

## **Healthcare Professionals' Use of Narrative Mediation to Address Disclosure and Apology in the Aftermath of Medical Errors**

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### **Abstract**

Despite overwhelming evidence that suggests that patients, families and health care systems benefit from offering appropriate disclosures and apologies to patients and families in the aftermath of medical errors, few health care organizations in the United States invest in consistent systematic training in disclosure and apology. Using a narrative analysis, this paper explores the cultural barriers in the United States health care environment that impede health care providers from engaging in restorative conversations with patients and families when things go wrong. The paper identifies a handful of programs and models that provide disclosure and apology training and argues for the unique contributions of narrative mediation to assist health care professionals to disclose adverse events to patients and families to restore trust.

### **Key Words**

mediation; narrative mediation; health care; disclosure; apology; medical error

### **Recommended Citation**

Monk, G., Sinclair, S., & Nelson, M. (2016). Healthcare Professionals' Use of Narrative Mediation to Address Disclosure and Apology in the Aftermath of Medical Errors. *Narrative and Conflict: Explorations in Theory and Practice*, 3(1), p. 24-43. Retrieved from <http://journals.gmu.edu/NandC/issue/view/195>

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## **Introduction**

With the implementation of the Affordable Care Act in the United States, hospitals, more than ever before, vie with one another for future consumers. Health care providers find themselves in a hyper-competitive marketplace, tempting future patients with health care plans that cater to demanding American customer service requirements. Health care publicity campaigns promise future patients clinical excellence, the highest-quality patient care, and doing the right thing every day. One marketing campaign of a large health care system claimed to offer future patients the “best health care provider in the universe!” (Sharp.com, 2014). Health care marketing strategies tell consumers that they will offer the highest ethical standards of integrity, honesty and trustworthiness.

These marketing campaigns strengthen the background cultural narratives about high quality and safe service provision for those who are sick. These cultural narratives are quickly internalized and then shape people’s expectations and the kinds of interactions they anticipate from health care providers. The realities, however, do not neatly match the marketed promises. Despite the vigorous promises of healing narratives, inadvertent harm is done to patients on a regular basis. The occurrence of adverse outcomes is more common in hospitals than most American citizens are prepared to acknowledge. According to a (1999) Institute of Medicine report entitled, “To err is human: Building a safer health system”, medical errors cause between 44,000 and 98,000 patient deaths in U.S. hospitals each year. This report called for immediate action to improve patient safety and subsequently spawned the patient safety movement.

Hospital errors in the United States are between the fifth and eighth leading causes of death (Kohn, Corrigan, & Donaldson, 2000). These medical error figures are sadly of a magnitude similar to other modern health care systems in the Western world. Deaths from medical errors are reported to be higher among Americans than breast cancer, traffic accidents or AIDS. Kohn et al. (2000) reported a stunning statistic that five to 10 percent of patients who enter the hospital would be subject to medical error.

### **Definitions of Medical Error and Adverse Outcomes**

The terms medical error and adverse event merit explanation. In general, patients use the term “medical error” broadly to include difficulty accessing care, poor relational skills, and low quality of service. Patients’ concerns about error might also include an actual delayed diagnosis, or the perception of an error or delay. Health care providers favor precision and use the term “adverse event” to describe injury caused by medical management

and not by the underlying disease or condition, and they avoid language that implies error or negligence. The legal criteria for negligence includes preventable adverse events that result from human error or equipment failure during medical treatment. There are two types of errors: “errors of execution” and “errors in planning” (Leape, 2002, p. 1633). Not all medical errors result in adverse events, and not all adverse events are the result of medical errors. Truog, Browning, Johnson, & Gallagher (2011) combine the two terms, because the process of disclosure requires that they be dealt with similarly. This paper will follow suit and use the phrase “medical error and/or adverse event” whenever practical.

### **Impact of Medical Error on Patients and Families**

Patients and family members who suffer catastrophic outcomes struggle to make sense of the contrast between the promise of care on the one hand, and the real suffering caused by inadvertent harm on the other. In addition, when patients and family members communicate criticism of their care at a time when they are most vulnerable, they are effectively challenging and disrupting the social order and power relations between doctor and patient. Patients who might consider challenging their doctor about a course of treatment may fear that their health care professionals will view them as ungrateful and unappreciative and paradoxically deserving of less care. There are strong cultural forces at work to silence patients and families who are unhappy with their medical treatment. For example, many patients, despite evidence to the contrary, are influenced by dominant cultural narratives such as, “The doctor and nurse know best, they will know what is wrong, and they will make me better,” and, “I can trust that the doctor and nurse will care for me and understand what I need.”

When the background assumptions of care are violated, patients experience not only damage to their functioning, but also a sense of personal betrayal by doctors and nurses. Pierce (2013) reports on some of the devastating consequences of these errors:

A patient who is denied validation for their medical injury is betrayed by the medical system they have learned to trust as an official authority. It is a shocking experience to realize that everything one has thought about trusting this authority is suddenly wrong. (p. 2)

The violation takes its toll on the people left behind.

When you have a child die from 100 percent medical error, you become every mother's worst nightmare ... It is a grief and pain most people, fortunately, can never understand and are afraid to come near. (p. 2)

Family members struggle to move on after medical harm has occurred, when every single aspect of their lives has been negatively impacted and when everything they trusted about health care professionals has been turned upside down.

### **Impact of Medical Error on Health Care Providers**

It is not just the patients and family members who are negatively affected, when things go wrong. Doctors are trained in medical schools and in hospital residencies to be perfectionists in their delivery of health care and not to make mistakes. When doctors and nurses cause catastrophic, or even less serious, but still unanticipated preventable errors, the effects can be devastating on the health care professionals, sometimes leading doctors and nurses to resign from their careers. In the worst cases, this can be a contributing factor to health care professionals committing suicide (Schernhammer, 2005).

Many physicians process these events by believing they have failed the patient, and by second-guessing their clinical skills, their knowledge base, and even their career choice. Wu (2007) captures the intensity of a physician's reaction, when confronted with violating the Hippocratic Oath of avoiding doing harm to patients:

Virtually every practitioner knows the sickening realization of making a bad mistake ... You know you should confess, but dread the prospect of potential punishment and of the patient's anger. You may become overly attentive to the patient or family, lamenting the failure to do so earlier and, if you have not told them, wondering if they know. (p. 726-727)

David Hilfiker (1984) commented about the inevitability of making medical errors as a doctor, the suffering this brings to physicians, and how ill-equipped they are to deal with the aftermath. Gazoni, Durieux, and Wells (2008) suggest that health care professionals need training in communicating an adverse event, and in how to handle the subsequent negative reactions of patient and family. Albert Wu (2000) coined the phrase "second victim" to describe the effects of medical errors and adverse events on the health care provider. In one physician's daily work experience, Gallagher, Waterman, Ebers, Fraser, & Levinson (2003) reported that this person gets the "sinking feeling" that he has done something wrong almost

on a daily basis (p. 1001). The combination of life-or-death decisions with infrequent opportunity to debrief can lead to unimaginable stress.

In order to address this lack of training and provide support for the “second victim”, the University of Missouri Health Care (UMHC) qualitative research team developed the Scott three-tiered interventional model of support and the inter-professional “forYouTeam” (2009). Teams consist of physicians, nurses, social workers, respiratory therapists, and other health care professionals. Immediately after a medical error or adverse event, senior health care leaders and supervisors are asked to conduct a “post-event professional critique” of the incident, and recommend an intervention, if needed. MUHC provides one-on-one crisis intervention, peer support mentoring, and team debriefings. The support afforded by this program positions health care providers to be more effective in conversations with families by reducing health care providers’ level of threat and anxiety to more manageable levels.

Attending to the well-being of doctors and nurses who are “second victims”, can build a support system around professionals to enable them to better take care of their patients and families when they are experiencing trauma. A survey of orthopedic surgeons and anesthesiologists by the Medical Protection Society (UK) (Gazoni, et al., 2008) reported that 55 percent of operating room personnel and surgeons requested being given the option to take the rest of the day off, if a patient died under their care. One-hundred percent of resident physicians and 90 percent of attending physicians disclosed the need for help in coping with death and dying. Forty percent of anesthesiologists who experienced death or injury of a patient felt at least partially responsible. Gazoni et al. (2008) recommended that health care institutions commit to providing debriefing activities for interns who had experienced the death of a patient.

### **Barriers to Disclosing Medical Error and Adverse Outcomes**

A health care system is a site where various cultural forces intersect and shape personal responses and interpersonal conflict in particular formats. Even in the face of tremendous human tragedy, it is possible to identify background cultural narratives at work, producing human interactions that become the source of ongoing suffering.

Many health care professionals do not believe that disclosure and apology will lead to favorable outcomes, because they believe that patients will lose faith in the health care system and that they will face litigation (Gallagher, Garbutt, Waterman, Flum, Larson & Waterman, 2006). This belief is inconsistent with data that clearly demonstrates a positive correlation between health care provider communication and patient/family satisfaction

(Mitka, 2010). Wojcieszak (2012) reports that over half of the hospitals and acute care facilities in the United States espouse a policy of disclosure and apology, but actual compliance varies. On an intellectual level, doctors and health care professionals understand these ideas, but in practice, the majority of health care providers do not engage in disclosure and apology. This lack of engagement maintains a form of distance between health care providers, and patients and families. These practices promoted by medical culture often invite behaviors that stand in stark contrast to the needs of patients and families.

Hilfiker (1984) and Delbanco and Bell (2007) claim that health care professionals doubt their ability to cope with their own feelings, or the feelings of the patients and families, when things go wrong. Historically it has been rare for health care providers to sit down and reconcile with patients and families, when that is the very thing that both parties need the most in order to move on with their lives and their respective careers (Wojcieszak, 2012). Providers have said much in favor of the offering of a disclosure and apology. Yet there are numerous barriers preventing health care providers from doing the right thing.

Yardley, Yardley and Wu (2010) address this question with a description of several categories of barriers to disclosure. Barriers involving physicians include humiliation and self-consciousness, a low level of relational confidence, and fear of diminished professional standing. Barriers related to legal issues include fear of legal action, and fear of severe disapproval or limitations to practice. Despite the health care professional's intentions to take ownership of making the medical error and apologizing, lawyers steer doctors away from making apologies for the very real fear of admitting liability. Only two-thirds of U.S. states protect specific statements made by doctors related to medical error disclosure from being admissible in a lawsuit. Most states only cover expressions of empathy or sympathy. Thankfully, there is a growing number of states who go further and protect admissions of fault (Wojcieszak, 2015). Working in a health care environment is demanding and stressful and doctors are trained in residency to be tough-minded autonomous problem solvers. Traditionally, physician culture demands of health care professionals to be dispassionate, to not show weakness or display vulnerability.

Subtle forms of persuasion to conceal error, which serve to maintain institutional barriers, can continue to be fostered by senior colleagues or hospital executives (Yardley, Yardley & Wu, 2010). Hospital management may espouse belief in disclosure and apology on the one hand but, on the other hand, administrators' own fears and attitudes come through in their vocal tone, body language and demeanor. Their employees are very attentive to the unspoken message. The long history of the "deny – defend" discourse adhered to by health

care professionals for decades to diminish any chance of litigation and being found at fault, can easily resurface when medical error should be discussed with patients and families.

While health care professionals live in fear of accusations of malpractice and of subsequent litigation, it is not only potential future narratives played out in the legal arena that exert influence on the present. Professional identities are also linked with personal narratives. Medical professionals are accountable to their own stories of professional pride and are keenly aware of how their reputations are treated by others. Feeling shame or guilt about not providing the care that one hoped to provide, can make it hard to apologize. Barriers to disclosure and apology are ways for doctors to manage fears, shame, and inadequacies. However, the lack of an apology and disclosure when things have gone wrong can stall the physical and psychological healing process for patients and families who are stuck with feelings of betrayal and distrust. These consequences for patients and families spill over onto physicians and prevent them from moving forward and getting over the adverse event as well. As Wei (2006) suggested, "If unable to admit mistakes, we physicians are cut off from healing ... we are thwarted, stunted, we cannot grow" (p. 35).

Tallentire and Smith (2012) studied several cohorts of medical students' responses to medical error. The researchers noted that the more severe the error, the less information would likely be disclosed. Students with previous training in medical error did not disclose more than students with no training. However, those with previous training were less perfectionistic, more accepting, and more willing to share emotion and uncertainty. Tallentire and Smith (2012) comment that attitudes and behaviors of all newly qualified doctors are heavily influenced by the prevailing culture of the organization and their perception of the hierarchy within which they work. The health care environment continues to operate within a discursive framework, whereby military forms of chain-of-command and hierarchies that accompany a top-down system can serve to silence physicians in the junior ranks, when medical error should be acknowledged.

Lucian Leape (2008) offers further insight into doctors' barriers to disclosure and apology and characterizes physicians as students who are used to getting As, high achievers, perfectionists, and highly invested in creating a perfect product. For a doctor, a mistake is a blow to the ego and self-image which is very intense, and those that seek to help should not underestimate this. It is this intensity that propels them to blame others, and get defensive. Leape (2008) proposed that physicians engage in these behaviors to protect their self-image. He suggested that this motive is behind the defensiveness, and they are protecting their self-image with denial, trying to prove to themselves that they are not at fault. He stated:

At the time when the patient needs us to be most understanding and the most open and listening and supportive, is right when we are psychologically the least able to do it because we are consumed with our own self doubt and self worry. (Leape, 2008, p. 127)

These dominant discourses of perfectionist practice of medicine create barriers that prevent health care professionals from being open to disclosure and apology and ultimately doing the right thing for the patient.

Wagner, Damianakis, Pho, and Tourangeau (2012) find that nurses are constrained from reporting, because of the excessive day-to-day demands on their time. Nurses must interact with family members, experience interruptions, emergencies, and chart their work, while management demands that there be no errors. These excessive expectations minimize error reporting, which is a part of disclosure. The hierarchical culture itself is a barrier to disclosure and apology. For example, there is strong evidence that nurses who are trained to speak up when things are going wrong, also learn from the hierarchical top down culture to take a subordinate position when things become stressful (Attree, 2007). About a third of nurses in the United States have difficulty speaking when there is an adverse event and are unable to disagree with a staff physician (Churchman, Doherty, 2010; Sayre, McNeese-Smith, Leach & Phillips 2012; Sayre, McNeese-Smith, Phillips & Leach, 2012). The old cultural discourses or narratives about nurse obedience and compliance to doctors' requests are hard to eradicate in a health care environment which is striving to develop new cultural narratives about how a hospital should function when medical error occurs.

A narrative analysis of this reluctance to disclose medical error and express a heartfelt acknowledgment avoids exclusively focusing on individual actions, expectations and interests. A narrative mediation approach (Winslade & Monk, 2000; 2008; Monk & Winslade, 2013) implicates the background cultural assumptions, or discourses, that inform people's understandings of what is acceptable, normal, right, or possible. Making the social and cultural world visible influences how these challenges for health care professionals to disclose can be thought of, understood and overcome to then help families find a pathway forward.

Decisions about what actions a doctor or nurse will make in response to error are ultimately shaped by discursive options and the positions offered by the background cultural terrain that exists in the health care environment. Yet, each health care professional is responsible for making an ethical choice about whether to disclose and apologize to patients



and family members, if something harmful has occurred. As McNamee (2009) suggests, professionals should engage in accountability acts that recognize the ways in which their own “ethical” actions are influenced by the taken-for-granted understanding of what is professionally ethical.

### **Using Heartfelt Acknowledgment and Apology in Responding to Adverse Outcomes for Patients and Their Families**

Approximately 15 percent of emergency medicine providers surveyed have been trained in disclosure and heartfelt apology (Manser & Staender, 2005). Patients and families need doctors and other health care professionals to disclose and apologize after a medical error or adverse event (Taft, 2005). The literature on disclosure and apology shows that a heartfelt apology helps to alleviate much patient and family distress over losses and injuries, and facilitates the healing process following the event. In an apology, the health care provider expresses remorse and sorrow and admits wrongdoing. The intent of the apology is to take responsibility for the injury, and open the door for reconciliation (Delbanco & Bell, 2007; Taft, 2008).

Trust is broken when an adverse medical event is concealed, and trust is rebuilt with disclosure, apology, and responsibility. The building of trust and respect involves risk-taking, emotional engagement, heartfelt acknowledgment of what has occurred, a non-distracted presence, caring, and humility on the part of the health care provider. This is by no means a complete list, but these qualities come through as strong themes in the adverse outcome communication literature (Berlinger, 2007; Boyd & Taft, 2009; Taft, 2000; Wei, 2006). Working at repairing the harm done is not neat and tidy. Skilled health care professionals grieve with their patients and their families; they listen to the patient and family speak; they humble themselves; they disclose their frailties; and they develop a more expansive, nurturing embrace of their already-demanding work. Restoring the harm done is a movement toward righting the wrong, by offering a heartfelt acknowledgment and apology followed by the health care system providing remuneration to the patient and family for the suffering that occurred.

Facilitators and trainers in apology and disclosure practices following medical errors and adverse events need to be aware that, while learning the mechanics of offering disclosure and apology is crucial, the nuances of learning related to emotional and cultural attunement are essential. The mechanics of communication structure the delivery and format of apology and disclosure. The emotional attunement is embedded within the words expressed.

## Responses to Addressing Patient and Family Needs Following Adverse Outcomes

In the last 15 years, there have been creative and diverse methods and activities employed by a few health care systems and health care professionals to address catastrophic health care outcomes caused by medical error that involve disclosure and apology. Among these innovative health care systems, there is a wide recognition that the post-adverse events should include, where possible, re-building trust between provider and patient. Providing remuneration to patients, without consumers having to seek recognition for their suffering through the terrible human and financial costs involved in a full-blown litigation, helps advance the quality of health care in taking care of patients and families when things go wrong.

The literature on communication following medical errors and adverse events has refined the language of apology (Browning, Meyer, Truog & Solomon, 2007; Lazare, 2006). At Boston Children's Hospital, the Program to Enhance Relational and Communication Skills (PERCS) focuses on process over content. The program emphasizes the authenticity of the communication, rather than a formulaic selection of phrases and choice of words. Patients and families want providers to engage in genuine heartfelt acknowledgment of their errors and the suffering the errors have caused. When the health care provider engages and exposes emotionality and vulnerability via disclosure and apology, she or he risks exposing their own shame and guilt, in addition to beginning the process of legal action, to name a few outcomes. But genuine heartfelt apology often facilitates forgiveness on the part of the patient and family (Taft, 2000). Perhaps this is one way in which trust is rebuilt.

Because of the pervasive discourses that produce barriers for health care professionals to apologize and disclose error, the time is ripe for some robust alternatives. John Banja (2005) describes "exemplary physicians" who ask the patient if they can come into the room; draw the curtains for privacy; attend to discomfort and shortness of breath; make physical contact with the patient; sit at the patient's level when speaking; tend the patient's bedding to make her more comfortable; change out trays; inquire regarding family and life of the patient; and personally feel the pulse of the patient. Banja goes on to say the exemplary physicians practice silence and attentive listening. "... One of the most basic expressions of respect for the other is concentrated silence that attends to the other's every word, every sigh, every pause, every vocal inflection, and every facial nuance and physical gesture" (p. 156).

## **Training Programs for Addressing Medical Errors and Adverse Events**

Training programs for facilitating meetings between families and health care professionals following medical errors and adverse events have been under development for over 15 years. An example of this is the Medically Induced Trauma Support Services (MITSS) founded in 2002 by Dick van Pelt and Linda Kenney, who partnered with Brigham and Women's Hospital, a non-profit entity, whose mission is to support patients, families, and clinicians in the aftermath of medical error and adverse event. MITSS also supports health care organizations with training materials and links to case study videos via the Clinician Support Toolkit (van Pelt & Kenney, 2010). This group contributes to the discussion of adverse medical events, by modeling the courageous behavior of a doctor engaging openly and honestly, with heartfelt acknowledgment of the suffering caused to the patient.

Soto and Rosen (2003) adapted the BICEPS (Brevity, Immediacy, Centrality, Expectancy, Proximity, Simplicity) model from military mental health practice to address the aftermath of medical error. This particular model contributes to work on helping doctors and nurses address adverse medical events with its emphasis on support, strength, and resiliency. These researchers argue that when health care providers are supported and can operate from a position of strength, they are far better situated to communicate with their patients and their families openly and effectively.

Martin Hatlie's (2012) "Partnership for Patient Safety" (P4PS) and businesses such as Sorry Works (Wojcieszak, 2005; 2012) assist health care providers, insurers and legal counsel to develop disclosure and apology programs to promote a health care culture that is safer, compassionate and just. Similarly, the Institute for Healthcare Improvement (IHI) offers national trainings and hosts health care-related conferences and online courses covering a broad range of services involving communicating with patients after adverse events (Institute for Healthcare Improvement website, 2015). Boston Children's Hospital created the Program to Enhance Relational and Communication Skills (PERCS) in 2002 in order to foster difficult communications in pediatric care. Expansion of difficult communications to adult treatment led to the foundation of the Institute for Professionalism & Ethical Practice (IPEP), which promotes interdisciplinary relational competence in the health care setting (Boston Children's Hospital Website, 2012).

The MITSS, P4PS, Sorry Works!, IHI, and PERCS are illustrative of a small number of models that are available for health care providers and institutions to assist them in

creating and supporting apology and disclosure programs. However, there is still a lot to be done in educating health care providers to provide a system-wide response to medical error.

### **Mediation in Addressing Adverse Outcomes**

Using mediation in health care disputes is another approach toward the goal of rebuilding understanding and trust between provider and consumer. Mediation models must be tailor-made for health care contexts. This is necessary as the mediator has a unique role in helping the health care professionals disclose and offer heartfelt acknowledgement and apology for the suffering of patients and their families following medical error.

Liebman and Hyman (2004) provided a template and training guide for the introduction of mediation into a health care setting. Their mediation project focused upon training communication skills, such as active and reflective listening and utilized the services of communication experts to focus on planning the disclosure conversation, acknowledge goals of all participants, and encourage family participation. They also created a model for the debriefing of all parties and providing emotional support for health care professionals. Liebman and Hyman teach apology, address barriers to disclosure, and employ mediation in malpractice and ADR. These elements can offer a good fit with the needs of patients and families, and provide good evidence of a progression toward increased productive contact between patients and their health care providers. It is interesting to note that President Obama's health care legislation, the Patient Protection and Affordable Care Act (PPACA), employs ADR in malpractice claims. The implementation of ADR in the Affordable Care Act will include apology in the mediation process, physician confidentiality, and incentives such as offering financial rewards for lowered rates of hospital-acquired conditions and the promotion of health care quality reporting (Foley & Lardner, 2010).

### **Narrative Mediation in Addressing Adverse Outcomes**

Narrative mediation, developed by Winslade and Monk (2000; 2008; Monk & Winslade, 2013) pays attention to how conflict is constructed from background cultural narratives that collide within people's relational lives. To put it another way, the wider social and cultural forces that give shape to the stories by which we live, produce conflicts that emerge between individuals or groups. These conflictual narratives embedded within the meaning-making systems we are raised within, produce problem-saturated narratives that diminish our lives and shut down opportunities for growth, change and progress toward preferred action. The major thrust of narrative mediation is to help people separate from conflictual narratives and consider moving toward narratives of relationship that they would

prefer. The central aim is to assist people to progress beyond the divisiveness of clashing cultural narratives and problem-saturated stories, by working to identify and develop counter stories to the story of conflict. Any story is a selection from available plot events and any relationship can support multiple stories. There is thus always a counter story that can be found.

Deconstructive inquiry, externalizing conversation, and mapping the effects of problem narratives, can loosen the potency of dominant conflict stories and make room for neglected counter stories present in the background. Non-conflictual moments can then be woven into a viable counter story through connecting them together. The goals of narrative mediation are: a) to create the relational conditions for the growth of a story of cooperation in the face of conflict; b) to build a story of relationship that is incompatible with the continuing dominance of conflict; and c) to open space for people to make changes and to negotiate new understandings.

The practice of narrative mediation in health care is careful to avoid attributing the suffering following adverse outcomes to any kind of essential deficit in either party. The profound respect involved in avoiding deficit thinking means taking people seriously, rather than interpreting them in terms of pathology, such as mental illness. This means consistently working from the assumption that The person is not the problem; the problem is the problem (White, 1989, p.6).

Since 2004, the lead author began implementing a narrative mediation model that addresses complex mediator roles to train dozens of health care ombuds mediators (HCOMs) in the Kaiser Permanente health care system. This work has been discussed in detail in *Practicing Narrative Mediation* (Winslade & Monk, 2008).

A narrative mediator recognizes that there are powerful forces operating in mediation meetings in health care settings where adverse outcomes have occurred. This includes the cultural narratives that shape the mediator's responses as well. As a result, ethics of impartiality, neutrality and objectivity, dimensions deemed essential for the mediator by many mediation models, cannot be realized in practice. Mediators are pulled in different directions by the cultural threads being played out in the conflict. A mediator cannot have a neutral reaction to the despair that the family must feel when their loved one is severely damaged by such a grievous act. Mediators are also family members and medical patients. Neither can a mediator remain unaffected by the professional positioning that shapes a doctor's responses. Mediators are also professionals. They can appreciate on a personal level,

the fear and self-criticism that a physician may experience when facing an angry family intent on pursuing litigation.

A focus in the training of health care mediators is to coach parties to express concerns or show understanding without inadvertently escalating the interaction. When an apology is required from a health care professional for incorrect action, we train mediators to coach health care professionals to take responsibility and express an apology. Mediators also learn to coach patients and families to challenge authority figures in a safe and structured way. Through role-play exchanges, mediators practice assisting parties to express distressing thoughts and feelings in a controlled fashion, without escalating conflict. Mediators also promote shared decision-making, facilitate constructive feedback between health care personnel, use shuttle diplomacy where necessary, and provide a safe caucusing environment for managing high-intensity emotional expressions. Health care mediators can also be very effective in resolving patient concerns about coordination of care problems.

In this training, health care mediators are prepared to follow a specific narrative protocol when bringing together patients, their families, and health care professionals after an adverse outcome when serious breakdown in communication has occurred. The protocol has four stages.

**Stage 1— Separate Meetings.** Stage 1 involves separate meetings that are conducted first with the patient and family members and then with the health care professionals. Individual meetings create an opportunity for careful preparation of the parties. The goals of these separate meetings are to hear the individuals' stories using externalizing language to talk about the adverse outcome, and to ask how each person was affected by it. The meetings can also canvas preferred outcomes in going forward. As the mediator listens to the patient's problem-saturated story, she should bear in mind some process goals. The mediator thoroughly explores the effects of the adverse events on the patient and family members involved. Hints or examples of any positive interactions between the patient and the health care representatives can be tracked and built upon in the joint mediation session. The focus of the separate session is to help prepare the patient and family members to develop questions to be asked of the health care representatives at the joint session. For example, she might ask the patient, "What do you need to know from the medical team about the situation?"

When the same meeting is held with health care personnel ahead of a joint session, the process is largely similar, with only minor differences. Careful listening, externalizing and communication of understanding are necessary. Mapping the effects of the situation will probably require less emphasis on the personal domain (although that still might apply) and

more emphasis placed on the domain of systems and professional service delivery. The mediator may have information to pass on from the patient meeting. More time will be spent on assisting the health care worker to formulate answers that will adequately address the concerns. Another task is to decide who should be present at the upcoming joint meeting and what role each participant should play.

Deciding who should attend the joint meeting to represent the hospital involves a consideration of the seriousness of the event and its likely impact on the hospital service involved. It also involves taking care to select someone whose presence will convey sufficient concern and regret, and someone who can accurately answer the clinical and administrative questions. Generally, the personal or attending physician can take the lead, but this person must be able to respond empathically and non-defensively.

**Stage 2 – Joint Meetings.** When it is determined that the parties are in a position to hear one another and show respect in the joint meeting, the mediator moves to Stage 2 in a joint session. Here the scene is set for the parties to build mutual understanding and perhaps agree on a specific course of action. Ground rules are established, and hopes for the mediation are identified. The mediator invites the parties to give an overview of their concerns and develops an externalizing conversation about these concerns. The conversation is particularly focused on identifying what is at the heart of the matter for the participants. The mediator then maps the effects of unfulfilled hopes and externalized problems on the patient, the family members, and each of the other parties. The health care professional may apologize for any miscommunication or take responsibility for any incorrect or harmful medical procedures carried out. He may also provide the patient or family with further information about any medical procedure that was previously misunderstood. As the session moves toward completion, the mediator summarizes understandings reached and outcomes agreed upon. Sometimes further separate and multiparty meetings are scheduled to ensure that agreed-upon milestones have been reached or proposals to make amends for some error have been realized.

**Stage 3 & Stage 4.** At Stage 3, health care mediators follow up with patients and families and with health care personnel to address ongoing concerns. Where appropriate, in a Stage 4 process, health care mediators work with senior management to explore possible changes to the way the hospital operates. The focus might be on the health care communication system, or some other malfunctioning element of health care delivery that may have contributed to the adverse outcomes in the first place. A mediator can help the hospital leaders to gain a better understanding of what is taking place in their organization.

We train health care mediators and ombuds to raise concerns about dominant cultural practices that are contributing to error, independent of the formal investigations conducted by the hospital's risk, quality, and member services departments.

Although health care mediators support senior medical personnel in addressing dominant practices that contribute to harm, they do not participate in formal root cause analyses of problems, in order to protect their role as evenhanded agents for patients, families, and health care personnel. Narrative mediation training supports health care mediators (both as internal and as external practitioners) to advocate for fair processes for patients, and providers. The training helps mediators engage with the organization in ways to improve physician and nurse interactions with patients and their families.

### **Conclusion**

Disclosure and apology following a medical error or adverse event is a new concept and practice for many health care professionals. Doctors expect only to heal, alleviate pain, utilize best practice, and deliver a perfect or near-perfect outcome. Sometimes health care professionals try so hard to live up to the idealized image of the healer that they stop being the healer, and instead distance themselves from the patients and families they treat, contributing to a breakdown of trust. Changing the health care culture requires staying in close contact with patients and families when harm is done. Only in this way can trust be rebuilt. Patients and families should speak up more and health care providers need to listen, respond, and connect in a sensitive and empathetic, heartfelt manner. Fortunately for future patients and families, there is a new cadre of health care providers emerging in the discipline who are being trained to do the right thing when things go wrong. Narrative mediation has a place in helping in this transformation by promoting transparency, apology, and disclosure that will enhance the delivery of respectful health care, even in the face of adverse outcomes or medical error.



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