

HOW ALTERNATIVE DISPUTE RESOLUTION ENCOURAGES SUBSEQUENT REMEDIAL
MEASURES AFTER MEDICAL MALPRACTICE, MEDICAL NEGLIGENCE,
OR ADVERSE OR UNANTICIPATED EVENTS

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I. Introduction

Leilani Schweitzer said she finally felt “safe.”¹ After spending nights without either sleep or answers at a local hospital, Schweitzer drove her 20-month-old son to Stanford’s Children’s Hospital: “a place full of the most advanced machines, brilliant minds and innovative best practices medicine had to offer. There was no place he could be safer.”² As Schweitzer attempted to rest at her son Gabriel’s bedside, a nurse turned off the blaring alarms to Gabriel’s heart and breathing monitor so that Schweitzer might sleep without panic or interruption. “I clearly remember thanking her when she did it,” Schweitzer recalled.³ What neither Schweitzer nor the nurse realized, however, was that disabling the alarms in the hospital room also disabled them at the nurse’s station and on the nurse’s pager.⁴ “When Gabriel’s heart stopped beating,” Schweitzer said, “there was no sound.”⁵

Schweitzer relived the harrowing experience of losing her son during a 2013 TedX Talk. She explained to her audience and implored with the medical community that a lawsuit was the very last thing on her mind. “Like most people who have experienced errors in medical care,” she explained, “we want three things: we want an honest, transparent explanation of what has happened. We want a full apology. And we want to know and see that changes have been made to ensure that what has happened to us never happens to anyone else.”⁶

Schweitzer compared her experience with the local hospital to her experience at Stanford’s Children’s Hospital. Both institutions contributed to her son’s death (the former,

¹ Leilani Schweitzer, *Transparency, Compassion, and Truth in Medical Errors*, TED.COM (2013) <http://tedxtalks.ted.com/video/Transparency-Compassion-and-Tru>

² Leilani Schweitzer, *Not with Great Frequency - Disclosure & Compassion = The Standard of Care (Medicine X)*, (Sept. 7, 2014) http://leilanis.typepad.com/my_weblog/

³ *Id.*

⁴ *Id.*

⁵ Schweitzer, *Transparency, Compassion, and Truth in Medical Errors*, *supra* note 1.

⁶ *Id.*

because of misdiagnoses; the latter, because of the tragic alarm mistake).⁷ Additionally, “[b]oth had the opportunity to learn from [Gabriel’s] death and be transparent, but only one did.”⁸ While the local hospital ignored Schweitzer’s requests for answers, Stanford “didn’t hide behind legal maneuvers and dismiss me. They learned, they explained, and they changed the procedures in their hospital to ensure that all of the children who were patients there were safer.”⁹

Although the presence of alternative dispute resolution (ADR) has lagged behind in health care,¹⁰ increasingly, hospitals like Stanford are turning towards alternative dispute measures to resolve disputes involving medical malpractice, negligence, and adverse or unanticipated health outcomes. ADR has been known to decrease costs, increase satisfaction, and preserve working relationships during various health care disputes.¹¹ In the healthcare field, and with regard to medical malpractice suits in particular, ADR can resolve claims “in a more efficient, cost effective manner than litigation and permit techniques to be utilized that are not available in litigation.”¹² Moreover, ADR may prompt or facilitate conversations like the one Schweitzer had with Stanford, thereby changing hospital procedures and improving patient safety.¹³ In traditional litigation, hospitals or providers are hesitant to change procedures after a malpractice, negligence, or an adverse event, due to the perceived threat that this change in procedure might be introduced during litigation to prove liability.¹⁴ This possibly has a chilling

⁷ *Id.*

⁸ *Id.*

⁹ *Id.*

¹⁰ David H. Sohn and B. Sonny Bal, *Medical Malpractice Reform: The Role of Alternative Dispute Resolution*, 470 CLIN ORTHOP RELAT RES. 5, 1370–1378 (2012) <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3314770/> (“ADR, however, has not been as quickly embraced in medical malpractice as in other fields of commercial and civil litigation.”).

¹¹ *Id.*

¹² *Report to the House of Delegates*, ABA SECTION OF DISPUTE RESOLUTION (2015).

¹³ See Michelle Mello et al., *Communication-And-Resolution Programs: The Challenges And Lessons Learned From Six Early Adopters*, 33 HEALTH AFFAIRS 20, 20 (Jan. 2014) (noting anecdotal reports suggesting that communication-and-resolution programs (“CRPs”) can “substantially reduce liability costs and improve patient safety.” For a more in depth discussion of CRPs, see Section IV, *infra*).

¹⁴ See Hyman, *Mediation and Medical Malpractice*, 2 (2011).

effect on the willingness of hospitals and providers to acknowledge mistakes and take steps to ensure that a similar mistake is not repeated. By contrast, in ADR, it would appear that subsequent remedial measures are both encouraged and even sought after by the adversely affected patient or family.¹⁵

This paper focuses on the role that various ADR models play in changing medical and administrative procedures after malpractice, negligence, or an adverse or unanticipated event. Part II of this paper tracks the overall paradigm shift from litigation (in which the injured party traditionally receives monetary damages), to alternative dispute resolution (in which an injured party may request non-traditional, non-monetary remedies such as changes to hospital procedures). Part III of this paper discusses the role of subsequent remedial measures in litigation versus ADR, and argues that traditional litigation discourages hospitals from implementing subsequent remedial measures, whereas ADR embraces subsequent remedial measures as part of the resolution process. In addition, this section advocates for the use of a neutral ombudsman to address and implement remedial measures proactively, before an adverse outcome even occurs. Part IV discusses the implementation of current disclosure and apology models (notably, “communication-and-resolution programs”) and advocates for increased data collection on subsequent remedial measures as a way of measuring program success. Future studies may demonstrate a correlation between subsequent remedial measures and variables such as reduced adverse outcomes and increased patient safety, thereby encouraging hospitals, insurance carriers, and patients to seek ADR over litigation and employ subsequent remedial measures as part of the resolution process.

¹⁵ *See id.* at 2-3.

II. *ADR and the Paradigm Shift Towards Non-Monetary Damages*

“The US Department of Health and Human Services has estimated that between \$76 and \$126 billion is spent per year on litigation in medical malpractice.”¹⁶ A portion of this cost is attributable to jury awards: a 2006 New England Journal of Medicine study reported that “awards in verdicts for the plaintiff on average were nearly twice the size of payments made outside of court (\$799,365 vs. \$462,099).”¹⁷ Another more recent study argued that medical malpractice litigation may not be responsible for the overall rise in health care costs, but cited statistics that, “while frequency and overall cost of claims are down, large losses of \$50 million and higher keep on getting larger.”¹⁸ In fact, between 2012 and 2014, “there have been 12 healthcare malpractice verdicts of \$50 million or more, with six of those verdicts exceeding \$100 million.”¹⁹ Unfortunately, promises of tort reform may not provide suitable answers: “Contrary to the promises of policymakers and leaders of physician groups who have spent the past two decades championing efforts to restrict patients’ legal rights, there is no evidence that patients receive any benefits in exchange for ceding their legal remedies.”²⁰

These incredible monetary awards are difficult to reconcile in light of Schweitzer’s TEDx talk and campaign to shift the healthcare dispute paradigm from “deny and defend” to “acknowledge and apologize.”²¹ “[T]he perception is that [victims of medical errors] just want

¹⁶ Sohn and Bal, *supra* note 10.

¹⁷ David M. Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 NEW ENG. J. MED. 2024, 2026 (May 11, 2006) <http://www.nejm.org/doi/pdf/10.1056/NEJMsa054479>

¹⁸ Andrew G. Simpson, *Malpractice Claims at Record Low, Not Driving Health Costs: Consumer Group*, INSURANCE J. (July 13, 2012) <http://www.insurancejournal.com/news/national/2012/07/13/255557.htm>.

¹⁹ *Healthcare Malpractice Claims: The Current Landscape*, AIG (June 2015) <http://www.aig.com/content/dam/aig/america-canada/us/documents/brochure/healthcare-malpractice-claims-the-current-landscape.pdf>.

²⁰ *Id.* (citing Taylor Lincoln, research director of Public Citizen’s Congress Watch division and author of the report, “Malpractice Payments Sunk to Record Low in 2011.”).

²¹ Schweitzer, *Transparency, Compassion, and Truth in Medical Errors*, *supra* note 1.

money, and I think that's wrong," Schweitzer said.²² Her hunch is correct: increasingly, studies show that a simple apology "may go a long way to satisfy a claimant, making settlement more likely and even forestalling suit altogether."²³ When victims do not receive this apology, however, Schweitzer believes that "people hire lawyers because they feel deceived and abandoned."²⁴ This is troubling, given that traditional litigation provides "only narrow forms of remedies," namely, "an award of money damages or limited injunctive relief."²⁵

By contrast, ADR does not rely exclusively on monetary damages to resolve disputes. In addition to monetary compensation, ADR offers other "creative solutions, longer-lasting outcomes, greater satisfaction, and improved relationships."²⁶ In ADR, "the ability of the parties to control the process permits them to agree to remedies that may not be available through litigation but serve to meet their needs."²⁷ In health care disputes, these remedies may take the form of an apology, "the willingness of counsel to make a contribution to an agreed upon charity" in lieu of attorney's fees, or renegotiation of complex hospital-physician contracts.²⁸ Other unique resolutions have included "providing funds for plane fare and lodging," thereby "allowing family members to stay with a patient during a postoperative recovery period," and the creation of a "scholarship fund in response to an unexpected death following a medical error."²⁹

²² *Id.*

²³ CHRISTOPHER B. MUELLER AND LAIRD C. KIRKPATRICK, EVIDENCE UNDER THE RULES: TEXT, CASES, AND PROBLEMS, 192 (8th ed. 2015), *citing* Jonathan R. Cohen, *Article: Legislating Apology: The Pros and Cons*, 70 U. Cin. L. Rev. 819 (2002).

²⁴ Schweitzer, *Transparency, Compassion, and Truth in Medical Errors*, *supra* note 1.

²⁵ *ADR Spectrum*, JAMS (<http://www.jamsadr.com/adr-spectrum/>).

²⁶ *What is ADR?* NYCOURTS.GOV (https://www.nycourts.gov/ip/adr/What_Is_ADR.shtml).

²⁷ Report to the House of Delegates, ABA SECTION OF DISPUTE RESOLUTION (2015).

²⁸ *Id.*

²⁹ Szmania, Johnson, and Mulligan, *Alternative Dispute Resolution in Medical Malpractice: A Survey of Emerging Trends and Practices*, *Conflict Resolution Quarterly*, 81 (2008).

Alternative remedies (and the ADR system, generally) are not limited to medical malpractice.³⁰ For example, an Indiana-based civil rights group has employed ADR as part of their mission to “investigate complaints of discrimination and educate organizations, companies, landlords, associations, and individuals on their rights and responsibilities under Indiana Civil Rights Laws.”³¹ Their website provides examples of

“non-monetary relief that have led to successful resolution of employment discrimination complaints includ[ing] neutral letters of reference, letters of apology, no retaliatory conduct, withdrawal of the complaint pending with the agency, agreement to adhere to non-discriminatory employment practices or an agreement to provide training to management and staff on equal employment opportunity laws and procedures.”³²

That being said, this paper argues that methods of non-monetary relief similar to “an agreement to adhere to practices,” or to “train management and staff on laws and procedures” are especially critical in the health care context, where procedural deviations can cost human life. It is estimated that “440,000 patients die every year from preventable medical errors.”³³ Although research on the importance of disclosure and apology has increased dramatically (prompting some states to adopt statutes that bar the use of apologies as substantive evidence of fault in lawsuits),³⁴ apologies on their own do little to prevent similar issues from occurring again.

In lieu of tort reform, this paper argues that the legal system must allow for a transparent feedback loop and provide for resolution of these preventable medical errors by encouraging

³⁰ JAMS, the “largest private alternative dispute resolution (ADR) provider in the world,” has resolved disputes in the following fields/industries: Antitrust, Bankruptcy, Business, Class Action, Commercial, Construction, Construction Defect, E-Discovery, Education, Employment, Engineering and Construction, Entertainment and Sports, Environment, Family, Federal, Financial Markets, Franchise, Government, Healthcare, Insurance/Reinsurance, Intellectual Property, Landlord/Tenant, Lender Liability, Professional Malpractice, Marital Dissolution, Mass Tort, Partnership, Personal Injury, Probate, Product Liability, Public Policy, Real Estate, Securities, Toxic Tort, Trusts and Estates. *About JAMS*, JAMS, http://www.jamsadr.com/aboutus_overview/.

³¹ Indiana Civil Rights Commission, *Who We Are*, IN.GOV (<http://www.in.gov/icrc/index.htm>).

³² Indiana Civil Rights Commission, *Alternative Dispute Resolution (ADR)*, IN.GOV (<http://www.in.gov/icrc/2386.htm>).

³³ *Medical Errors*, AMERICAN ASSOC. FOR JUSTICE, <https://www.justice.org/what-we-do/advocate-civil-justice-system/issue-advocacy/medical-errors>.

³⁴ See MUELLER AND KIRKPATRICK, *supra* note 23.

changes in procedure and subsequent remedial measures – the very remedies that are already available through ADR, communication-and-resolution programs, and institutional ombudsmen. The following sections explore how traditional litigation arguably stifles changes to procedure and prevention of medical errors; comments on how alternative dispute methods have improved upon this systemic reluctance to change; and evaluates whether these alternative dispute methods have made a difference in the delivery of health care.

III. *Subsequent Remedial Measures: Traditional Litigation versus ADR*

a. Traditional Litigation and the Rules of Evidence

The Federal Rules of Evidence state that evidence of subsequent measures is *not* admissible to prove “negligence; culpable conduct; a defect in a product or its design; or a need for a warning or instruction,” thereby encouraging defendants to take steps to evaluate and fix processes.³⁵ Nevertheless, evidence of a change in procedure may be introduced for impeachment purposes or for “proving ownership, control, or the feasibility of precautionary measures” if disputed.³⁶ Accordingly, “there is pressure not to change systems during litigation based on the thinking that a change may be an admission of liability.”³⁷

How does the rule protecting subsequent remedial measures work? In one example, after a routine, uneventful surgery on her toe, a plaintiff began using a device which wrapped around her affected foot and was intended to provide cold therapy in order to reduce swelling and pain.³⁸ The device came with a warning to discontinue use if “a noticeable change in skin appearance in the area of the cold application is observed such as burning, itching, blistering, discoloration, or

³⁵ FED. R. EVID. 407.

³⁶ *Id.*

³⁷ Hyman, *supra* note 14, at 2.

³⁸ *Chlopek v. Fed. Ins. Co.*, 499 F.3d 692, 695-96 (7th Cir. 2007); Marjorie A. Shields, *Admissibility of evidence of subsequent remedial measures under Rule 407 of Federal Rules of Evidence*, 158 A.L.R. FED. 609, 11b.

increased swelling.”³⁹ Ultimately, the device caused frostbite on the plaintiff’s toe, requiring amputation.⁴⁰ The plaintiff sued the device manufacturer for failure to include a warning that continuous use could lead to thermal injuries.⁴¹ At some point after the plaintiff’s injury, the manufacturer did in fact change its warning labels; the court excluded this evidence at trial, however, holding “the evidence was barred under Federal Rule of Evidence 407 as a later remedial measure.”⁴² Upholding the trial court’s decision to bar the evidence, the appeals court iterated the policy behind FRE 407:

[The manufacturer’s] *motive* for making the change is irrelevant. All the rule requires is that the measure “would have made the injury or harm less likely to occur.” Fed. R. Evid. 407. Regardless of [the manufacturer’s] stated reason for the change, the plaintiffs undoubtedly wanted the *jury* to conclude that [the manufacturer] added the warning because the product was unsafe without it. That is precisely the type of inference that Rule 407 forecloses, in order to avoid discouraging the taking of remedial measures.⁴³

Notwithstanding the commendable policy behind FRE 407 (and analogous state evidentiary laws), the rule does not always prevent subsequent remedial measures from entering the courtroom. One such example occurs when “the remedial measures were undertaken by someone not a party to the suit.”⁴⁴ In *McLaughlin v Rush-Presbyterian St. Luke's Medical Center*, the plaintiff sued “for personal injuries sustained when a subclavian catheter was lost in plaintiff’s body due to defendant’s alleged negligence.”⁴⁵ A verdict was returned in favor of the hospital, in part because the hospital introduced evidence that the manufacturer of the catheter (who was not a party to the suit), modified the design of its product to prevent similar

³⁹ *Id.* at 696.

⁴⁰ *Id.* at 697.

⁴¹ *Id.*

⁴² *Id.* at 697.

⁴³ *Id.* at 700.

⁴⁴ Thomas M. Flemming, Annotation, Admissibility of evidence of repairs, change of conditions, or precautions taken after accident -- modern state cases, 15 A.L.R. 5th 119, 87b, *citing McLaughlin v Rush-Presbyterian St. Luke's Medical Center*, 68 Ill App 3d 546, (1st Dist. 1979).

⁴⁵ *McLaughlin*, 68 Ill. App. 3d at 547.

incidents.⁴⁶ Again, the reviewing court iterated the policy reasons behind its decision to uphold the verdict:

[E]vidence of post-occurrence changes has been excluded on policy grounds to avoid discouraging defendants from improving the place or thing that had caused the injury . . . In our opinion there is no policy reason for excluding evidence of post-occurrence catheter design modifications in this case because the manufacturer of the product is not a party to the suit. The evidence of post-occurrence change in the catheter design did not prejudice the manufacturer nor was it introduced to prove the manufacturer's negligence.⁴⁷

Accordingly, in this instance, the admission of subsequent remedial measures actually worked in the hospital's favor.

Evidence of subsequent remedial measures does not always work to the defendant hospital's advantage, however, and may be introduced to impeach defendant witnesses.⁴⁸

Davenport v. Ephraim McDowell Memorial Hospital consisted of facts eerily similar to Schweitzer and Gabriel's story: when the plaintiff was in the recovery room after surgery, she went into cardiac arrest.⁴⁹ Her heart monitors failed to sound, however, because the alarm system "had either not been activated or its volume had been adjusted low enough to be inaudible."⁵⁰ The court permitted evidence that the hospital "changed its policy regarding monitor alarms and began consistent utilization of them immediately after the incident," not to prove the hospital's negligence, but to "impeach testimony by several defense witnesses that such alarms were not used at the hospital because they frequently sounded for inappropriate readings and were unnecessary."⁵¹

⁴⁶ *Id.* at 547-48.

⁴⁷ *Id.* at 549.

⁴⁸ Flemming, *supra* note 44, citing *Davenport v. Ephraim McDowell Memorial Hospital, Inc.*, 769 SW2d 56 (Ky App 1988).

⁴⁹ *Davenport*, 769 SW2d at 58.

⁵⁰ *Id.*

⁵¹ Flemming, *supra* note 44.

Additionally, evidence of subsequent remedial measures may also be introduced to show a patient's "probable condition" and his physician's observations at the time of his treatment.⁵² In *Wilson v. Gilbert*, Dr. Gilbert, a general surgeon, attempted to treat a patient's severed femoral artery.⁵³ Dr. Gilbert had no training in vascular surgery, did not call in a vascular surgeon, and attempted to reconnect the artery without first performing an arteriogram "to determine whether circulation in the femoral artery had become obstructed by blood clots."⁵⁴ The operation did not restore circulation in the patient's leg, and after several other unsuccessful procedures, the patient lost his leg to amputation.⁵⁵

In addition to testimony from the plaintiff's expert (who testified that Dr. Gilbert failed to follow standard of care), Dr. Gilbert himself was required to testify that, "after having treated [the patient], he had taken 'a course on giving arteriograms.'"⁵⁶ The court also admitted deposition testimony stating that, after his experience with the patient, Dr. Gilbert "referred similar cases to vascular surgeons."⁵⁷ Though the defendant argued that admission of this evidence was "error by reason of the rule excluding evidence of "subsequent precautions,"" the court disagreed on two grounds:

The facts shown in this testimony, however, had to do with [the patient's] "probable condition" when he was under treatment by Dr. Gilbert, and with the latter's observations at the time; accordingly, the testimony was admissible under a familiar exception to the rule cited. . . . It was also admissible, in each instance, because it tended to impeach Dr. Gilbert in the respective testimonial context. . . . For either or both reasons, no error appears."⁵⁸

In sum, although FRE 407 and analogous state evidentiary laws protect hospitals and providers from having subsequent remedial measures introduced as proof of negligence or fault,

⁵² *Wilson v. Gilbert*, 25 Cal. App. 3d 607, 615 (1972)

⁵³ *Id.* at 610.

⁵⁴ *Id.* at 610-11.

⁵⁵ *Id.* at 611.

⁵⁶ *Id.* at 611, 615

⁵⁷ *Id.* at 615

⁵⁸ *Wilson v. Gilbert*, 25 Cal. App. 3d at 615.

subsequent measures may still be introduced under “exceptions” to the rule, and to the hospital or provider’s disadvantage. The litigation environment therefore implicitly stifles the use of subsequent remedial measures to resolve unanticipated or adverse health outcomes in healthcare disputes.

b. ADR Processes in Healthcare Disputes

In contrast to traditional litigation, ADR not only encourages subsequent remedial measures, but also employs remedial measures as part of the resolution process. Subsequent remedial measures are not simply a litigation tool used to shift blame or prove that a doctor or hospital fell below the standard of care. Instead, with ADR, adversely affected patients actively seek promises that administration and hospital staff will implement remedial measures and learn from the adverse event. This section of the paper discusses two “traditional” ADR models (arbitration and mediation), as well as “communication-and-resolution” programs and institutional ombudsmen as methods of addressing adverse health outcomes and implementing subsequent remedial measures.

i. Arbitration and Mediation

Two forms of ADR most commonly used in healthcare disputes include binding arbitration and mediation.⁵⁹ Arbitration involves a neutral party (the arbitrator) who hears a dispute between parties, “very much like a judge in a courtroom.”⁶⁰ Arbitration offers similar remedies to those available via the litigation process, including monetary damages and equitable

⁵⁹ Katherine Benesch, *Why ADR and Not Litigation for Healthcare Disputes?*, DISPUTE RESOLUTION J. at 2 (Aug./Oct. 2011); Report to the House of Delegates, ABA SECTION OF DISPUTE RESOLUTION (2015)

⁶⁰ Report to the House of Delegates, ABA SECTION OF DISPUTE RESOLUTION (2015)

relief.⁶¹ Like litigation, however, the end result is polarized: The arbitrator considers all relevant evidence and renders a decision, which may be binding and enforceable by a court.⁶²

Mediation also involves a neutral party, but focuses instead on the parties agreeing “to participate in good faith in an effort to reach a mutually agreeable resolution of their dispute.”⁶³ The mediator does not “decide” the issue, but rather, facilitates discussion by “asking questions, pointing out strengths and weaknesses of the respective litigants, and exploring creative means to accomplish the objectives of both parties.”⁶⁴ Because “creative” remedies are available in mediation, it lends itself well to implementing subsequent remedial measures as part of the resolution process, as the following examples demonstrate.

In one instance, a man on Coumadin was admitted to the emergency room after a fall; he died after he was misdiagnosed as having an infection rather than internal bleeding.⁶⁵ As part of the mediation process with the man’s widow, the hospital “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.”⁶⁶ In another case, a widow lost her husband to complications stemming from the placement of a subclavian central line.⁶⁷ After the event, and as part of the mediation process, the hospital implemented two separate procedures.⁶⁸ One change related to the central line placement: the chief of medicine “implemented a new procedure . . . regarding the placement of central lines. The purpose was precisely to avoid harming other patients in the future.”⁶⁹ The other pertained to how the widow

⁶¹ Benesch, *supra* note 59, at 5.

⁶² Report to the House of Delegates, ABA SECTION OF DISPUTE RESOLUTION (2015)

⁶³ *id.*

⁶⁴ *id.*

⁶⁵ Hyman, *supra* note 14, at 2.

⁶⁶ *Id.* at 2-3.

⁶⁷ *Id.* at 2.

⁶⁸ *Id.*

⁶⁹ *Id.*

was treated when she received the news that her husband had passed. “The doctor who related the terrible news abandoned her and left her standing alone in the hall outside her husband’s room,” and no one explained to her what had happened.⁷⁰ Accordingly, the hospital promised to train medical staff on “how to respond to family members grieving as a result of the death of a loved one in the hospital.”⁷¹ Though the hospital may have eventually come around to updating their central line placement procedures, the latter change – training staff to treat family members with compassion and transparency – could only have come from an open and honest dialogue, away from the pressures of the courtroom.

ii. Communication-and-Resolution Programs (CRPs)

In addition to mediation, a few health systems and liability insurers have implemented “communication-and-resolution programs” (“CRPs”) to disclose and address unanticipated care outcomes.⁷² Anecdotal data suggest that CRPs “can substantially reduce liability costs and improve patient safety.”⁷³ One particular CRP model, the “early settlement” model (discussed in more detail in Section IV, *infra*), investigates whether the unanticipated health outcome was caused by a lapse in standard of care, thereby allowing administrators to “identify opportunities to improve patient safety.”⁷⁴

Interestingly, (though perhaps not unsurprisingly), physician fears about malpractice and traditional litigation have made it difficult to implement CRPs.⁷⁵ Some institutions with CRPs reported that “physicians were uncomfortable with making disclosures to patients, probably because of a lack of training in disclosing errors and a cultural disinclination to admit error.

⁷⁰ Hyman, *supra* note 14, at 2.

⁷¹ *Id.*

⁷² Mello et al., *supra* note 13, at 20.

⁷³ *Id.*

⁷⁴ Mello et al., *supra* note 13, at 24.

⁷⁵ *See id.* at 24, 26.

Other clinicians worried that disclosures and settlement offers might increase their liability risk.”⁷⁶ Program leaders of other CRPs found that the hostile litigation environment actually helped with CRP implementation, as providers and physicians sought new approaches to resolving healthcare disputes.⁷⁷ Ultimately, program founders implemented the CRPs by shifting physician concerns away from legal risk, and instead focusing on ““doing the right thing.””⁷⁸ As such, CRPs have helped foster “a climate and culture of patient safety.”⁷⁹

iii. The Role of Ombudsmen in Healthcare Disputes

The concept of an “ombudsperson” is a useful, but still widely underutilized option for non-litigation conflict resolution within the medical center setting.⁸⁰ The ombudsperson can “promote the anticipation, discussion, and resolution of impending conflicts before they evolve into formal disputes.”⁸¹ The ombudsman is often a trained mediator, and can also be an experienced clinician.⁸² At The National Naval Medical Center in Bethesda, Maryland, the internal ombudsman/mediator is “an impartial third party who facilitates discussions between patients and providers, focuses upon underlying issues, needs, and interests, clarifies perceptions, frames issues, helps to create options and . . . assists parties in reaching sustainable and mutually-satisfactory solutions to patient care disputes.”⁸³ Importantly, the ombudsman promotes confidentiality: at Stanford University, the ombudsman’s office is a “‘safe’ place to discuss a

⁷⁶ *Id.* at 24.

⁷⁷ *Id.* at 26.

⁷⁸ *Id.* at 24.

⁷⁹ Mello et al., *Implementing Hospital-Based Communication-And-Resolution Programs: Lessons Learned in New York City*, 33 HEALTH AFFAIRS 30, 34 (Jan. 2014).

⁸⁰ Merle Waxman, *A Nonlitigational Approach to Conflict Resolution: The Medical Center Ombudsperson As a Model*, Corporate Counsel’s Guide to ADR Techniques (2006).

⁸¹ *Id.*

⁸² See Carole Houk, *The Internal Neutral: Why Doesn’t Your Hospital Have One?*, MEDIATE.COM (June 2002) (describing the ombudsman/mediator in place at The National Naval Medical Center in Bethesda, Maryland).

⁸³ *Id.*

problem with the assurance that no action will be taken nor will the fact of the visit or anything the visitor says be disclosed to anyone.”⁸⁴

An ombudsman may be useful in implementing “remedial measures” before an adverse event even occurs. This is due in part to characteristics of the ombudsman’s office, which include “knowledge of the administration and of policies and procedures of the institution,” “experience in enforcing these established policies and procedures,” and experience handling situations where “such policies were not effectively implemented or for which no firm policies exist.”⁸⁵ The ombudsperson also has access to personnel and offices at a variety of levels, and “can function as a facilitator of upward, downward, and lateral communication at many levels.”⁸⁶ Additionally, the ombudsman has an “anticipatory or proactive” role, and the ombudsman “is in a position to identify and monitor institutional problems or trends and to anticipate issues and their solutions.”⁸⁷

How might an ombudsman effectuate a subsequent remedial measure before an adverse event even occurs? Consider one example from Merle Waxman, current Ombudsperson and Associate Dean for Academic Development and the Yale School of Medicine.⁸⁸ Waxman described a situation in which a resident had complained of “inequities in the night coverage schedule.”⁸⁹ In fact, “a situation had arisen where there were not enough house officers to cover night call without a significant increase in the workload of the remaining residents.”⁹⁰ This issue not only affected this resident’s particular department, but also reflected an “institutional

⁸⁴ Stanford School of Medicine, Office of the Ombudsperson

⁸⁵ Waxman, *supra* note 80.

⁸⁶ *Id.*

⁸⁷ *Id.*

⁸⁸ *Id.*

⁸⁹ *Id.*

⁹⁰ *Id.*

discord” that affected many workers in various departments.⁹¹ The problem was “referred upward, within the appropriate hierarchy,” and administration “arranged to allocate funds for alternative coverage in such emergencies.”⁹² Increasingly, data suggest that staff member overload and fatigue “is recognized as a significant threat to patient safety.”⁹³ Accordingly, resolving the coverage issue was a remedial measure that may well have prevented an adverse event from ever occurring in the first place.

IV. Implementing and Measuring the Success of Subsequent Remedial Measures

a. Effectuating Subsequent Remedial Measures – The Stanford CRP Model

“After the university hospital investigated Gabriel’s death, and the weakness in the monitors was discovered,” Schweitzer explained, “all other hospitals using the same equipment were alerted to the vulnerability.”⁹⁴ In addition to providing Schweitzer with an apology and an explanation, the hospital “involved her in the steps it [was] taking to make sure it didn’t happen to another patient.”⁹⁵ In fact, six years after the tragic event, “Stanford hired Schweitzer as a consultant for its program that works with patients to reach a resolution when something has gone wrong. Today she’s assistant vice president of communication and resolution.”⁹⁶

Schweitzer’s story might be an atypical example of how a hospital implements remedial measures after an adverse event, but Stanford’s resolution program is instructive. The program’s acronym is PEARL – Process for Early Assessment and Resolution of Loss – and “is based on

⁹¹ Waxman, *supra* note 80.

⁹² *Id.*

⁹³ Greg Freeman, *Nurse Fatigue a ‘Huge’ Threat to Patient Safety*, AHS (Mar. 1, 2015)

<http://www.ahcmedia.com/articles/134803-nurse-fatigue-a-huge-threat-to-patient-safety-but-can-be-addressed>

⁹⁴ Schweitzer, *Not with Great Frequency - Disclosure & Compassion = The Standard of Care*, *supra* note 2.

⁹⁵ Elizabeth Cohen, *When a surgeon should just say ‘I’m sorry’*, CNN (Mar. 24, 2016)

<http://www.cnn.com/2016/03/24/health/surgeons-im-sorry/index.html?sr=fbCNN032416surgeons-im-sorry0416PMStoryGalLink&linkId=22652154>

⁹⁶ *Id.*

fundamental principles of accountability, transparency and integrity.”⁹⁷ The program is “a model for more so-called communication and resolution programs that hospitals are adopting to interact with patients when things go wrong and avoid costly litigation.”⁹⁸ Importantly, Stanford notes that PEARL “further strengthens our commitment to quality and patient safety by allowing us to better understand what has happened in a patient’s care, and if preventable, keep it from happening in the future.”⁹⁹ In turn, “the PEARL process allows us to learn from our experiences, and use that knowledge to improve safety and all aspects of our patients’ care.”¹⁰⁰

b. Other CRP Models

Communication-and-resolution programs (“CRPs”) encourage health systems and liability insurers to disclose “unanticipated care outcomes to affected patients and their families and proactively seek solutions,” thereby avoiding costly litigation and improving patient safety.¹⁰¹ Though Stanford’s PEARL program is a model CRP, it is not the only such program. Stanford is part of the “Collaborative for Accountability and Improvement,” alongside Beth Israel Deaconess Medical Center in Boston and the University of Michigan, as well as malpractice insurance providers and patient safety organizations.¹⁰² CRPs are a hallmark of the Collaborative for Accountability and Improvement.¹⁰³ With the CRP model, “[h]ospital staff are trained to report problems as soon as they become aware of them, without fear of

⁹⁷ Lucile Packard Children’s Hospital at Stanford, *PEARL - The Process for Early Assessment and Resolution of Loss*, STANFORD HOSPITAL & CLINICS (Aug. 2012), <http://www.stanfordchildrens.org/content-public/pdf/pearl.pdf>

⁹⁸ Laura Landro, *Hospitals Find a Way to Say, ‘I’m Sorry’*, WALL ST. J (Feb. 1, 2016) <http://www.wsj.com/articles/hospitals-find-a-way-to-say-im-sorry-1454355564>

⁹⁹ *Id.*

¹⁰⁰ *Id.*

¹⁰¹ Mello et al., *Communication-And-Resolution Programs: The Challenges And Lessons Learned From Six Early Adopters*, *supra* note 13, at 20.

¹⁰² Landro, *supra* note 98.

¹⁰³ *Communication and Resolution Programs*, COLLABORATIVE FOR ACCOUNTABILITY & IMPROVEMENT (last visited Apr. 8, 2016) <http://communicationandresolution.org/communication-and-resolution-programs/>

punishment.”¹⁰⁴ More importantly, “[h]ospitals are expected to use findings from investigations to put preventive measures in place,” and take steps to “[e]nsure that lessons are learned to prevent recurrences.”¹⁰⁵

Michelle Mello and her colleagues studied six “pioneering CRPs” to glean information about the use of CRPs and how they work.¹⁰⁶ The programs that Mello studied followed one of two distinct CRP models: early settlement and limited reimbursement.¹⁰⁷ The early settlement model involves investigating “whether the unanticipated outcome was caused by a lapse in the standard of care.”¹⁰⁸ Administrators explain the investigation’s findings to the patient or his family, and if the care provided was assessed as substandard, the administrators apologize, admit any errors, and offer appropriate compensation.¹⁰⁹ Importantly, “[t]he administrators also implement care improvements to address patient safety failings brought to light by the unanticipated care outcome.”¹¹⁰ Accordingly, the early settlement CRP model promotes subsequent remedial measures after an adverse or unanticipated outcome.

The limited reimbursement model differs slightly in its scope, as it excludes cases in which “the injuries are severe or the patient or family has taken steps towards litigation.”¹¹¹

Limited reimbursement programs

[E]ncourage but do not directly facilitate disclosure conversations. Program administrators determine whether the unanticipated care outcome was caused by the medical care that was delivered or was the result of the patient’s underlying disease . . . [but] do not review the quality of care or talk with patients about it.

¹⁰⁴ *Id.*

¹⁰⁵ *Id.*

¹⁰⁶ Mello et al., *Communication-And-Resolution Programs: The Challenges And Lessons Learned From Six Early Adopters*, *supra* note 13, at 20.

¹⁰⁷ *Id.* at 20. The three early settlement programs were developed in self-insured hospital systems, whereas the limited reimbursement programs were by noncaptive medical professional liability insurers. *Id.* at 23.

¹⁰⁸ *Id.*

¹⁰⁹ *Id.* at 21.

¹¹⁰ *Id.*

¹¹¹ *Id.*

However, providers are encouraged to tell patients what is known with reasonable certainty about what occurred.¹¹²

In lieu of investigating standard of care, limited reimbursement programs maintain a “no-fault approach” in order to increase physician participation.¹¹³ Unfortunately, this no-fault approach may not provide the same feedback loop as the early settlement model; for early settlement participants, “investigating the quality of care was important because doing so would identify opportunities to improve safety.”¹¹⁴

Notwithstanding the programs’ differences, both the early settlement and limited reimbursement models “emphasize ongoing communication with patients or their families to share what has been learned, assess family needs, and preserve a strong patient-provider relationship.”¹¹⁵ Additionally, CRPs encourage ongoing communication “even after resolution has been reached,” thereby ensuring that “the patient is kept informed of the improvements implemented by the hospital/clinic.”¹¹⁶ Moreover, patients and families are often “invited to be an active part of this process, which allows them to witness the improvement in action.”¹¹⁷

c. *Measuring the “Success” of ADR, CRPs, and Subsequent Remedial Measures*

Data from Stanford’s PEARL program and Mello’s studies of CRPs suggest that early disclosure and apologies save money: “From 2009, when Stanford introduced its resolution program, until 2015, its indemnity costs -- the amount of money paid to compensate patients -- decreased by 27%, and the amount of money spent defending lawsuits went down by 24%.”¹¹⁸

¹¹² Mello et al., *supra* note 13, at 21.

¹¹³ *Id.* at 24 (noting that “participants in the limited reimbursement programs felt that this model’s no fault approach would increase participation by reassuring physicians that the program would not lead to adverse consequences.”)

¹¹⁴ *Id.*

¹¹⁵ *Id.* at 22.

¹¹⁶ COLLABORATIVE FOR ACCOUNTABILITY & IMPROVEMENT, *supra* note 103.

¹¹⁷ *Id.*

¹¹⁸ Cohen, *supra* note 95. The Wall Street Journal provided slightly different data, stating that from 2009 to 2014, after Pearl was implemented, the frequency of lawsuits was 50% lower, and indemnity costs in paid cases were 40% lower compared with 2003 to 2008. See Landro, *supra*.

Captive insurers implementing the limited reimbursement CRP model noted “an important alignment of incentives: When a captive insurer saves money through a CRP, departments pay less to the insurer,” thereby encouraging the reporting and disclosure of unanticipated outcomes.¹¹⁹

As Mello and her colleagues observed, however, “institutions considering the use of CRPs still have scant information about how they work.”¹²⁰ The data are even less clear about the success of subsequent remedial measures. Administrators in Mello’s first CRP study believed that “rates of adverse events had decreased because the programs fostered a culture of safety and of incident reporting, which in turn facilitated more event analyses and the identification of interventions to improve safety.”¹²¹ Yet all six CRPs recognized “that there was still much room for improvement in making full use of lessons learned for improving patient safety.”¹²² A follow-up study of CRPs in New York City hospitals showed that the programs might improve patient outcomes generally, by “‘enabling’ a climate and culture of patient safety.”¹²³ In addition to overall improvement in tracking of reported events, the CRP “helped foster an environment in which clinicians felt they could speak openly about adverse events, and it bolstered a shared perception of the value of the safety-enhancing practices of disclosure and reporting.”¹²⁴ Promisingly, of the 115 New York City cases involving an initial disclosure conversation, 70 involved additional conversations with “resolution elements,” including “offers

¹¹⁹ Mello et al., *Communication-And-Resolution Programs: The Challenges And Lessons Learned From Six Early Adopters*, supra note 13, at 26.

¹²⁰ *Id.* at 20.

¹²¹ *Id.* at 27.

¹²² *Id.*

¹²³ Mello et al., *Implementing Hospital-Based Communication-And-Resolution Programs: Lessons Learned in New York City*, supra note 79, at 34 .

¹²⁴ *Id.* at 34-35.

of remedial measures.”¹²⁵ However, the study did not capture any data about the specifics of these remedial measures or whether they were successfully implemented.

The Collaborative for Accountability and Improvement recognizes that “CRPs are a relatively new concept” and that “performance measures to determine their effectiveness are still being developed and refined.”¹²⁶ This paper argues that performance variables should include data collection on subsequent remedial measures, including how often patients request subsequent remedial measures as part of mediation or resolution discussions; whether hospitals take it upon themselves to revisit institutional policies and procedures after an adverse event; and whether subsequent remedial measures have had an attributable impact on patient safety.

V. *Conclusion*

“Betterment is a perpetual labor.”¹²⁷ Notwithstanding rules of evidence that bar the use of apologies and subsequent remedial measures as proof of liability, traditional litigation inhibits hospitals and providers from identifying and correcting procedures after an adverse medical event. By contrast, alternative dispute resolution provides a confidential and transparent forum for parties to discuss and implement subsequent remedial measures, thereby providing concrete and productive changes to administrative and medical procedures. In the future, studies on various ADR methods in healthcare (including mediation, CRPs, and internal neutrals or ombudsmen) should focus on subsequent remedial measures as a way of measuring program success and documenting improvements in patient safety. In the interim, as Leilani Schweitzer said after her son’s tragic death alerted hospitals across the nation to his heart monitor’s

¹²⁵ *Id.* at 32-33. Resolution discussions also involved the hospital and insurer determining “what steps should be taken to avoid recurrence,” but this was not necessarily communicated to the patient or family. *Id.* at 32.

¹²⁶ *Communication and Resolution Program FAQs*, COLLABORATIVE FOR ACCOUNTABILITY & IMPROVEMENT, <http://communicationandresolution.org/download/crp-faqs-2/> (last visited Apr. 8, 2016).

¹²⁷ ATUL GAWANDE, *BETTER* 9 (2007).

shortcomings, “maybe that helped someone else. I will never know. But it still comforts me now.”¹²⁸

¹²⁸ Schweitzer, *Transparency, Compassion, and Truth in Medical Errors*, *supra* note 1.