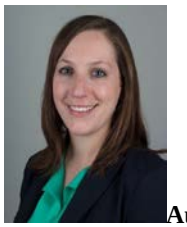

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PATIENT REPRESENTATION IN COMMUNICATION AND RESOLUTION PROGRAMS: WHAT IS THE BEST MODEL?

STRUCTURED ABSTRACT

Background

Communication and Resolution Programs (CRPs) aim to address adverse events with transparency and rapid and fair resolution. Best practices for patient representation in CRPs have been unexplored.

Study Goals

The study goals are to review various types of representation models for CRPs and recommend best practices for patient representation in CRPs.

Methodology

A literature review and semi-structured interviews of stakeholders in the medical liability process were conducted.

Results

Participants' concerns regarding patient representation included: balancing information asymmetry, leveling the negotiation playing field, setting expectations, creating a collaborative environment, ensuring reasonable costs, and supporting the patient emotionally.

Discussion

Participants recommended attorneys with medical malpractice experience and commitment to and understanding of CRP goals as a best practice for patient representation. Finding attorneys that match this profile is challenging, and thus, a list of such attorneys should be curated and given to patients, preferably by a neutral third party. Separate emotional support for the patient should also be considered.

Conclusion

An attorney experienced in medical malpractice and committed to the collaborative process of a CRP is the best form of representation for patients in CRPs.

BACKGROUND – The Traditional Medical Malpractice Litigation Process

In the United States, resolving disputes related to medical injury often involves pursuing litigation.[i] Through this mechanism, patients can receive compensation from the insurer of a healthcare facility or provider when the case meets two criteria: first, the patient must demonstrate a violation by the provider and/or facility of the legal standard of care, and second, the patient must demonstrate that this violation of the standard of care caused injury. When a patient hires an attorney, that attorney most often litigates a case based on a contingency fee model, in which the attorney only collects payment – a percentage of the damages recovered through trial or settlement – if there is a finding for the plaintiff. The attorney must pay the costs of litigating the case up front, creating inherent risks for such attorneys. This payment model effectively results in an implied third criterion that a patient's case must meet in order to be taken on by an attorney: the harm the patient experienced must be significant enough that the attorney can expect to be paid reasonably for time and expenses at its conclusion.[ii]

Healthcare facilities, in turn, have historically engaged in a "deny-and-defend" approach in response to medical malpractice litigation.[iii] Hospitals and other healthcare entities enlist the help of their insurers and retained defense firms who withhold information from the patient about what actually happened during care with the goal of achieving the best defensive position possible at trial.[iv] Healthcare facilities, insurers, and their lawyers determine whether the care given is defensible, that is, whether a colorable legal argument exists that either the standard of care was met, or if inadequate care was provided, that it did not cause the injury. As a result of focusing on how to defend the care regardless of whether it was reasonable, as well as the lack of transparency about actual events, healthcare facilities often do not focus on improving care in the future.[v] These facilities fear that changing the way they deliver care would be an admission of error, thus causing additional liability risks.

The traditional medical malpractice litigation system has several additional flaws including: highly variable awards uncorrelated with the merits of the claim,[vi] long delays between injury and compensation, and high attorney fees. The strategy of shielding information from injured patients prohibits them from getting the answers they are entitled to regarding deficiencies in care.[vii] Furthermore, facilities harm future patients by thwarting improvements providers can undertake to prevent the adverse event from recurring.[viii] These aspects of the traditional system have serious negative impacts on the healthcare system as a whole, perpetuating so-called "defensive medicine,"[ix] poor doctor-patient relationships, and weak quality improvement efforts.

Communication and Resolution Programs

Communication and Resolution Programs (CRPs) aim to address the flaws of the traditional medical malpractice system and offer additional benefits to all involved parties.[x] CRPs address adverse events by:

1) Communicating with the patient about the adverse event, explaining what happened and why, and keeping the lines of communication open for the patient to ask questions and meet with providers and other facility representatives.
2) Expressing empathy for the unexpected outcome, apologizing to the patient if the facility or a provider made an error in the patient's care, and detailing a plan for corrective action.
3) Referring them to the facility or provider's insurer if an error was made and caused the patient significant harm, so that the patient can receive additional review of their case and compensation as soon as possible.

Communication and Resolution Programs are proactive and emphasize honest communication among all parties involved in order to resolve many of the negative externalities noted above in the deny-and-defend system. Patients have the opportunity to learn specifics of the event and ask questions. Hospitals and clinicians have the opportunity to empathize, apologize, and describe the efforts they will take to prevent similar events from happening to another patient in the future. Both parties can move to a resolution in a timely manner that prevents many of the emotional and psychological issues that can result from prolonged trials.[xi]

While a number of institutions nationally have reported anecdotal benefits of the CRP model, the University of Michigan experience is notable as one of the earliest examples of full adoption, and one that has made the greatest effort to publish outcomes. The University of Michigan demonstrated a reduction in claims, lawsuits, and costs in their first 10 years using a CRP, while patients received a larger proportion of the expenditures from the hospital.[xii] The experience at the University of Michigan is leading many institutions to

evaluate adoption of CRP, but concerns about successful implementation remain, and therefore adoption has been slow.[xiii]

Representation

One of the major issues regarding CRP implementation relates to whether the patient should have legal representation while participating in a CRP. To date, little research has been conducted regarding which method of patient representation, if any at all, fits best with CRP philosophy, and which will be most effective in getting an equitable result for all parties involved. In order to make CPRs successful, representation options must be weighed to ensure that settlements reached are fair (i.e., would be upheld in a court proceeding by a judge as a sound agreement) and align with the overarching principle of the programs, which is to do the right thing for everyone involved. It is this gap in understanding the best models for patient representation in CRPs that we aim to address with this study.

STUDY GOALS

The goals of the study were threefold: (1) to take stock of the variety of patient representation models available in a CRP program through interviews of key stakeholders in medical malpractice disputes; (2) to analyze the stakeholder interests in the various types of representation models to identify common ground to isolate those models that benefit as many parties as possible; and (3) to recommend a type of representation model or combination of models for patients in a CRP that will appeal to the core principles of CRPs. Since little to no data exist regarding representation models in CRPs, making a quantitative methodology unsuitable for addressing these three goals, this study used qualitative methods to gain a better understanding of the objectives of major stakeholders and the challenges of representation outside of the traditional tort system.

METHODOLOGY

The methodological approach consisted of both a literature review and semi-structured interviews of key stakeholders involved in medical malpractice disputes. The literature review included scholarly articles from academics in law and public health both in favor of and opposed to CRP programs as a whole. It also consisted of several articles from peer-reviewed medical journals about CRPs—including the limited number with quantitative results—state laws and statutes regarding CRPs, and opinion pieces authored by attorneys, administrators, and clinicians from local and national news outlets.

The interview team was comprised of three students enrolled in the Harvard Negotiation and Medication Clinical Program as part of their academic work at Harvard Law School. Their expertise lies in the areas of interest mapping, stakeholder assessment, and dispute system design. The team attempted to interview stakeholders from the following categories:

- Malpractice attorneys (from both the plaintiff and defense bars)
- Administrators of CRPs
- Disclosure consultants to CRPs
- Patient liaisons
- Nonprofit support service groups
- Patients who experienced adverse events
- Patients who participated in a CRP
- Hospital social workers
- Hospital risk managers
- Academics in public health and law
- Insurance claims managers

Interviews lasted between 30 minutes to 1 hour in most cases, and followed a semi-structured question set that guided the conversation to focus on representation in CRPs, while allowing the interviewee to speak freely about his or her recommendations and concerns. The Institutional Review Board at Beth Israel Deaconess Medical Center deemed this research exempt from ethics review, as it was deemed quality improvement research.

RESULTS

The literature review provided the team with extensive background on CRPs, including the advantages of the program for all involved parties, as well as the major arguments for and against attorney presence in CRPs and the changing roles of attorneys in these processes. With this information, the team conducted interviews with stakeholders in the aforementioned areas. Twenty-one individuals were interviewed in all desired stakeholder groups, with the exception of patients who had participated in a CRP. No such patients were interviewed due to confidentiality concerns on behalf of both the hospitals and the patients. However, the team strove to capture patients' voices by interviewing stakeholders who work directly with patients in medical liability situations, and patients who had experienced adverse events but were not offered the chance to participate in a CRP.

Stakeholders revealed several issues to consider in developing a representative model for CRP programs:

Balancing information asymmetry

Although patients are directly harmed by adverse events, they are often in the dark regarding information about their events as compared to their clinicians and facility representatives. Causes, contributing factors, and systemic failure points are just some of the pieces of information that a healthcare team's investigation of an event unearths. Several stakeholders mentioned that patients often feel they are at a disadvantage after an adverse event, having only the information given to them by the healthcare facility, and sometimes lacking medical expertise to interpret the information they are given. As one stakeholder pointed out, "the patient doesn't know what the patient doesn't know," suggesting that the patient is not aware of what information they should request. Another stakeholder stated that, in her experience, patients feel there are "too many doctors" telling patients "too many things" after a traumatic event, and it is hard for patients to comprehend everything or ask the right questions. While hospitals may well act in good faith during CRP discussions, this can still overwhelm the average patient. As one stakeholder stated, the average person "would feel somewhat overwhelmed by that process, sitting in a room with a risk manager, a couple of physicians, [and a] defense lawyer," and these meetings can even further traumatize patients who do not have support.

Several interviewees suggested that an experienced medical malpractice attorney could help balance this information asymmetry. An attorney knows what questions to ask and what information could be missing. While the patient may be overwhelmed, an attorney is likely to be experienced in conversing with several providers at once and can process such conversations effectively.

Leveling the negotiation playing field

Most stakeholders felt that assuring that patients receive a fair offer of compensation necessitated an attorney. One stakeholder commented that it was rare for patients to "negotiate on their own for anything, unless what they were looking for was absolutely clear," such as missed wages from a week of work or a certain dollar amount for discrete medical expenses. Another stakeholder expressed worry that a patient could not properly evaluate the amount of monetary compensation she will need unless there is a strong understanding of her long-term prognosis, or simply put, "What seems minor may not be minor."

Another interviewee was concerned that patients often will not accept the compensation offered, even when it is clear to the hospital or insurer that they deserve it, because the patient is uncomfortable discussing money or placing a dollar value on an injury. However, attorneys will not experience discomfort related to conversations about compensation. As one stakeholder said, the attorney can "separate the money from the emotion."

Other stakeholders believed that leveling the playing field was important for healthcare facilities and insurers as well. Some said that hospitals with CRPs have an interest in reaching substantively fair agreements, and in being and *seeming* fair, both to patients and to the public more generally. Appearing fair helps to promote the credibility and legitimacy of the CRP process, which, in turn, strengthens trust and public confidence in the CRP. One stakeholder commented that if a patient did not have an attorney or at least "someone looking out for [her]," one might have reason to be suspect of any resolution reached. Another said that ensuring that patients have access to a good attorney not only brings credibility but also "respect."

Setting expectations

Communication and Resolution Programs are relatively new programs, and patients often do not know what to expect. Interviewees sited issues ranging from patients having wildly out of proportion compensation expectations, to being unable to understand why compensation is not warranted in a case where the standard of care was met. Some stakeholders felt that attorneys could help resolve these issues. One stakeholder who had studied several CRPs stated that, in some CRPs, attorneys were "welcomed" for their ability to "manage patients' expectations about the value of the case." The involvement of attorneys "frequently facilitated resolution."

Attorneys can help calibrate the patient's expectations about alternatives to CRP – that is, about the risks of traditional medical malpractice litigation. Most stakeholders agreed that if an attorney were involved, an experienced medical malpractice attorney was preferable. As one Risk Officer put it, "I am benefited by dealing with someone who knows what they're doing." Medical malpractice attorneys understand how much cases are worth based on patient injury, what the patient will require to be made whole, and what the expected value of going to trial would be. As one interviewee commented, this understanding of the complexities and risks of medical malpractice litigation means that the attorney will not be unduly bullish about going to trial. The attorney can therefore also help the patient understand the risks of going to trial based on factors such as the complexity of the case, demographics, or the location of the trial.

Creating a collaborative environment

Successful CRPs rely on collaboration and mutual agreement regarding resolution and improvement by all parties involved. Several stakeholders suggested that the tenor of the conversation between the patient and the hospital could change with the introduction of an attorney into CRP discussions. Specifically, they worried that the conversation could become adversarial and that attorneys may engage in hard-bargaining techniques such as making misleading statements or obscuring whether they can commit to proposed settlements. Most of the stakeholders we interviewed believed that most plaintiffs' attorneys would negotiate in good faith. One interviewee described a few instances where the patient's attorney "took complete advantage of the situation… and entered into harsh negotiations to increase the amount of money [offered]," but also pointed out that these instances are "rare." Another stakeholder echoed this sentiment when she stated, "There are a few unreasonable attorneys out there, but overall, the folks who do the majority of medical malpractice are reasonable."

Ensuring reasonable costs

Respondents from the majority of stakeholder groups, including the plaintiff's bar, expressed concern about a traditional 33% contingency fee model for attorneys in CRP negotiations as a potential barrier to success of the program and thought it potentially unfair to the patient or family member represented. An hourly fee or similar flexible arrangement was recommended by several interviewees, particularly if an offer had already been made and the legwork of trial (e.g., hiring experts, engaging in discovery) was eliminated.

Supporting the patient emotionally

Several stakeholders felt that psychosocial support for patients suffering adverse events is paramount, and that this support is often the type of "representation" patients need, rather than, or in addition to, legal counsel. As one interviewee put it, "Counsel in itself could, in some cases, prove insufficient," and another stated, "emotional needs are distinct from legal needs." Still another voiced worry that legal representation and focus on compensation would shift the work to the wrong place, stating that it could stop the hospital from "listening effectively" and prevent the facility from actually improving the quality of care, which is often more important to the patient than compensation. Finally, many stakeholders stated that resolutions can and often should include resolution measures other than financial compensation, and that while attorneys can facilitate atypical resolutions, experience in medical malpractice law is likely a prerequisite to understanding effective alternatives to monetary compensation.

DISCUSSION

During the interviews, stakeholders revealed various interests regarding representation of patients in CRP programs. The team found that many of those interests were not in direct conflict with other stakeholders,

even though the interests are self-serving. In several key areas interests were common across all stakeholder groups. **Table 1** displays a summary of those interests that stakeholders held in common, those that are potentially conflicting, and those that are in direct conflict.

Table 1 - Stakeholder Interests

	Healthcare Facilities	Insurers	Defense Attorneys	Plaintiffs' Attorneys	Patients
Rapid resolution	Maximize	Maximize	Neutral	Maximize	Maximize
Increased Quality Improvement/High Quality Care	Maximize	Maximize	Maximize	Maximize	Maximize
Trust among parties	Maximize	Maximize	Maximize	Maximize	Maximize
Binding agreements	Maximize	Maximize	Neutral	Neutral	Maximize
Legal Liability	Limit	Limit	Neutral	Maximize	Maximize
Attorney fees	Limit	Limit	Maximize	Maximize	Limit
Financial Compensation to Patient	Limit	Limit	Limit	Maximize	Maximize

Key 1 - Green=shared, Yellow=potentially conflicting, Red=conflicting

An attorney was most often mentioned in the interviews as the ideal representative for the patient in a CRP, with some caveats. All stakeholders have an interest in resolving the case quickly, with a lasting agreement that will result in a positive safety outcome at the source facility. However, a run-of-the-mill attorney would not necessarily facilitate a resolution with these interests in mind. Attorneys with medical malpractice experience understand the logistical complexities associated with bringing forth a claim in a specific state or region, which means they can navigate the requirements with ease and speed. Such experienced attorneys can help patients receive fair compensation for their injury and obtain and interpret important information concerning the adverse event to assist the patient in wholly understanding what happened to them, and why. Medical malpractice attorneys are also familiar with the needs particular to patients who have been not only physically harmed, but also often emotionally harmed. While they may not be able to offer all the support a patient needs, they have enough awareness that patients may want non-monetary recompense, including safety improvements at the site (which benefits all parties), and can advocate for such in a resolution.

The presence of attorneys is also critical for building a favorable public perception of CRPs, which is a key interest for healthcare facilities so that the program can maintain a positive reputation. Critics of CRPs contend that the programs are designed to encourage patients to accept less money than the amount to which the law entitles them. CRPs can defend against such charges if they encourage all patients to consult with a medical malpractice attorney before accepting any resolution, because these attorneys have a sophisticated understanding of both damage valuation and the long-term consequences of adverse medical events. An unrepresented patient is on the low end of a great power differential, and an attorney who can help balance that power gradient builds trust between the parties and creates lasting agreements, which all stakeholders desire.

Additional, crucial features of the patient's attorney that would allow CRP resolutions to proceed smoothly and benefit all parties are familiarity with CRPs, and a willingness to abide by a collaborative process. These are often not characteristic of even an experienced medical malpractice attorney because a) CRPs are new in most areas of the country, and b) the pre-existing litigation system sets up parties to be adversaries. Over time reputations have been built that those on the "other side" hide information and stretch the truth to their advantage. While this concern is significant, stakeholders suggest that it can be overcome by assisting patients in finding appropriate attorneys who are well-versed in the principles of CRPs, and who are willing to work with others to come to a resolution that is fair. However, the finding an appropriately knowledgeable attorney

willing to engage in a CRP process can be challenging. Patients often do not know where they should begin their search to obtain representation. The average person uses internet search engines and word of mouth to find an attorney,[xiv] and these methods would rarely produce an attorney familiar with CRPs.

Patient participants must be able to find a competent and affordable lawyer who is educated in the principles of a CRP and understands the goals of the process and their role in it, without significant inconvenience. Otherwise, patients may obtain a lawyer that will inhibit the ability of a CRP program to progress, or, in some cases, may cause patients to refrain from retaining a lawyer altogether. In order to help patients in this endeavor, a list of top plaintiff's lawyers with expertise in negotiated settlement through CRP programs could be curated for the patient – with the caveat, of course, that the patient is permitted to choose any attorney the patient desires, on *or* off the list.

Regional collaboratives that support CRPs are the ideal candidates for curating such a list. For example, the Massachusetts Alliance for Communication and Resolution following Medical Injury (MACRMI) includes members from the Bar Association, the Medical Society, healthcare facilities, insurers, and patient advocacy groups.[xv] If such a collaborative vetted attorneys and maintained the suggested list of those committed to CRP processes, this could minimize the appearance of bias of a hospital- or insurer-suggested list and serve as an expedient and valuable resource for patients. If there is no such regional collaborative, a list curated by the healthcare facility and given to the patient during CRP discussions is acceptable, as it increases the chances of a successful CRP process that will benefit the patient.

The lawyers selected for this list should devise a compensation scheme that does not provide patients with a disincentive to retain an attorney. The traditional contingency fee model assumes that lawyers should receive a significant percentage of a patient's damages because the attorney has borne extensive risk in bringing the case to trial free of charge. The contingency model is typically used in malpractice litigation because most plaintiffs are unable to pay their lawyers a standard hourly rate to cover the years of preparation which the lawyer must invest in the case. Communication and Resolution Program cases are significantly less risky, and, in many cases, the healthcare facility has already offered a monetary settlement in addition to admitting liability. The task of the lawyer in the context of a CRP is to review said offer and evaluate its fairness considering the impact on the patient. Thus, an hourly fee or other alternative may be more appropriate.

While attorneys can best represent the patient's interest in a CRP process, many stakeholders felt that a patient often will require additional support that a lawyer alone cannot provide. Attorneys can listen to the patient's experience, discern non-monetary recompense that may help the patient heal, and advocate for the patient so that they feel empowered, but they may not be able to make the patient emotionally whole again. This is an important aspect of resolution, and as such, it is recommended that facilities identify a social worker, patient liaison, or other support for the patient so that they can help them work through the emotional trauma they have suffered. The support person does not have to be an employee of the facility, but, at a minimum, should connect patients to existing support groups or professionals that can help them through this difficult time is essential.

CONCLUSION

Interviews revealed that most stakeholders involved in a CRP process believe that patients should have their own representation when involved in a CRP, and that an attorney is best suited to perform this function. Attorney representation by an experienced malpractice attorney supports the mutual interests of rapid resolutions, improved patient safety at the facility where the even occurred, increased trust among parties, and lasting and fair agreements. Those attorneys should be educated about the programs and their unique role so that they can better understand the goals for the patient, ensure that the patient receives fair compensation, and propose solutions beyond financial compensation that may help the patient heal.

To address the challenge of patients finding the most appropriate attorneys for CRP, healthcare facilities should either curate and distribute a list of qualified plaintiff's attorneys or utilize a neutral entity such as a multi-stakeholder collaborative to curate and distribute the list of qualified plaintiff's attorneys. This list, regardless of it is keeper, will facilitate the patient's process of selecting a qualified attorney. Attorneys on this list should consider alternative payment models that are fair to the patient and take into account the amount of effort expended by the attorney in the process.

Finally, the patient needs emotional support after an adverse event. Attorneys can be one source of support, but often cannot provide adequate psychosocial assistance. Specialized resources should be put in place to support patients' emotional needs. Healthcare facilities should attempt to be proactive in linking patients with social workers, patient relations professionals, and other resources that will help patients weather the traumatic experience of an unexpected medical injury. With these patient representation elements in place, CRP processes can succeed in satisfying all stakeholders with fair and timely resolution and in making meaningful change in improving patient safety at healthcare facilities.

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