Disclosure and Offer at Twenty-Five: Time to Adopt Policies to Promote Fairly Negotiated Compensation

Gabriel H. Teninbaum* and Dr. Steve S. Kraman**

A quarter century ago, the Lexington, Kentucky Veterans Affairs (VA) Medical Center pioneered a risk management program now known as "disclosure and offer." Its guiding principal was that patients injured by malpractice should be told about the incident and "made whole" without having to litigate.

After a patient suffered an injury that the VA judged to have been caused by a departure from the standard of care, the VA contacted the patient and, along with an attorney of his choosing, invited him to meet with VA staff. At the meeting, the VA disclosed the error to the patient and discussed a plan about how to meet the patient's medical needs. With guidance from his own legal counsel, the patient was offered fair, negotiated compensation (defined as what a judgment would be, including pain and suffering, if the case went to trial).

The VA program's creators believed advising patients to seek counsel was necessary to protect the program's integrity: Negotiating compensation for malpractice requires experience and expertise in law and medicine alike. Risk managers have this experience, unrepresented patients do not. And, because the goal was to be completely transparent and honest, the fact that a patient had legal representation was not seen as a threat. If the attorney made an unrealistic demand, VA risk managers simply said no to it.

In 1999, the Lexington VA team published a paper describing their experience using this method.[1] They concluded that payouts were similar to hospitals in a comparison group that did not have disclosure-and-offer protocols. It also appeared to save the VA money by reducing legal expenses

* Associate Professor of Legal Writing, Suffolk University Law School. Professor Teninbaum has written extensively in the area of medical apology. His other publications include *How Malpractice Apology Programs Harm Patients*, 15 CHAP. L. REV. 307 (2011) and *Medical Apology Programs and the Unauthorized Practice of Law*, 46 NEW ENG. L. REV. 505 (2012).

** Professor, Division of Pulmonary, Critical Care and Sleep Medicine, Department of Internal Medicine, University of Kentucky. Dr. Kraman is the former chief of staff of the Lexington, Kentucky VA Medical Center. Together with medical center counsel, he started and managed that facility's disclosure-and-offer program.

1. *See generally* Steve S. Kraman & Ginny Hamm, *Risk Management: Extreme Honesty May Be the Best Policy*, 131 ANNALS INTERNAL MED. 963 (1999), *available at* http://annals.org/article.aspx?articleid =713181.

that would have been incurred had these cases been litigated. This was deemed a success: The program treated patients ethically, helped the VA realize savings, and facilitated patient safety analyses without fear of legal ramifications.

Today, disclosure-and-offer programs are fixtures at facilities nationwide.[2] The current generation of programs, however, appears to have adopted a self-serving approach that eliminates safeguards designed to assure patients get fair advice regarding compensation. The most recent data revealed that only four percent of disclosure programs advise patients to seek independent legal advice.[3]

This should not be. To disclose an error and not to offer full compensation—or to disclose an error, but then leave a patient to negotiate with a trained risk manager with adverse financial interests—puts physicians on the wrong side of a conflict of interest.[4]

Recent research shows why programs that avoid attorney involvement may, intentionally or not, take advantage of patients.[5] Only sixty percent of the study participants (each of whom was asked to assume they had suffered an injury and then had it disclosed to them as having been caused by a clear act of malpractice) described themselves as being very likely or somewhat likely to seek counsel regarding their legal rights. The potential for abuse becomes clear when coupling this with the finding that 78.8% of those surveyed stated they would be very likely or somewhat likely to accept waiver of medical expenses only (as opposed to full damages) as compensation.

The VA believed that the disclosure-and-offer programs' collaborative tone made it difficult for unrepresented patients to recognize the need to ask nuanced questions that were likely beyond their legal understanding. Risk managers have a primary financial responsibility to their employers that should be balanced by a skilled representative for the patient. Without this, unrepresented patients would likely never know whether an offer was sufficient to pay future injury-related expenses (for medical costs and lost earnings);

2. *Medical Error Disclosure: Admitting Mistakes Can Help Mend Fraying Relationships*, VANTAGEPOINT (CNA HealthPro), Feb. 2010, at 1, *available at* http://www.cna.com/vcm_content/CNA/internet/Static%20File%20for%20Download/Risk%20Control/Medical%20Services/MedicalErrorDisclosureAddmittingMistake%202010-1.pdf. ("This traditional stance is changing. Disclosure programs are becoming the norm in many healthcare organizations . . . .").

3. *See generally* Rae M. Lamb et al., *Hospital Disclosure Practices: Results of a National Survey*, 22 HEALTH AFF. 73 (2003), *available at* http://content.healthaffairs.org/content/22/2/73.full.html.

4. COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AMERICAN MEDICAL ASSOCIATION, CODE OF MEDICAL ETHICS opinion 8.03 (2012), *available at* http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion803.page. ("If a conflict develops between the physician's financial interest and the physician's responsibilities to the patient, the conflict must be resolved to the patient's benefit.").

5. *See generally* Lindsey Murtagh et al., *Disclosure-and-Resolution Programs that Include Generous Compensation Offers May Prompt a Complex Patient Response*, 31 HEALTH AFF. 2681 (2012), *available at* http://content.healthaffairs.org/content/31/12/2681.full.pdf+html?sid=23bd0287-e058-419b-8c2c-f3416f53f26b.

whether offered pain and suffering damages (if any) approximated a likely jury value; or if the offer had been discounted for any reason (e.g. unclear liability or to build-in room with the expectation the patient would attempt to negotiate).

To prevent miscommunications or misunderstandings, we recommend that disclosure programs adopt a two-part protocol as part of any discussion of malpractice with a patient:

> 1. Advise injured patients, verbally and in writing, to seek advice from independent counsel, stressing that risk management is not a disinterested party;
>
> 2. If a patient does not seek counsel, require a reasonable cooling-off period before a discussion between the patient and risk manager takes place.

Nothing in these protocols should be considered revolutionary. In fact, attorneys who suspect they have committed legal malpractice must exercise these same practices with their own clients.[6]

Advising patients to seek counsel protects their interests and the process's integrity too. Without it, patients may not recognize that the discussion about compensation is inherently a legal negotiation in which those making the offer have a conflict of interest. It is also important to allow patients to have a cooling-off period if they initially decline to consult an attorney. Ultimately, some patients may decide not to seek counsel, or even not to take compensation. Making this decision, however, presupposes the patient has a fair opportunity to consider the options and the effects of foregoing compensation. For that reason, no decisions should be made with unrepresented patients until they have had a fair opportunity to understand the significance of their decisions.

These best practices are not intended as a windfall for plaintiffs' attorneys. Instead, plaintiffs' attorneys are ethically bound to do the right thing by significantly reducing their fees if claims are resolved as a result of the disclosure-and-offer process.[7] If patients are able to afford it, plaintiffs'

6. MODEL RULES OF PROF'L CONDUCT R. 1.8(h) (1983), *available at* http://www.abanet.org/cpr/mrpc/rule_1_8.html.

> A lawyer shall not: (1) make an agreement prospectively limiting the lawyer's liability to a client for malpractice unless the client is independently represented in making the agreement; or (2) settle a claim or potential claim for such liability with an unrepresented client or former client unless that person is advised in writing of the desirability of seeking and is given a reasonable opportunity to seek the advice of independent legal counsel in connection therewith.

Id.

7. MODEL RULES OF PROF'L CONDUCT R. 1.5(a) (1983) *available at* http://www.americanbar.org/groups/professional_responsibility/publications/model_rules_of_professional_conduct/rule_1_5_fees.html ("A lawyer shall not make an agreement for, charge, or collect an unreasonable fee or an unreasonable amount for

attorneys should work for a reasonable hourly fee. If not (or if patients would prefer to pay on a contingency fee basis), the plaintiff's attorney is obligated to offer a contingent fee significantly less than the traditional one-third.

Compensation is a tricky issue and one in which a patient both deserves and requires advice from experienced advisors whose only loyalty is to the patient. By adopting these protocols, medical facilities and patients alike can resolve a bad situation in an ethically sound way. In the event that negotiations fail and result in a trial, hospitals are in a strong position to prove that their postincident activities were fair and patient-centered rather than self-serving.

expenses. . . ."). The rule subsequently lists factors to use to determine what is reasonable. *Id.* Factors include "the time and labor required" and "the novelty and difficulty of the questions involved," among others. *Id.*