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RELIAS MEDIA

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Mediation Can Resolve Disputes Faster, at Less Cost Than Litigation

Mediation is an effective strategy for resolving a range of disputes in healthcare, but success with this approach depends on understanding the process and selecting the right mediator. When carried out well, mediation can leave all parties more satisfied than they would have been with other resolutions.

Achieving good results from mediation depends largely on the preparation and attitude of the participants, says **George B. Breen**, JD, an attorney with the law firm of Epstein Becker Green in New York City. He has experience both as an attorney on behalf of a party participating in a mediation and as a mediator, principally dealing with healthcare issues.

"While mediations are often imposed on parties in litigation by court order, successful mediations are ones where parties have had the opportunity to evaluate their own positions and those of their adversary, and are willing, interested, and committed to participating in the process and in reaching a resolution," Breen says. "Preparation is key both in ensuring that your client has expectations reasonably set [and] that the lawyer as advocate has a mastery of the facts."

> "PREPARATION IS KEY BOTH IN ENSURING THAT YOUR CLIENT HAS EXPECTATIONS REASONABLY SET [AND] THAT THE LAWYER AS ADVOCATE HAS A MASTERY OF THE FACTS."

That means the lawyer needs to play "devil's advocate" in advance of the session, Breen says, anticipating the positions to which a response may be needed and being ready with that

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response. Without that kind of preparation, client representatives may just be going through the motions, and the mediation will be unsuccessful.

"Similarly, there is a real need to try to make sure your mediator is as prepared as possible. A mediator prepared with a strong knowledge base in advance of a mediation can make a world of difference in the ultimate outcome," Breen says.

Nonbinding Resolutions

Mediation is different from arbitration in that it is nonbinding, explains **Matthew W. Wolfe**, JD, partner with the Parker Poe law firm in Raleigh, NC. The mediator can suggest a resolution and the parties can agree to it during the mediation process, but that agreement is nonbinding, he says.

"With arbitration, the parties are putting the case in the hands of the arbitrator to make a decision that is legally binding," Wolfe says. "There are jurisdictions and times where a court will require mediation before the parties proceed with litigation, which means they have to pursue mediation in good faith but they are not bound by what the mediator says. The mediator may determine the case is worth $2 million, but the parties can take it or leave it."

Caution is advised with the rules of evidence as they apply to mediation, Wolfe says. Federal and state rules of evidence generally make inadmissible compromises and offers to compromise, which means statements during mediation cannot be used later at trial to prove liability, he says.

"However, statements made in mediation can be used in other ways besides proving liability, so it is important to have an attorney who understands these limitations and can make sure you are not increasing your exposure during the course of mediation," Wolfe says.

Mediation can be the best option when there is a clear middle ground that the parties might reach with a little help, says **Gary S. Qualls**, JD, partner with the K&L Gates law firm in Research Triangle Park, NC. In such cases, Qualls advises clients to mediate early — before a lot of expenses are incurred and the parties dig in their heels.

"When the middle ground is not obvious, however, I've found that it can be a waste of time and effort to mediate too early," he says. "When you mediate after you have done depositions and discovery, clients and attorneys are making more informed decisions about their risk/reward assessments. It's kind of shocking sometimes to see how much your positions and expectations shift after what you learn in discovery."

EXECUTIVE SUMMARY

Mediation can be the right strategy for resolving disputes that could otherwise lead to litigation. The process can bring resolution more quickly and with lower costs than other options.

- Both parties should be open to pursuing mediation in good faith.
- Choose a well-qualified mediator.
- Mediation often allows parties to vent and address emotional issues more effectively than litigation.

An Early Strategy

Mediation is particularly useful early on in the process, says **Rupa S. Lloyd**, JD, shareholder with the Gray Robinson law firm in Gainesville, FL. It can be useful, for example, when a legal claim is anticipated or threatened but not yet filed, she says. Mediation also can occur after litigation, provided the parties can set aside hard feelings and hear the other parties' perspectives, she notes.

A key benefit of mediation is that the costs, time, and friction associated with mediation are generally far less than with litigation or arbitration, Lloyd says. It also provides an opportunity for parties to repair or improve their relationships, whereas litigation generally makes a bad relationship even worse.

"In healthcare, disputants often need to work together in the future, so the quality of their relationship is critical," she says. "The downside of mediation is that it can be abused as a tool for discovery or intimidation, or can show up as a waste of time if one or both parties are not prepared to compromise."

Open Mind Necessary

The key questions for determining when mediation is the right choice are whether the parties have sufficient information to propose and evaluate terms of agreement, and whether the parties are psychologically ready to put the dispute behind them, Lloyd says.

"Mediation is successful when parties come prepared to listen with an open mind and make compromises," she says. *(See the story on page 19 for tips on successful mediation.)*

To get the most from the mediation process, Lloyd advises finding a good, competent mediator with expertise in the healthcare field. A mediator who is not knowledgeable about the complex rules and regulations in the industry that might be relevant to a dispute will lack the requisite expertise to understand the issues and guide the parties in resolving them, she says. To be eligible to sit on the American Health Lawyers Association (AHLA) roster of mediators, the mediator must have completed a minimum of 20 hours of training.

"In the beginning, it is normal that parties are guarded and pessimistic. An effective mediator will be able to open up communication and develop faith in the process," Lloyd says. "Generally, this is much easier if she speaks the parties' language and can empathize with their situation."

Be Open to Negotiation

A truism in mediation is that "People don't care how much you know until they know how much you care," Lloyd says. This means that in order for mediation to be successful, each side needs to be willing to open up and share their feelings in their private sessions with the mediator — including not only what they are most upset about, Lloyd says, but also what they might see as positives about the other side, and where they may be willing to meet the other side halfway.

Being open with the mediator and trusting that he or she will not share the confidences relayed in private sessions are critical for effectiveness to guide the parties to their points of common ground, Lloyd says.

"At the end of mediation, when offers are on the table and parties are digging in on their demands, the mediator often steps into more of an advisory role. The mediation may turn on the parties' degree of trust and respect for her advice," Lloyd says. "A well-established expert naturally commands more respect than a skilled but nonexpert mediator."

Lloyd cautions that one should not rely on any oral promises made in mediation. For any resolution reached in mediation to be legally binding, the parties need to sign a written settlement agreement.

"This is a key distinction between mediation as compared with a trial or arbitration. There is no judge or arbitrator to set forth a binding decision," she explains. "The parties and their counsel remain in control to ultimately determine and sign off on the agreements reached through the mediation process."

Parties Likely More Satisfied

Mediation is underused in healthcare, says **Carol Barkes**, MBA, CPM, a mediator and conflict resolution expert in Boise, ID.

"Even if mediation doesn't lead to resolution — which they almost always do — it leads to a better understanding. Conflicts often arise from misinformation or when people stop talking to each other," she says. "Mediation is a cost-effective and easier way to get people to back off from that intense desire to get justice. It gets the issue de-escalated much faster than other options."

Parties who mediate are typically more satisfied with the outcomes and abide by their agreements with a much higher rate than those who go to litigation, Barkes says.

Mediation helps facilitate a conversation that helps the conflicting

parties come up with solutions that they created. Consequently, it is much easier to come up with a variety of creative solutions that are not possible through the legal process, Barkes says. Mediation is future-focused and aimed at getting the parties beyond their conflict, not about proving who is right or wrong — it is about finding resolutions, she says. When blame and judgment are removed, resolutions come much quicker, Barkes says.

It is typically a much faster process than litigation, which contributes to making mediation much more cost-effective, she says.

"It also allows the parties to talk to each other, which is something we find often does not happen prior to mediation," she says. "And when people actually talk to each other a lot of misconceptions, hurt feelings, and anger dissipate."

The best way to get the most out of mediation is to be open minded and more interested in the resolution than blame, Barkes says. Effective communication skills also are important, such as speaking briefly, seeking to understand, staying calm, and not lashing out.

Mediation can go astray if the mediator is not well-skilled, she says.

"Also, if attorneys are involved in the process and use mediation as a process to prelitigate their case and get locked into their positions, a key opportunity to talk and collaborate is lost," she says. "I believe mediation should be used much more often than it is. Most cases can benefit from mediation, and even if a resolution is not found during the mediation, both parties will come away from the process with a much better understanding of the matter from both perspectives."

Barkes believes that when a risk manager is looking for a mediator, content knowledge often is not as important as the ability of the mediator to be able to facilitate a productive conversation.

"In fact, I often find not knowing anything about the topic can be of huge value, as it gives me the opportunity to ask questions that shed light on something being overlooked or assumed while I am being educated," she says. "Being able to manage the emotions, power, and direction of the conversation is a much more important skill set for which to look."

Mediators also can model good communication skills, she says. Many people have a difficult time with conflict, and when it is about health or associated costs, emotions can be high.

"This can make it even harder for parties to communicate, as it generates a limbic response on our brains associated with fight or flight. When this part of our brains gets activated, the rational, genius part of our brain is shut down, and this makes it harder to find answers, even if we originally had them," Barkes says. "Mediators can make a safe place for conversation and know how to manage emotions, making it easier for the parties to find bridges for resolution. They can

There's No Crying in Mediation

The movie *A League of Their Own* is known for the line "There's no crying in baseball!"

The same rule applies in mediation, says **George B. Breen**, JD, an attorney with the law firm of Epstein Becker Green in New York City.

"Emotion offers little value. Parties need to be prepared to be clear-eyed and realistic in the merits of their own case, as well as that of their opponent. While the issue may be exceedingly personal to one party — something the other party should recognize — sensitivity needs be checked at the mediation room door," Breen says. "Parties must be ready to listen to information they do not like, even that which can be demonstrably wrong, and still be able to continue to proceed in a businesslike fashion. Arguing about who is right only serves to waste time and distances the parties from a resolution."

Emotion should be saved for the courtroom, Breen says, where its best use is on the finder of fact.

The parties must recognize that mediation is a process, he says. It can take time, and even multiple sessions, to resolve disputes. Parties sometimes need the opportunity to re-evaluate positions and time for needed reflection and reassessment, Breen says.

"However, the need for patience is not limited to parties; it is a critically important characteristic for a mediator," he says. "Well-experienced mediators know that initial positions are not final and that to get there can take time. A guiding and patient hand from a mediator can be invaluable." ■

model behavior that helps parties feel less stressed and safer.

Emotional Issues Addressed

The emotional issues in healthcare are greater than those in most other types of litigation, and that can make mediation the right strategy in many cases, says **David L. Gordon**, JD, shareholder with the law firm of Buchanan Ingersoll & Rooney in Princeton, NJ, and co-chair of the firm's Litigation Section and the Healthcare Litigation practice group. Collectively, they mediate more than 30 cases a year.

"There are almost always significant medical conditions at issue with a question of whether the care caused or contributed to those issues. It is often hard for a family to understand that these issues may not be the result of negligence but may stem from their loved one's underlying medical conditions," Gordon says. "Moreover, the family sometimes is in denial about what happened to their loved one or may have regrets about decisions they made regarding their care."

The damages permitted in lawsuits differ per state, but Gordon notes that families also struggle to understand what damages they are entitled to recover, the cost of litigation, the emotional toll of litigation, the length of litigation and the possibility of appeals, and the fact that they may lose and recover no damages.

Mediations give the families an opportunity to vent, sometimes cry, and hear from an experienced, retired judge about the risks, the damages, the costs, and the benefits of settlement that can give them closure, Gordon says. That message is much better sent from a neutral mediator than their own attorney who is a paid advocate, he says.

Not all cases settle at mediation, but most settle at some point, and the mediation plays a significant role in increasing those chances, he says.

"If the family or plaintiff is not respected at mediation, mediations can have a negative effect on the ultimate result — but most defendants have the experience and tact to prevent that from happening," Gordon says. "Mediations are a significant tool in the world of professional liability litigation."

Because it is contractual and nonbinding, mediation has little downside risk, says **John C. Ivins Jr.**, JD, partner with the Hirschler Fleischer law firm in Richmond, VA. If the parties cannot agree to resolve their dispute in mediation, they simply proceed with the dispute process or litigation.

"In some instances, mediation may be the first time the parties have met or the first time the parties have been together since the dispute or litigation began. In all instances, this makes for a generally tense meeting," Ivins says. "Where the parties have agreed to share their positions, this is done, formally, with the mediator guiding that process. Once positions are shared, each party retires to their own conference rooms, and the mediator moves between the rooms, conveying permitted information in an effort to resolve the dispute."

In certain types of cases, such as personal injury, there is a benefit in allowing the injured parties to personally describe their injuries to the defendants who they contend are responsible, he says. That sharing can be cathartic, especially where there are explanations and the defendants come across as reasonable and interested in reaching a resolution. In other instances, the injured plaintiffs may have an unrealistic view of causation and damages, and the process can help to educate them, Ivins says.

Mediator Gains Understanding

As the mediation progresses, the mediator holds private meetings with each party, Ivins explains. The strengths and weaknesses of the party's positions are shared with the mediator — and usually not shared with the opposing party.

"Because the mediator is prohibited from sharing any information the party has not authorized for sharing with the opposing party, the mediator oftentimes gains an overall understanding as to what issues are important or not important to each side — which knowledge can help the mediator shape the settlement discussions," Ivins says.

It is important to ensure that the opposing party has the same interest in mediation, Ivins says. If they don't, the mediation can be a waste of time and resources. Additionally, it is critical to establish rules that ensure that facts conceded in an effort to reach a successful mediation cannot be used against the party in litigation if the mediation fails, he says.

Almost any type of dispute/litigation can be the subject of mediation, Ivins says. The keys to effective mediation are having an experienced mediator who meets the criteria for resolving that dispute and conducting mediation at a point in time when the facts and law are relatively well-developed, he says.

"Some mediators are also very good at staying involved when the parties' mediation is unsuccessful, especially where the mediator knows that the parties are not as far apart as

they may believe they are," Ivins says. "In those instances, a mediation may end, but through the efforts of the mediator, pick back up again at a later time and then result in a successful conclusion."

Information Needed for Success

Parties generally like the idea of mediating early in order to save money that would otherwise be expended in the litigation process. However, when mediation occurs before the basic facts have been developed through discovery or before the experts have produced reports, Ivins says, the process will be difficult due to the number of unknown factors needed to evaluate the case's worth. Without sufficient information, it is difficult for the parties to properly assess what the reasonable payment/value range should be in order to resolve the dispute, he says.

"On the other hand, where the facts are well-developed, the damages are easily identifiable, and the legal theories and defenses are well-understood, a case may be mediated at a much earlier time in the dispute/litigation process," Ivins says. "For the best success, do not mediate too early, retain an experienced mediator, realistically evaluate the case ahead of time, and ensure that all persons who must approve of any resolution are either personally present or are otherwise available prior to and during the mediation."

Mediation can be most appropriate in business disputes, such as those between payors and payees or between practitioners and the hospital, says **Robert Shaw**, JD, an attorney with the Smith Anderson law firm in Raleigh, NC. All parties have a motivation to resolve the dispute privately, with little advantage to a jury trial, he says.

The cost of mediation can be a stumbling block, Shaw says. Although it is far less expensive than litigation, mediation does require expenses that may cause parties to question why they can't just hash things out through their lawyers.

"Mediation requires paying your attorney as well as the mediator and preparing a mediation statement, all of which can be expensive and time-consuming, as well," Shaw says. "The parties involved generally have to meet physically for the mediation, so if there is travel involved, that is another expense that can be a hindrance."

A typical mediator's fee is from $250 to $500 per hour, says **Wendy Lappin Barragree**, JD, senior counsel with the Chamberlain Hrdlicka law firm in Philadelphia. Mediation may take several hours or an entire day, and even with associated costs like attorneys and research added to the mediator's fee, it will still be a good deal when compared to litigation, she says.

"I have clients who come to me and say 'It's not about the money, it's about the principle.' I tell them that I'm happy to stand with them all the way to the end on principle, but principle is expensive," Barragree says.

"Those people can sometimes be shown that mediation is a better route to satisfaction by assuring them they will get to say their piece and be heard. If they are hell-bent on standing on principle to the bitter end and getting a pound of flesh, mediation is not going to be useful." ■

SOURCES

- Carol Barkes, MBA, CPM, Mediator

Choose a Qualified Mediator

Choosing a mediator from a reputable organization is critical to ensure the parties feel comfortable that the mediator will remain neutral, says **Rupa S. Lloyd**, JD, shareholder with the GrayRobinson law firm in Gainesville, FL.

There are Model Standards of Conduct for Mediators, which are followed by the American Health Lawyers Association (AHLA), the American Bar Association, and the American Arbitration Association, she notes. These standards impose important safeguards, such as impartiality, avoidance of conflicts of interest, and competence.

The AHLA has a standard Agreement to Mediate that is signed by the participants at the outset to set forth basic safeguards, such as disclosing any conflicts of interest with the mediator and keeping confidential any information and statements that occur during the mediation.

Mediation often is conducted by retired judges, notes **David L. Gordon**, JD, shareholder with the law firm of Buchanan Ingersoll & Rooney in Princeton, NJ. A retired judge may be a good choice as mediator when the issues in dispute are more legal rather than factual in nature. A retired judge can help the parties see the strengths and weaknesses of their legal arguments, he says. ■

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Tips for Getting the Most Out of Mediation

Consider the following tips for successful and effective mediation:

• Remember that mediation is not about right and wrong. Rather, it is about fixing the problem at hand, says **Carol Barkes**, MBA, CPM, a mediator and conflict resolution expert in Boise, ID. How do you move beyond this problem, or how do you fix it? Don't get entrenched in parties telling their stories or declaring who is right and wrong.

• Focus on interests, not positions. A person's interests are needs, whereas the person's position is a demand, Barkes says. A patient's position may be that he or she wants a payout from the hospital. When the hospital says yes or no, there is one winner and one loser. But the person's interests may lie in being heard and validated. The patient may need to know that what happened will not happen to another patient, Barkes explains.

"When you start talking about their interests, what they need, there may be a lot more options to bring satisfaction other than a payout," she says.

• Disclose sufficient information prior to mediation. The other party must know enough to be comfortable with the process, says **Robert Shaw**, JD, an attorney with the Smith Anderson law firm in Raleigh, NC. That usually requires proceeding with discovery enough to make sure the other side can fairly evaluate the case and be willing to accept a resolution.

"Until you have that comfort level, mediation is generally not successful," Shaw says.

• Take mediation seriously, and devote the proper resources. Do not look at mediation as a halfway measure that you will try in a halfhearted way, knowing you can always move on to litigation if it fails, Shaw says.

• Choose the right mediator for each case. Avoid relying on a single mediator even if that person is excellent and has performed well for you in the past, says **Matthew W. Wolfe**, JD, partner with the Parker Poe law firm in Raleigh, NC. Certain mediators are better at addressing different kinds of disputes and will increase the likelihood of a satisfactory resolution because they have more background and experience in that specific area.

• Prepare with counsel before mediation. The risk manager or other hospital representative should work with the hospital attorney before the mediation process to establish facts, goals, and limits for the mediation process, Wolfe says. The mediation proceedings should not be the first time these discussions take place, he says.

• Limit the bluster and bravado. Even if you think you have right on your side and a strategic advantage, don't emphasize that too much, says **Gary S. Qualls**, JD, partner with the K&L Gates law firm in Research Triangle Park, NC.

"One thing that can sour a mediation pretty quickly is for there to be too much saber-rattling. You want to walk the line of telling the other side how good your case is without offending the opposing party to the extent that they come out of the opening session just wanting to go home and not wanting to talk settlement," Qualls says.

"We've all seen the bridge-burning attorney who comes off as too caustic and the other side doesn't want to deal with them. That's entirely counter to the concept of mediation."

• Don't be the caustic client. Just as attorneys can come off as too harsh and aggressive, so can the hospital client. For this reason, Qualls says it is usually not a good idea to let the client speak

during the opening statements of mediation.

"Personalities, if too caustic, can certainly disrupt and sometimes derail mediation," Qualls says.

• **Set appropriate expectations and limits.** Clients should have reasonable expectations going into mediation, and the attorneys should agree beforehand on limits to the process, says **Wendy Lappin Barragree**, JD, senior counsel with the Chamberlain Hrdlicka law firm in Philadelphia. She says mediation can drag on for hours and days if the parties insist on revisiting issues or expanding the scope of the discussion, or if the parties simply cannot reach an agreement.

• **Be clear about confidentiality of submissions.** Mediators usually require information and summary statements before mediation begins, but it should be clear whether that information will be shared with the other party.

"You can tell the judge you have this novel legal defense and don't want it divulged to the other party, but that you want the mediator to be fully informed so the process is useful. The mediator can use that information when pressuring one side to moderate their position but without revealing what you have in your pocket," Barragree says. ■

Electronic Discovery Can Be Costly, Time-Consuming

Electronic discovery (e-discovery) is employed more and more by plaintiffs' attorneys seeking large volumes of data, particularly for class-action lawsuits and similar large-scale proceedings.

E-discovery issues can be particularly challenging in healthcare, says **Christopher J. Adams**, JD, chief strategic counsel with the law firm of McDermott Will & Emery in Washington, DC. Preserving electronic data for discovery can be far more difficult than in the past, when records retention meant not throwing out an old file box of records.

"The scope of what a healthcare provider has to deal with is significantly larger than most corporate entities," Adams says. "The first challenge is getting your hands around just how much data you're dealing with."

From there, the organization must have policies consistent with state and federal law on data retention not affected by a legal hold, he says. Other questions include who is custodian of the data, where is it being held, who is responsible for implementing a legal hold, and how data is controlled and accessed on nonemployee devices.

"Healthcare is a particularly risk-heavy area for e-discovery, compared to almost any other industry we deal with," Adams says. "There are some healthcare organizations that handle this issue very well, but it's a cost-benefit analysis that determines how well or how poorly most do with this. A program to save all this electronic data can cost a tremendous amount of money in software and people they have to hire."

EXECUTIVE SUMMARY

Discovery requests for electronic data can be especially burdensome in healthcare because of the vast amount of data involved. Some patient information must be redacted.

- Avoid keeping data longer than legally required.
- Have a plan for preserving and accessing data.
- Compliance systems can bring business value.

Create a Plan

Even without a robust records retention policy and staff for monitoring e-discovery, healthcare organizations should employ one or two people responsible for recognizing when a situation requires preservation of records and knowing how to conduct that process, Adams says.

"Having that game plan goes a long way toward compliance and mitigating the chance of getting a spoliation claim," Adams says. "This should be a repeatable, well-defined process that specifies who is responsible for each step of the process. Having a plan on paper is one thing, but it's not worth much if no one knows who is responsible and no one carries out the steps in the plan."

Personally identifiable information (PII) can be problematic in e-discovery because, in some cases, it is difficult to

remove and protect from view. The personal information must be redacted before providing data in e-discovery. Adams says that process can be difficult and time-consuming because of a lack of consistency in how it is recorded on forms, for instance.

Software can redact the PII, but a human eye is still required to go back and verify that all the data were removed properly, Adams says.

Data loss is another potential problem with e-discovery, Adams says. This becomes a bigger risk as healthcare organizations move more data management and storage to electronic systems, and particularly to cloud-based systems, he says.

"The need to maintain and save data in usable formats is becoming more challenging to healthcare providers," Adams says. "If you have traditionally printed out ECG recordings and filed those paper records, maybe now it's an electronic file that you can save as part of the patient file. But you can't store data on these machines forever. Where that data goes and how it is accessed can become an issue in a legal hold."

Don't Keep Too Much

E-discovery in healthcare is subject to the same expectations and obligations as any other industry, notes **Kelli Brooks**, JD, global leader of forensic technology services and the partner-in-charge of forensic technology services practice in the Los Angeles office of professional services company KPMG.

The presence of PII does not change how the law requires discovery of data, Brooks says. Furthermore, many healthcare e-discovery requests will involve records with much PII, she says.

"Typically we don't see as much in the e-discovery space around how an individual was treated because those malpractice cases are handled individually rather than in a class-action suit," Brooks says. "The broad class-action activity in healthcare has involved more medical devices or drug interactions, so those are going to look more at issues like vendor concerns, fraud, payment information, and financial audits."

Complying with e-discovery can be expensive and tedious, but that is sometimes because healthcare organizations have too much data available, says **Steven Stein**, JD, a principal in KPMG's cybersecurity practice, principal in the U.S. advisory services practice, member of the cyberservices team, and co-chair of KPMG's privacy and information governance services practice in Chicago.

"Companies are amazing at retaining information, and they are terrible at deleting that information at the end of the retention period. As a result, the data is there when the discovery request comes in, and if it's there, it may have to be produced," Stein says. "Companies have to figure out a coherent strategy for not just maintaining the information but for deleting it at the appropriate time so that it has a proper and well-defined life cycle."

There sometimes is a business need for retaining data past the legal requirement, but if you still hang on to it, "you've just broadened the pool of places you need to go to collect, process, and review data for production in discovery," Brooks says. "The more data you have, especially when you didn't need to keep it in the first place, the more complex and exponentially expensive your e-discovery gets."

Supporting e-discovery does not have to be a system separate from other operations in the healthcare organization, notes **Michael J. Boland**, JD, firm-wide e-discovery manager with the Clark Hill law firm in Chicago. There is a business value beyond e-discovery compliance to the ability to access data rapidly and efficiently, he says.

"We are living now in the world of data analytics, which is all about improving our product and making ourselves better. Having access to that kind of data allows you to do that, so a process that ensures you can comply with electronic discovery requests doesn't have to be just a straight cost resource," Boland says. "You can look at it in terms of it being a data resource and look for the business value there rather than it just being something you have to put in place to protect yourself." ■

SOURCES

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Developing a Culture of Healthcare Safety Requires Multifaceted Approach

Strengthening safety culture remains one of the greatest challenges faced by healthcare organizations, where the demanding environment makes it critical to have high-performing teams. There are specific ways to start building a safety culture by introducing a transformational culture shift, says **Tanya Fish**, employee experience strategy advisor with ITA Group, a consulting company based in West Des Moines.

Healthcare leaders will face challenges creating high-performing teams and a safe healthcare experience, including staff shortages, work hours, workloads, and staffing ratios that affect patient safety, she says. Lack of staff engagement, staff burnout, rapidly changing work environments, and a culture of blame also can complicate the effort.

Risk managers are increasingly pressured to reduce potentially preventable events (PPEs), which requires a multifaceted effort, Fish says. Gaining buy-in to quality improvement initiatives starts with building a partnership between leadership and the workforce, she says.

Healthcare leadership should strive to improve not only the lives of the patients but also the lives of the care teams, Fish says. This builds confidence that the health system can be trusted to deliver on its promises, act with integrity, and treat all fairly. It also leads to a pride in the quality improvements and a workplace the team can be passionate about, she says.

> TO ALLOW PEOPLE TO PERFORM AT THEIR BEST, IT IS CRITICAL TO REMOVE FEAR FROM THE ORGANIZATION BY USING OPEN AND HONEST COMMUNICATION.

"Identify and articulate clearly how quality improvement initiatives will improve things that matter to the team, such as freeing up time, making their jobs easier, and delivering safer, better patient care," Fish says. "When launching the initiative, tell stories about how the initiative has led to improvements important to the internal team to emotionally connect with them. While leadership cares about the metrics behind the initiative, the team needs to hear how it aligns to what they care about."

Fish recommends recognizing and rewarding early adopters for behaviors that will drive success of the program. This extrinsic form of motivation will reinforce actions that will drive success, she says.

"To intrinsically motivate and sustain that behavior, consider making people who demonstrate alignment to the initiative ambassadors. Elevate them through communicating to them more often, have them track their department's key metrics, and involve them in future decisions," she says. "By offering both extrinsic and intrinsic forms of motivation, you can engage both short-term for adoption and long-term for sustainability."

With regard to reducing PPEs, Fish advises focusing on these factors:

• **Learning environment:** In psychologically safe environments, people are willing to offer up ideas, questions, and concerns, Fish says. They are even willing to fail and to learn from those experiences, she says.

"In studying some of the highest performing teams at Google and Toyota, they have found that process guidelines are important, but more important is that people frame every problem as a learning opportunity, where success is dependent on people taking risks and being vulnerable in front of their peers," Fish says.

• **Employee engagement:** Morale can be related to nurse engagement — the dedication they have for their job and how effective they are. Employees who are present, focused, happy, and healthy are more likely to

EXECUTIVE SUMMARY

Improving the safety culture of a hospital or health system will require tackling challenges on several levels of the organizational structure. The culture of blame must be eliminated.

- Create an environment that encourages learning.
- Define the culture of safety.
- Establish ambassadors who can promote the culture of safety.

bring positive energy to the team and to the patient experience, while also having a willingness to take on daily challenges, Fish says.

• **Open communication:** To allow people to perform at their best, it is critical to remove fear from the organization by using open and honest communication, Fish says.

• **Teamwork and respect for others:** Two of the central tenets of a safe culture — teamwork across disciplines and a blame-free environment for discussing safety issues — are directly threatened by disruptive behavior.

To encourage learning, employees cannot fear being belittled or marginalized when they disagree with peers or authority figures, ask naive questions, own up to mistakes, or present a minority viewpoint, Fish says. Instead, they must be comfortable expressing their thoughts about the work at hand.

The risk manager seeking to improve the culture of safety must tread carefully because today's healthcare workers are already stressed with multiple safety and quality improvement concerns, Fish says.

Education about safety culture is characterized by shared core values and goals, nonpunitive responses to adverse events and errors, and promotion of safety through education and training, she says.

"A safety culture requires strong, committed leadership, along with the engagement and empowerment of all employees," Fish says.

Fish offers the following five tips for engaging and empowering employees to improve the culture of safety:

• Define your culture of safety, recognition, and engagement by communicating your culture story and creating a movement within your organization that reminds employees every day why their acts of safety are important and why they love to work for your organization.

• Establish ambassadors to advocate a safety culture. Position them as leaders in the organization who will promote safety and listen to the voices of employees on the topic.

• Provide training and education on acts of safety, including interprofessional communication and collaboration (particularly important in transitions in care and hand-offs), with recognition and rewards for completion and competency.

• Recognize and reward real-time behaviors of teamwork, collaboration, open communication, and accountability so individuals depend on each other and feel secure and supported in sharing their feedback in day-to-day work.

"When you show you value these things, people will gain comfort in using their voices and collaborating more openly," Fish says. "Better yet, give your people the ability to reward each other — not just top-down recognition — for acts tied to safety, from proper lifting form to open team collaboration about an issue."

• Communicate key metrics related to the success of your people and organization as they relate to safety. When people can see their progress toward personal and organizationwide goals, they will stay engaged and motivated.

To build a safety culture with high-performing teams, Fish says, risk managers should focus on the healthcare professionals rather than policies and procedures.

"Who is on a team matters less than how the team members interact, structure their work, and view their contributions. Your people are more than just who they are during their shift, and the success of your culture is directly linked to the emphasis you put on your people," Fish says.

"Give them the ability and autonomy to succeed and the benefits they crave, and you'll get a boost in individual performance, engagement, and motivation," she says.

"Ignite passion in your people and transform your culture to engage, motivate, and future-proof your organization." ■

SOURCE

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HEALTHCARE RISK MANAGEMENT™

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CME/CE QUESTIONS

1. **What element does George B. Breen, JD, an attorney with the law firm of Epstein Becker Green in New York City, say should be avoided in mediation?**

   a. Emotion
   b. Cost consciousness
   c. Deference to organizational hierarchy
   d. Speed

2. **According to Rupa S. Lloyd, JD, shareholder with the Gray Robinson law firm in Gainesville, FL, what is generally true of the costs, time, and friction associated with mediation?**

   a. They are higher than those associated with litigation.
   b. They are lower than those associated with litigation.
   c. They are about the same as those associated with litigation.
   d. They are the only factors not controlled by the mediator.

3. **Why does Steven Stein, JD, a principal in KPMG's cyber security practice in Chicago, advise not keeping data longer than legally required?**

   a. The data may become subject to discovery, creating unnecessary work and costs.
   b. The data may cost too much to store.
   c. The data may conflict with more current data.
   d. The data may create new liabilities.

4. **Why does Tanya Fish say healthcare leadership should strive to improve not only the lives of the patients but also the lives of the care teams?**

   a. It builds confidence the health system can be trusted to deliver on its promises and act with integrity.
   b. It is an easily achieved goal.
   c. This approach will be supported enthusiastically by administration, resulting in more funding.
   d. It will build a better relationship with nursing unions.

LEGAL REVIEW & COMMENTARY
EXPERT ANALYSIS OF RECENT LAWSUITS AND THEIR IMPACT ON HEALTHCARE RISK MANAGEMENT

Obstetrician Liable For $1.75 Million Due to Permanent Brain Injuries to Infant During Delivery

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UCLA School of Law, 2018

News: An appellate court recently confirmed the liability of an obstetrician who, through the use of a vacuum extractor during the delivery of an infant, caused severe brain injuries that resulted in permanent neurocognitive deficits in the newborn.

Following a trial, a jury found that the physician was liable for damages in the amount of $1.75 million. The obstetrician appealed multiple court orders, asking the appellate court for judgment as a matter of law dismissing the complaint, or to set aside the verdict as contrary to the weight of the evidence and grant a new trial. The appellate court denied all requests and found that the plaintiff had presented sufficient evidence to satisfy the legal burden of proof.

Background: A pregnant woman checked in to a hospital to give birth to her son. During delivery, the obstetrician made multiple attempts at using a vacuum extractor to deliver the infant. The physician also used the vacuum extractor to rotate the child from an occiput posterior position to an occiput anterior position. Upon delivery, the newborn had suffered several severe injuries to his head.

Among other complications, it was noted that the infant was bleeding between his scalp and his skull. Abnormalities also were discovered during a neurological examination. The infant's head injuries resulted in significant brain damage and permanent neurocognitive deficits.

The mother later brought a medical malpractice suit on behalf of her son against the obstetrician. The plaintiff alleged that the obstetrician had deviated from the applicable standard of care by making multiple attempts to deliver the infant with the vacuum extractor and by using the vacuum extractor to rotate the infant. The plaintiff claimed that this use of the vacuum extractor had been the direct cause of the injuries suffered by the newborn and observed upon delivery, which caused the permanent neurocognitive deficits.

THE PLAINTIFF CLAIMED THAT THIS USE OF THE VACUUM EXTRACTOR HAD BEEN THE DIRECT CAUSE OF THE INJURIES SUFFERED BY THE NEWBORN AND OBSERVED UPON DELIVERY.

The jury reached a verdict in favor of the plaintiff and awarded $250,000 for past pain and suffering and $1.5 million for future pain and suffering. The defendant obstetrician brought a post-trial motion seeking relief. The trial court denied the obstetrician's motion to set aside the verdict for judgment as a matter of law or for a new trial, and entered judgment in favor of the plaintiff. The obstetrician appealed on two separate grounds; however, the appellate court determined that there was sufficient evidence to support the jury's verdict and affirmed that the damages awarded to the plaintiff in the amount of $1.75 million were reasonable.

What this means to you: This case focused on the use, or misuse, of a medical device: the vacuum extractor. Physicians and medical care providers must be cognizant of the proper applications and usage procedures for medical devices prior to use. When a reasonable physician in

the same or similar circumstances would not use a device or would not use a device in a specific manner, a physician's deviation from those standards may constitute medical malpractice.

In this case, the device at issue was a vacuum extractor, used for two different purposes. The American College of Obstetricians and Gynecologists guidelines and most hospital policies have recommended and/or mandated no more than three "pop-offs," which is the detachment of the vacuum from the infant's head during delivery. With each reapplication of the extractor, the physician risks injuries such as bruising and abrasions. The suction level can be adjusted to assure a secure attachment and reduce the number of pop-offs. Suction levels that are too strong can cause significant injuries such as hemorrhage or skull fracture.

Physicians should have documented evidence of proficiency with operative deliveries before attempting the procedure unassisted. Vacuum-assisted deliveries, whether vaginal or cesarean, are high-risk and require informed consent by the mother after a detailed explanation from the physician of the risks and benefits of this type of operative delivery.

Additionally, vacuum devices are not recommended for rotation of the fetus during labor. If the presentation is posterior vertex and the physician feels that the posterior presentation of the infant's head will not pass through the mother's pelvic arch, a manual rotation can be attempted. With macrosomia — larger fetuses with head diameters that exceed that of the mother's pelvic arch — deliveries often are planned as cesarean sections or become emergent trips to the operating room for a cesarean delivery.

This case involved an appeal by the party unsuccessful at the trial level. In this case, the physician was found liable and appealed on two separate grounds, including in an attempt to set aside the jury verdict or to grant a new trial. The physician raised arguments on both issues of liability and issues of damages, attempting to undermine the jury's significant award of damages. However, the physician's appeal was unsuccessful: The appellate court confirmed that a jury's verdict is not to be set aside unless no reasonable interpretation of the evidence could have yielded the verdict.

Appellate courts usually are very deferential to trial court and jury findings, largely because appellate courts are presented with only a written record of the proceedings. Since appellate courts do not hear live testimony from witnesses, including experts, they generally do not re-evaluate the credibility of such witnesses, as that is proper for the trial judge or jury.

For this case, the appellate court warned that the discretionary power to set aside a jury verdict and grant a new trial must be exercised with great caution because the successful party should benefit from the outcome of the successful litigation process. The appellate court addressed the medical malpractice issues present in this case and the elements necessary to prove liability in such a medical malpractice case.

In particular, the appellate court noted that the plaintiff must introduce evidence proving that the physician deviated from the accepted standards of practice in the community and that such deviation proximally caused the plaintiff's injuries. During the trial, the plaintiff successfully introduced expert testimony that corroborated the allegations that the defendant's use of the vacuum extractor deviated from the accepted standards of practice.

The physician's use of the vacuum extractor was improper for two reasons. First, the physician made too many attempts to deliver the child using the extractor. Second, the physician used the extractor to rotate the infant, which, according to the plaintiff's expert testimony, diverged from the standards of care. Thus, the plaintiff satisfied the burden of proof and successfully established that the obstetrician breached the standard of care, which is the first step in a medical malpractice case.

Another necessary part of a medical malpractice suit requires the plaintiff to establish that the defendant's conduct was the actual and proximate cause of the plaintiff's injuries. Here, the infant was noted to have several head injuries upon delivery. It was undisputed that the head injuries, including the bleeding between the infant's skull and scalp, had been caused by the use of the vacuum extractor during delivery. In addition, as is common practice, the infant immediately underwent a neurological examination that revealed abnormalities.

Depending on the facts and circumstances of the case, it may not be worthwhile for a physician or medical care provider to challenge issues of causation when the substantial weight of the evidence demonstrates a causal connection between the improper actions and the injury. Making such an attempt when there is a clear connection serves only to undermine other aspects of the defense that provide a stronger basis for defeating the plaintiff's claims.

An important lesson to be learned from this case is that while appealing is inevitably an option, unsuccessful physicians and medical care providers at the trial level must consider the additional time and expense that accompanies such an appeal. Trial

judges and juries make mistakes, but depending upon the nature of the mistake — whether it is a misapplication of the law by a judge, or a disregard of factual evidence by a jury — an appeal can be an uphill battle for a party unsuccessful at trial. Medical care providers must consult with counsel in order to evaluate whether an appeal is worth the burden, or whether it may be more practical to forgo an appeal process. ■

REFERENCE

Decided on Oct. 3, 2018, in the Supreme Court of the State of New York, Appellate Division, Second Judicial Department; Case Number 601321/09.

Court Denies New Trial After Jury Exempts Doctor in Retained Object Case

News: A patient developed a hematoma and vocal cord paralysis following a thyroidectomy. This was treated by the same physician who performed the surgery approximately three weeks after the first procedure. Although the patient's voice was improving, two months after the hematoma extraction the wound was leaking and had not completely healed. Four days later, the physician performed another surgery to remove a piece of gauze from the patient's wound.

The patient brought suit, alleging that the gauze removed from her neck had been left in the wound by the defendant in an earlier procedure on the day of the hematoma extraction. The jury returned a verdict in favor of the physician. The patient appealed, arguing that the court had abused its discretion in barring certain expert witnesses from testimony. She demanded a new trial, asserting that the jury's verdict was against the manifest weight of the evidence. The appellate court affirmed the trial court's position, exempting the physician from any liability in the matter and denying the plaintiff's motion for a new trial.

Background: A physician performed a thyroidectomy on a patient. The patient subsequently developed a hematoma in her neck and vocal cord paralysis. The same physician extracted the hematoma from the patient's neck and cured and packed the wound. Approximately one month later the defendant performed a wound exploration and removed a piece of gauze from the patient's wound.

The patient alleged that the physician was negligent by failing to properly perform the hematoma extraction and wound exploration and by failing to remove a foreign object from the wound. Furthermore, the plaintiff claimed that the defendant's negligence was a proximate cause of the injuries she sustained, including damage to her left recurrent laryngeal nerve which resulted in vocal cord paralysis. All of the patient's claims relied upon the assumption that the gauze removed by the physician in the wound exploration procedure had been present since the hematoma extraction procedure.

At trial, the patient was barred from calling a physician expert witness to testify about possible causation between leaving the gauze in her wound and the injuries she suffered. Furthermore, the patient was not allowed to question the defendant physician about his two-time failure of the medical board examination. The court also sustained the physician's objections to the patient's line of questioning concerning informed consent and denied the patient leave to amend her complaint to allege a new legal theory.

The physician's expert witness testified, claiming that the gauze was not deep in the patient's wound and was nowhere near her laryngeal nerve. Furthermore, the patient's injuries were known complications of the initial thyroidectomy, and such injuries can occur even if the standard of care is followed. Despite the patient's appeal asserting that the trial judge had abused its discretion on the aforementioned matters, the appellate court found in favor of the defendant.

What this means to you: Lessons from this case reveal the importance of proving or disproving causation, a critical element in any medical malpractice case. Fortunately for the defendant physician in this case, the physician was able to undermine the plaintiff patient's presentation of evidence and to present compelling testimony that the injuries were consistent with appropriate care. Expert testimony also played an important part in this malpractice action, and the physician succeeded in barring one of the patient's potential experts from testifying.

On the issue of causation, the jury ultimately agreed with the physician and the physician's expert that the injuries may have occurred even though the physician abided by the appropriate standard of care. Causation is an area that frequently requires testimony from an expert witness to establish the connection

between the action or incident that allegedly produced the injury and the specific injury.

In this matter, the patient's case relied on two fundamental assumptions relating to the event, injury, and causation: First, that the piece of gauze removed by the defendant had been "forgotten" in the plaintiff's wound during or immediately after the extraction of the hematoma; and second, that the piece of gauze was responsible for causing the complications that led the plaintiff to develop vocal cord paralysis.

To support these assumptions and the case generally, the plaintiff attempted to introduce evidence by two expert physicians. However, the trial court determined that one physician was not qualified to provide expert opinion testimony and, although the plaintiff claimed the trial court abused its discretion in making such determination, the appellate court explained why the trial court's decision was proper. The plaintiff wanted to introduce the physician's testimony as evidence of causation between the gauze left in her neck and the injuries suffered. The expert physician's opinion rested on the general principle that when a foreign object is left in a wound it causes inflammation which results in scarring.

However, at his deposition, the expert was questioned on whether he was familiar with the causes of vocal cord paralysis. He responded that he was not. Furthermore, the expert had never treated a patient who sustained injuries similar to those suffered by the plaintiff. In addition, the expert — a pathologist — had not treated a live patient since 1984 and had not had privileges at a hospital since 1986. As a result of all of these factors, the defendant argued and the trial court agreed that the offered expert physician was unqualified to opine on these issues of causation. This type of attack — undermining an opposing party's case by disqualifying one of the identified purported experts — can be extremely effective as it was in this case. Medical care providers, along with their counsel, should thus evaluate the qualifications and background of a patient's proffered experts in order to determine whether such challenges may be successful.

By contrast, the defendant was able to introduce a qualified expert who testified as to how vocal cord paralysis resulting from an injury to the left recurrent laryngeal nerve is a known and recognized complication of both a thyroidectomy and the development of a hematoma. According to the defendant, the injuries suffered by the patient occurred prior to the hematoma extraction and were in no way related to the piece of gauze left in the wound. Another expert physician — called by the plaintiff — also admitted that these complications were well-known and could occur as a result of a thyroidectomy procedure even in absence of negligence.

In this case, the jury did not find that the plaintiff satisfactorily proved causation. With these two experts concurring on causation, the defendant successfully raised significant doubt as to whether the plaintiff's injuries were caused by any wrongdoing of the defendant. However, retained objects during surgery generally are extremely problematic and most do, eventually, cause serious problems.

Hospitals and surgery centers have been mandated to reduce the incidence of retained foreign bodies during surgery. Counting the sponges before and after a procedure is one more common way that these facilities deal with preventing retained sponges. If the sponge or instrument count is incorrect, there is a process to locate the missing item. Most sponges are now made with a radiopaque strip that can be viewed using an X-ray. By using X-ray evaluations of the surgical area, medical professionals can locate the foreign object or confirm that the object must be in a trash receptacle, on the operating room floor, or in an unknown location.

Finally, concerning the plaintiff's challenges on appeal, the appellate court did not agree with the plaintiff's claim that the trial court abused its discretion and denied the plaintiff's request for a new trial. Such post-trial or post-verdict motions may be possible, but courts often are hesitant to undermine the findings and results from a jury unless there is a clear showing of wrongdoing or a disconnect between the presentation of evidence and the jury's findings.

In the case at hand, the plaintiff failed to prove her case for negligence while the defendant provided evidence that the injuries suffered could have occurred in absence of any negligence. Although it could not be determined with certainty whether the physician had left the gauze in the patient's neck for nearly two months, through expert testimony, the defendant successfully introduced evidence that the plaintiff's conditions were well-known complications of a thyroidectomy. Furthermore, the plaintiff's own expert corroborated this theory. Thus, the jury's finding was consistent with the evidence presented at trial, and the appellate court denied the motion for a new trial. ■

REFERENCE

Decided on Nov. 13, 2018, in the Appellate Court of the State of Illinois, First District; Case Number 1-17-1307.