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Dispute resolution in medicine — a casestudy in patent advocacy

Implementation of dispute resolution in refractive surgery

John W Potter

Background

TLC Laser Eye Centers is in the business of providing facilities and equipment where independent contracting physicians could perform laser vision correction procedures, including laser in situ keratomeliusis (LASIK), photorefractive keratectomy (PRK), as well as other refractive surgeries.[1]

In 2002, TLC Laser Eye Centers faced a number of looming medical malpractice issues. Premiums were rising, and insurance coverage was becoming overall more difficult to obtain. Doctors feared medical malpractice claims more as they became reportable events in the National Practitioner Data Bank.[2] Furthermore, the volume of procedures was increasing as the refractive surgery market expanded and larger jury awards became more publicised.[3]

Our new provider of medical malpractice coverage expected the company to put programs in place to reduce medical malpractice claims. One component of the requirements to maintain coverage was a patient advocacy program. At the time we had no such program, and we had no models to duplicate within the office-based, refractive surgery field.

Patient advocacy

Because there were no models for patient advocacy in office-based refractive surgery, we had to look to other health models in ambulatory surgery centres and hospitals, but none of them seemed to be quite what we needed.[4] Then we looked at other businesses where litigation might be a significant issue, and we discovered a company that had a remarkable program in ADR.

The Toro Company manufactures turf maintenance equipment and precision irrigation systems for a variety of needs worldwide.[5] Their ADR program began in 1992, and by 2000 the company had more than 900 product liability claims referred to what it called its 'early intervention program'. The Toro Company reported that it reduced its legal costs per claim (attorney costs and litigation expenses) by 78% from an average of $47,252 to $10,420, and reduced dispute resolution costs by 70%, from $68,368 for settlements and judgments to $20,248.[6]

We were struck by an idea that came from a discussion about The Toro Company and their dispute resolution program. In the discussion, Mr Steeland stated:

> I'm very concerned about diversity. I think it's terribly important. I think that the most successful dispute resolution programs are built on two principles: (1) they have to be absolutely collaborative in terms of being constructive in a dialogue with the users; and (2) the goal has to be user satisfaction, not just reduction of pending disputes or congestion or accelerated resolution. If we're going to look at customer satisfaction, then it's terribly important that parties involved in this collaborative process be comfortable with and identify with the neutral.[7]

We decided to use a doctor to interact with patients with unexpected results from refractive surgery and with whom there were disputes and conflict with the attendant risk of medical malpractice claims. The value to the doctor–patient relationship became predominant in our work in comparison with the outcome of the dispute resolution, as important as the latter was.[8]

We began our TLC Patient Advocacy Program in 2003. Patients were referred to the TLC Patient Advocacy Program by optometrists and ophthalmologists within the TLC Laser Eye Centers family.

Doctors can be complex and often difficult to understand. Avoidance as a conflict management style is very common among doctors, and this is the polar opposite behaviour of what we needed in terms of dispute resolution and conflict management. Again, the relationship with the doctor was essential to maintain the critical doctor–patient relationship.[9] Furthermore, emotions can run high and make dispute resolution and conflict management more complex.[10]

> Furthermore, the complexity of the dispute resolution and conflict management issues brought a number of ethical and practical issues to the forefront. ... Often a dispute and/or a conflict had escalated to such a level that it was difficult to help the patient.

Three important ideas

It quickly became very clear that health care services were very different from product liability in turf maintenance equipment and precision irrigation systems. Simply put, patients wanted to resolve their disputes with doctors playing a significant role in dispute resolution. The relationships

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were essential, and the overall program became more interest-based.[11]

Furthermore, the complexity of the dispute resolution and conflict management issues brought a number of ethical and practical issues to the forefront.[12] I am an optometrist by training, so the first step in the formulation of my own internal ethics was easy. A normative standard exists for the profession, The Optometric Oath.[13] So, 'I will place the treatment of those who seek my care above personal gain and strive to see that none shall lack for proper care' became my first standard in our approach. If we could help patients, then many of our disputes and conflicts would evaporate.

Although helping patients was a noble idea, it became challenging. Often a dispute and/or a conflict had escalated to such a level that it was difficult to help the patient. So, the second standard became supporting the doctors to help their patients. This required an approach that was more mediation than anything else because the doctors are independent contractors, not employees. It became essential to know when to use mediation and when not to use it.[14]

If I could not help the patients, and the doctors would not help their patients, even with our support, then it became necessary to resolve disputes and manage conflict using mediation, negotiation, and other skills. It became necessary to adapt an adventurous approach to dispute resolution and conflict management, complete disclosure and an honest approach to what is a an obvious conflict of interest for mediators.[15] These ideas are outlined in Table 1.

Table 1: Three important ideas

1. Help the patient
2. Support the doctors
3. Resolve disputes and manage conflicts

Apologies and expressing regret

Our first contact with a patient became such a critical part of our dispute resolution and conflict management effort that we developed a system for it and a program to teach it to our doctors. The Toro Company found the first contact was critical, too. We found that it was essential to express our regret as quickly and sincerely as possible.[16]

Five steps in expressing regret

We use a five-step process in making a meaningful apology to a patient. Because apologies can be difficult if it is not something that doctors do frequently, a memory can be used to make the language used accomplish what it is intended to do without seeming awkward or contrived.[17] The five steps needed to be considered are all 'r-words' and in order they are (1) recognition; (2) regret; (3) responsibility; (4) remedy; and (5) re-alignment. (Table 2)

Table 2: Steps in expressing regret

Step 1 Recognition
Step 2 Regret
Step 3 Responsibility
Step 4 Remedy
Step 5 Re-alignment

Recognition

It might seem that knowing when to express regret would be obvious, but in our experience it is not as straightforward as one might think. If a refractive surgery patient is having a difficult time with their vision loss, their doctor may be suffering, too. Patients' doctors would not be caring people they are if they did not have the emotional tie to their patients that is a necessary cornerstone of a good doctor–patient relationship.

Regret

Expressing regret comes in two forms. Doctors need some format to use to develop their own approach to patients. Each situation is different, but here is a basic approach we often use, 'I regret that you have had a bad experience with your refractive surgery. Neither one of us expected you to have these problems. I am very sorry this has happened.'

Responsibility

This aspect of an apology is the most difficult, and it is the kind of thing that keeps doctors up late at night with worry and anxiety: should they tell the

complete truth or not? It is our experience that it is most important that the doctors be straightforward and completely honest with patients. Our experience has shown us that patients expect their doctors to tell them the truth, even if they have to say that they may have done something that caused the patient harm. In fact, it is our experience that a sincere expression of regret and complete assumption of responsibility is the best policy in every instance.

Remedy

Immediately following acceptance of responsibility, we move to offering a remedy for the patient's problem. The remedy has two distinct parts:

(1) a precise and clearly stated remedy for the patient, and

(2) a statement that we will do what we can to use what we learn from the patient's experience to try to prevent others from having the same or a similar problem in the future.

If we do not have a remedy yet, that is perfectly acceptable. We say we do not have a remedy, but then clearly state when we will. On the other hand, if we know the remedy, we state it directly and accurately to the best of our ability.

Re-alignment

Unlike many other kinds of procedures, refractive surgery is elective and it deals with a complex and highly sensitive function: vision. In addition, it is still new enough in the world of eye and vision care that patients often feel as if their problem occurred because they are on the edge of new developments in a new procedure and this can lead to suspicion and anxiety far beyond what other patients may experience from other procedures. As a result, we use and teach our doctors to add one final step in the expression of regret. The doctor needs to state directly that anything that is learned from the patient, or from what happened, will be used by to try to prevent other patients from having the same or a similar problem in the future.

Understanding vision loss

The implementation of a process for expressing regret quickly and sincerely with complete disclosure became the most important step in the beginning of our dispute resolution and conflict management effort. However, what we learned next was startling in its clarity and it was the most important discovery we made in first year of our program. After several dozen patient disputes, it became apparent that patients were behaving in very characteristic ways, regardless of the specific nature of the unexpected results from refractive surgery. We discovered that some patients grieve over vision loss, and even loss that may not seem clinically significant can be unexpected for patients and lead to grieving. This understanding became the cornerstone of our program.

Ten steps in grieving

Grieving is a normal human response to significant loss. It is healthy to grieve, and it is a part of the fabric of each of our lives. However, understanding grieving requires some knowledge and sensitivity that may not come naturally without additional education and training in the subject.

Unexpected results are not common following refractive surgery, and because they are uncommon doctors may or may not have ever had a patient who has gone through the experience.[18] When grieving occurs following unexpected results in refractive surgery, we believe there are 10 stages (Table 3).

Table 3: The 10 stages of grieving

1. The patient is in shock
2. The patient expresses emotion
3. The patient feels depressed and alone
4. The patient may develop physical symptoms
5. The patient may become anxious
6. The patient may develop a sense of guilt
7. The patient may become angry and resentful
8. The patient may resist returning to their normal self
9. Gradually hope returns
10. The patient affirms the reality of their loss

The patient is in shock

When a patient has an unexpected result from refractive surgery, their first response is to enter a state of shock. This period of shock lasts for days or weeks, but not months.

The patient expresses emotion

Shock does not last for a long time, so the next phase a patient will go through may surprise doctors if they are not expecting it. This next phase is highly predictable, so it is important to understand it when it occurs. The patient will become very expressive, and that almost always takes the form of anger and frustration.

A sudden jump from the more reticent state of shock to such a great level of expression of emotion almost always catches doctors unaware. The reaction, unfortunately, is to withdraw from the patient, which is a very human reaction, but it is not the reaction that a well-informed doctor should take.

We teach our doctors and we use the technique ourselves, which is to put some distance between the doctor and the patient by using the image of 'going to the balcony'.[19] We imagine ourselves in a large auditorium. The patient is on the stage, and we are in the last row of the balcony. This image of distance helps maintain poise in the face of anger, frustration, and hostility.

The patient feels depressed and alone

The patient may very well be feeling emotions they have never had before. Such emotion becomes very confusing and often leads to a behaviour that is very much a situational depressive state. It is not at all uncommon for patients to tell us, or to express to their doctors, that they have thoughts of ending their own life. We may not hear from the patient for months, and if the doctors have been struggling to understand their patient's behaviour so far, they may welcome the idea that they have not heard from the patient. This is, again, a very common and human response, so it is perfectly acceptable to have these feelings, even if they are inappropriate. What we need to understand is that the patient needs us now more than ever, but it is regardless a difficult challenge to take the initiative to continue to try to help a patient when doctors are struggling themselves to deal with the patients' problems.

The patient may begin having physical symptoms

This next stage of grieving over unexpected results from refractive surgery is often very alarming to the doctors. And again it is important to be able to identify the stage and to understand it so we can help the patient.

A common expression in this stage is for the patient to say something like, 'My eyes are so bad that I cannot see to do my work at all.' Or, 'My eyes are so bad, and my vision so poor, that I cannot drive a car at night.' We have had patients express this emotion as back pain and other symptoms that would not be directly related to eyes or vision, but it is important to know what the emotion is telling us.

The test for this stage in the two examples above is to reframe and say that it must be difficult for the patient not to be able to work, or drive at night. Frequently, we will hear a reply that says that the patient is still working full-time or still driving at night. Now, we must be careful. The reframing identified the stage of grieving and highlighted it well, but if we become angry with the patient because it appears they are misleading us or simply not telling the truth we will be making a very grave error. The response should be, again, that we understand such activities like working or driving at night must be difficult. If we challenge the patient on what appears to be a contradictory position, we will push them backward and cause them to withdraw because they will believe that we simply do not understand how much they have suffered.

The patient may become anxious

The patient may become anxious. If so, there is nothing else they can think about except their eye and vision problems. This is the stage where operating surgeons in refractive surgery make their most common errors. A doctor may well be tempted to do what the patient has asked for and an additional surgery may be performed 'because the patient really wanted me to fix their problem.' In fact, nothing could be further from the truth in the situation. Additional refractive surgery is not a treatment for anxiety in grieving over unexpected results from refractive surgery.

The patient may develop a sense of guilt

This next phase does not last very long, but it can be quite problematic for the patient and their doctors. In our experience, this phase lasts only a week or two, but it is important to recognize it if it occurs with patients. The patient may ask us if they made a mistake having refractive surgery in the first place.

The patient may become angry and resentful

The next stage in a patient's journey can be quite difficult to understand. The patient may develop an anger and resentment of the doctors and what our dispute resolution process has done, or not done, to help them. Almost always the anger is completely out of character for the patient, and it may be directed at family members and/or loved ones too.

Furthermore, the patient may begin to feel that we have forgotten how much they have suffered, and so they must keep the memory of their suffering alive and well. In fact, it may become their personal mission in life for some period of time that can be months, or in some situations years, to remind us, and others in their life, just how much they have suffered.

There are several internet sites that are populated with patients' feelings and their emotion over what they feel they have lost with their unexpected results from refractive surgery.[20]

The patient may resist returning to their normal self

Far and away the most complex situation we find ourselves in is one where the patient is resisting returning to their normal self. We may very well have a treatment, or have arranged for additional surgery, that the doctor and patient believe will help with their unexpected results, but the patient will not utilise the treatment, or won't show up for appointments. In fact, doctors may become quite frustrated with the patient, and it is always a mistake when they do. The harder the doctors push, the more resistance they encounter, even to the point of what may appear to be absurd.

In this stage, there are many challenges to the management of the dispute and the conflict. A great deal of

communication occurs as we mediate between the doctor and patient to keep both engaged and understanding without interfering too much in the doctor-patient relationship. On the other hand, when this stage is poorly understood or mishandled, the patient is left with really only one alternative to remind the doctors of how much they have suffered: they file a medical malpractice action.

Gradually hope returns

What has been one of the most meaningful experiences of my professional life is to have worked with a patient and their doctors for several months and to see hope return. The patient will begin to talk about their future and not dwell on the past.

The reality of loss

Ultimately, as is the necessity of being human, we all must come to accept the reality of a loss. It may take time and careful assemblage of insight, but it is the result that matters most, and accepting the reality of loss is essential to effective dispute resolution and conflict management in refractive surgery.

Program status

It was important to obtain information about the different forms of dispute resolution and conflict management used, and it was essential to gather some verification of the data. So every third chart (N=500) was reviewed for primary dispute resolution and conflict management functions based upon '*Conflict Diagnosis and Alternative Dispute Resolution*' by Laurie Coltri.[21] Then, every fifth chart was reviewed by a paralegal and/or associate general counsel for correlation using the Coltri textbook's definitions. Changes in correlation were 3% from the 100 patient records. The data was sorted and organised in table format (Table 4).

Table 4: Forms of dispute resolution

DISPUTE RESOLUTION FORM	PERCENTAGE OF PATIENTS
Mediation	78%
Negotiation	21%
Arbitration	0.2%
Litigation	0.3%

Porter and Olmsted-Teisberg summed up our effort nicely in *Redefining Health Care*:

> Moving early is particularly important in the area of clinical information. More information will not only improve practice, but will also allow more convincing demonstrations of excellence, and better insight into costs. Providers that are early and aggressive in collecting and analysing results information will also be in a position to influence the measures used and to set the standards that others will have to live with.[22]

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ADR Diary

- **LEADR** is holding 5–day **Mediation Workshops** around the country that meet the standards for the National Mediator Accreditation Scheme. The last course of the year is being held in Sydney from 1–5 December 2008. The Mediation Workshops will be offered again in 2009 in Sydney on 23–27 February; Adelaide on 17–21 March; Perth on 24–28 March; Melbourne on 27 April–1 May; Darwin and Brisbane on 5–9 May and many more dates for the remainder of 2009. LEADR will also be holding 4–day **Cinergy Conflict Coaching Workshops** in Sydney on 3–6 March; Brisbane on 10–13 March; Melbourne on 21–24 April; and Adelaide on 5–8 May. For registration forms, early bird registration dates and more information on courses, visit <www.leadr.com.au/training.html>
- The **Fifth Asia Pacific Mediation Forum Conference** will be held in India on 21–27 November 2010. For further information go to <www.ausdispute.unisa.edu.au/apmf/>.
- The **Bond University Dispute Resolution Centre** has just released its 2009 program of courses. The year starts off with a 2–day **Assessment Course** 13–14 February; a 4–day **Basic Mediation Course** on 19–22 March. Bond will also be offering, in conjunction with University de Catholique, a course in **Global Negotiation** in Lyon, France from 27 April–2 May 2009. For more information email <drc@bond.edu.au< or visit <www.bond.edu.au/law/centres>.
- **Australian Centre for Peace and Conflict Studies (ACPACS)** has a 5–day **Mediation** course and a 3–day **Negotiation 2** course on 10–12 December in Melbourne. For further information go to <www.uq.edu.au/acpacs/workshops-program>.
- The **Alternative Dispute Resolution Conference 2008** is being held in Brisbane on 28 November. For further information go to <www.thomsonreuters.com.au/catalogue/shopexd.asp?id=9586&utm_source=url_adr&utm_medium=customurl&utm_campaign=adr>.
- The Australian Commercial Disputes Centre's (ACDC) next **5-Day Mediation Training** course will next run 23–27 February, 2009 in Sydney. Participants wishing to become ACDC Accredited mediators and apply for recognition under the Australian National Mediator Accreditation System should undertake the additional Accreditation Day (optional) held on Thursday 5 March, 2009. ACDC will be holding a **Mediation Professional Development Workshop** on 15 December 2008. Visit <www.acdcltd.com.au> for further information.

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