karen S. Fasler, *A Niche of Its Own – The Use of Collaborative Law in Medical Malpractice Cases,* 2005 (for overview). *See generally* SHERRIE R. ABNEY, AVOIDING LITIGATION: A GUIDE TO CIVIL COLLABORATIVE LAW (2005).

5 Philip Aspden, Janet M. Corrigan, Julie Wolcott, & Shari M. Erickson eds., PATIENT SAFETY: ACHIEVING A NEW STANDARD FOR CARE 3 (2004).

[6] *Id.* at 18.

[7] *Id* at 169.

[8] *Id* at 171-72.

[9] *Id* at 34.

[10] *Id* at 32.

[11] Barry R. Furrow, Thomas L Greaney, Sandra H. Johnson, Timothy S. Jost & Robert L. Schwartz, HEALTH LAW: CASES, MATERIALS AND PROBLEMS 33-34 (3d ed. 1997) (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)). This New York study estimated that eight times as many patients suffered negligent injury as filed malpractice claims and that sixteen times as many were injured than received compensation.

[12] Note: the potential to span the complete spectrum of near-miss and injury cases will require that the program be funded by a means other than contingency-fee agreements.

[13] Some refer to similar episodes as "harmless hits" (as in cases where there is no appreciable effect on the patient). *See* Carol Bayley, *Medical Mistakes and Institutional Culture, in* ACCOUNTABILITY: PATIENT SAFETY AND POLICY REFORM 108 (Virginia A. Sharpe ed. 2004).

[14] Note: the "prevention" category of near-miss episodes does not require Collaborative Law intervention, as there would be no patient contact; the circumstances can be addressed solely within a safety program.

[15] Liebman & Hyman, *supra* note 1, at 63 (questions, grief, understanding and empathy are expressed during mediation caucuses).

[16] Hetzler, *supra* note 2, at 902. Separating the parties into caucus rooms may be more familiar to some attorneys and neutrals and may quickly become an exercise in shuttle diplomacy.

[17] Liebman & Hyman, *supra* note 1, at 51.

[18] *Id.*

[19] *See* ABNEY, supra note 4, at 93.

[20] *Id.* at 95.

[21] For a discussion of HIPPA, see Bryan A. Liang, *Error Disclosure for Quality Improvement: Authenticating a Team of Patients and Providers to Promote Patient Safety, in* ACCOUNTABILITY: PATIENT SAFETY AND POLICY REFORM 69-71 (Virginia A. Sharpe ed. 2004). Patient safety researchers may consider obtaining HIPAA authorization from patients to gain access to patient-identifiable materials. *Id.* at 70.

[22] Steve S. Kraman & Ginny Hamm, Ginny, *Risk Management: Extreme Honesty May Be the Best Policy,* 131 ANNALS INTERNAL MED. 963 (1999).

[23] Nancy Berlinger, AFTER HARM: MEDICAL ERROR AND THE ETHICS OF FORGIVENESS 40 (2005) (citing Code of Medical Ethics of the American Medical Association).

[24] JOHN D. BANJA, MEDICAL ERRORS AND MEDICAL NARCISSISM 25 (2005).

[25] E. Haavi Morreim, *Medical Errors: Pinning the Blame versus Blaming the System, in* ACCOUNTABILITY: PATIENT SAFETY AND POLICY REFORM 216 (Virginia A. Sharpe ed. 2004). (arguing that if errors are understood by gathering detailed information, it makes little sense to exclude information from possible firsthand witnesses).

[26] Albert W. Wu, *Is There an Obligation to Disclose Near-Misses in Medical Care?*, in ACCOUNTABILITY: PATIENT SAFETY AND POLICY REFORM 141 (Virginia A. Sharpe ed. 2004).

[27] *Id.* (although discretionary, it is also desirable).

[28] *Id.* at 142.

[29] William M. Sage, *Reputation, Malpractice Liability, and Medical Error, in* ACCOUNTABILITY: PATIENT SAFETY AND POLICY REFORM 167 (Virginia A. Sharpe ed. 2004).

[30] *See generally* Furrow et al., *supra* note 11, at 175.

[31] See Bayley, *supra* note 13, at 101.

[32] Liang, *supra* note 21, at 61.

[33] Robert Wachter ed., *AHRQ Interview with Professor John Banja,* AHRQ WebM&M, SORRY WORKS! NEWSLETTER (March 1, 2006).

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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

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[34] For a patient / family perspective, see Sandra M. Gilbert, *Writing/Righting Wrong, in* ACCOUNTABILITY: PATIENT SAFETY AND POLICY REFORM 36 (Virginia A. Sharpe ed. 2004). When errors occur, patients want, need, and should demand accountability – as another word for justice.

[35] Steve S. Kraman, *A Risk Management Program Based on Full Disclosure and Trust: Does Everyone Win?* 27 COMPREHENSIVE THERAPY 257 (2001).

[36] Liebman & Hyman, *supra* note 1, at 22-23.

[37] Wachter, *supra* note 33.

[38] *Id.*

[39] For a discussion of a program at Catholic Healthcare West directed at changing the culture of medical mistakes, see Bayley, *supra* note 13, at 102.

[40] Kraman, *supra* note 35, at 255.

[41] Liang, *supra* note 21, at 61.

[42] Hetzler, *supra* note 2, at 894.

[43] BANJA, *supra* note 24, at 23.

[44] Hetzler, *supra* note 2, at 894.

[45] Notification opportunities should be made available to all healthcare employees and even to patients. Consider that 33% of patients sued when advised to do so by a third party, often other healthcare personnel (see n.1, *supra*).

[46] Liang, *supra* note 21, at 69-71. Patient safety researchers may consider obtaining HIPAA authorization from patients to gain access to patient-identifiable materials. *Id.* at 70.

[47] Hetzler, *supra* note 2, at 899.

[48] Kraman & Hamm, *supra* note 22, at 967; *see also* Bayley, *supra* note 13, at 106.

[49] Note: Even if "outside" Collaborative Law attorneys are used, discussions may be held at the facility if an appropriate venue is available and if desired by the participants.

[50] ABNEY , *supra* note 4, at 25.

[51] *Id.* at 132.

[52] Morreim, *supra* note 25, at 217 (claiming recent evidence indicates that "extreme honesty" may reduce rather than exacerbate the net cost of claims).

[53] Liebman & Hyman, *supra* note 1, at 53-54. The Veterans Administration instituted a radical policy of apologizing to patients as soon as possible after medical error and, when appropriate, offering a fair settlement. They experienced sharp increases in settlements and reductions in the mean malpractice settlement. Savings in litigation costs have been significant. The policy of "assuming responsibility" has led to more healthcare providers promptly reporting errors.

[54] *Id.* at 54. Physicians report error and (after review by risk management) disclose and apologize. Open claims fell from roughly 250-260 down to 120-130 and were resolved in approximately 320 days (down from 1,100 days). The annual cost of handling claims declined from approximately $3 million to $1 million.

[54] *Id.* at 55. Under the 3R's Program, the physician and patient engage in open, honest and empathic conversation within forty-eight to seventy-two hours of a complication or injury. COPIC offers immediate compensation (if appropriate) for out-of-pocket expenses without requiring a release of legal claims.

[55] *d.* at 55-56. After an adverse event, patients are given a copy of the medical record and all relevant information about the event. They are told of the cause and extent of the harm and of their right to compensation. CHW takes responsibility for mistakes and apologizes. They advise patients to consult a lawyer to decide whether offers of compensation are fair.

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The pursuit of peace and progress cannot end in a few years in either victory or defeat. The pursuit of peace and progress, with its trials and its errors, its successes and its setbacks, can never be relaxed and never abandoned.

Dag Hammarskjold