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COMMENTS

HEALING ANGRY WOUNDS: THE ROLES OF APOLOGY AND MEDIATION IN DISPUTES BETWEEN PHYSICIANS AND PATIENTS

I. INTRODUCTION

This country is in the midst of what has been identified as a medical malpractice "crisis."[1] A similar "crisis" was recognized over a decade ago.[2] In both eras, rates for medical liability insurance soared,[3] frequency and severity of claims reportedly increased,[4] and damage awards spiralled.[5] Decreased availability of malpractice insurance coverage,[6] and its increased cost, threatened availability of physician services in certain specialties and geographic areas.[7]

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1. *See generally* SPECIAL TASK FORCE ON PROF. LIAB. AND INS., AM. MEDICAL ASS'N, PROFESSIONAL LIABILITY IN THE '80S, REPORTS 1, 2 & 3 (1984-85) [hereinafter AMA REPORT].

2. *See generally* U.S. DEP'T. HEALTH, EDUC., & WELFARE, REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE & APPENDIX (1973) [hereinafter HEW REPORT].

3. Medical malpractice insurance premiums increased by up to 500% in some states during the 1970's. *See* P. DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY 97-117 (1985). *See also* Kendall & Haldi, *The Medical Malpractice Insurance Market*, HEW REPORT 494 (1973); the 1980's have witnessed additional 20-40% increases in premiums. Posner, *Trends in Medical Malpractice Insurance, 1970-1985* 49 LAW & CONTEMP. PROBS. 38, 48-49 (Spring 1986). (This volume has been reprinted as a symposium: MEDICAL MALPRACTICE: CAN THE PRIVATE SECTOR FIND RELIEF? (R. Bovbjerg & C. Havighurst eds.)).

4. AMA REPORT, *supra* note 1, at 5. *See also* Danzon, *The Frequency and Severity of Medical Malpractice Claims: New Evidence*, 49 LAW & CONTEMP. PROBS. 57, 58 (Spring 1986).

5. Hirsch, *Malpractice Crisis of the '80's*, 13 LEGAL ASPECTS OF MED. PRAC. 5 (Oct. 1985).

6. Posner, *supra* note 3, at 51.

7. Zuckerman, Koller, & Bovbjerg, *Information on Malpractice: A Review of Empirical Research on Major Policy Issues*, 49 LAW & CONTEMP. PROBS. 85, 109-110 (Spring 1986).

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State legislatures have responded to the "crisis" with a variety of tort reforms.[8] Shortening statutes of limitation, mandating pre-trial screening or arbitration, placing ceilings on damage awards, modifying evidentiary requirements, and creating patient compensation funds are but some of the means enacted to address the problem.[9] These measures have been only marginally successful in abating the symptoms of the "crisis."[10] Proposed reforms include adopting a no-fault system[11] and accepting contractual limits to liability.[12]

Blame for the "crisis" is placed on "one or another of the key players in the malpractice system: the physicians, the juries, the court system as a whole, the plaintiffs' attorneys, or the broader cultural expectations about medical care within the United States."[13] Medical technology, consumer unhappiness with medical care in general, and the litigious nature of society have also been implicated.[14]

None of these proposed causes address the root of the problem: patients and their physicians have disputes, and they often use the court system as their battleground. This comment will examine the differing perspectives that create a ripe environment for these conflicts. The acceleration of these conflicts into disputes and lawsuits will be explored. The roles of apology and reconciliation, as means to prevent these lawsuits, will be discussed. Finally, opportunities for change will be addressed.

II. The Patient's Perspective—Illness

People seek out physicians when they are "ill." They may be suffering from a "disease," which is the "physical manifestation of sickness, as well as the official medical interpretation and labeling of sickness,"[15] better known as the medical diagnosis. People come to a physician, how-

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8. Robinson, *The Medical Malpractice Crisis of the 1970's: A Retrospective*, 49 Law & Contemp. Probs. 5, 18-26 (Spring 1986).

9. *See* Qual, *A Survey of Medical Malpractice Tort Reform*, 12 Wm. Mitchell L. Rev. 417 (1986).

10. Danzon, *supra* note 4, at 78-79. *See also* Law, *A Consumer Perspective on Medical Malpractice*, 49 Law & Contemp. Probs. 305, 315-320 (Spring 1986); Robinson, *supra* note 8, at 27-30.

11. *See generally* Tancredi, *Designing a No-Fault Alternative*, 49 Law & Contemp. Probs. 277 (Spring 1986).

12. *See generally* Ginsburg, Kahn, Thornhill & Gambardella, *Contractual Revisions to Medical Malpractice Liability*, 49 Law & Contemp. Probs. 253 (Spring 1986).

13. Posner, *supra* note 3, at 37.

14. Robinson, *supra* note 8, at 11-18.

15. Press, *The Predisposition to File Claims: The Patient's Perspective*, 12 Law, Med. & Health Care 53, 55 (April, 1984).

ever, with an "illness." "Illness" is a broader concept than disease and includes the "behavioral, emotional, and expressive components of sickness."[16] "Often the elements of illness far out-number the perceived symptoms of disease."[17]

A person's "illness" is a product of his culture.[18] Sensation and perception of symptoms are affected by a person's age, gender, race, ethnic background, geographic location, and prior experiences.[19] All human beings develop a repertoire of "explanatory models" that enable them to understand and attack the unpredictable and threatening. In the case of sickness, these explanatory models consist of explanations for "what the patient has, why he is afflicted and why at this time, and what the treatment should be."[20] These explanatory models are derived from archaic biomedical beliefs, contemporary mass fads, individual family traditions, ethnic and religious customs, and "common sense."[21] Explanatory models affect the decision to seek medical care, interaction and expectations during care, and compliance with the medical regimen afterward. "[They] are logical and meaningful to the patient, and . . . form a significant part of the cultural baggage which all patients bring to the clinical setting."[22]

In addition to culture, a person's "illness" is determined by the societal and private roles he fills.[23] These roles are threatened by sickness.[24] Sickness curtails the maintenance or resumption of obligations, identities, and rewards. Self image suffers.[25] These threats to roles are an important factor in "illness."

Thus, a person comes to a physician with a unique and personalized "illness," determined by his culture, societal roles, explanatory models,

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16. *Id.*
17. *Id.* at 57.
18. *Id.* at 55-56.
19. *Id.* at 56.
20. *Id.*
21. Press, *Problems in the Definition and Classification of Medical Systems*, 14B Soc. Sci. & Med. 45, 48-50 (Feb. 1980).
22. Press, *supra* note 15, at 56-57.
23. *Id.* at 57.
24. This alteration in roles has been described as affecting the sick person's environment.

> A disease is an alteration in a person for the worse, and, while it lasts, he is physically and emotionally mal-adapted to his environment. Further, disease creates a problem, not only for the man himself, but also for other people. Only in very exceptional circumstances is he ill in splendid isolation. Far more often someone else must do his work. Someone else may have to continue theirs, and at the same time look after him. His illness may lead to anxiety in his family. It may be infectious. It may be serious. He may be dying. . . . In short a sick man influences his environment profoundly.

A. Clark-Kennedy, Man, Medicine, and Morality 130 (1969).

25. Press, *supra* note 15, at 57.

as well as specific bodily complaints. Illness is a human condition which affects every aspect of a person's life. A sick person has concerns far beyond questions about his specific "disease." A sick person wants to know why he is sick, how he and his family will manage complex treatments, how much discomfort will be involved in the treatment, when, and if, he can return to a normal lifestyle, and how he will pay for treatment. There may be additional worries about events that are missed and obligations left unfulfilled as a result of the sickness.

Most illnesses resolve themselves or are self-treated with over-the-counter medications, home remedies, dietary shifts, old prescription drugs, or a "wait-it-out" approach.[26] The precise mechanism that causes people to seek medical care is not known. The decision to seek treatment, however, is not based on the disease alone.[27] Once the decision is made, the individual exchanges his "status of person for that of patient."[28]

Illness mobilizes "self-estrangement," because patients experience a loss of control over their bodies and minds.[29]

> Suddenly, [patients] are more in touch with unaccustomed feelings of fright, dependence, neediness, precariousness, and insecurity—feelings that they generally either have kept under control or have disregarded, except in instances of identifiable external danger.
>
> Patients bring this sense of self estrangement to doctors' offices on their first visit. In addition, they bring to their appointment other feelings that have not been given the attention they deserve. Even before their initial meeting, patients have formed an intense bond with the doctor, engendered by a positive transference-readiness that is rooted in infancy, re-evoked by illness, and fed by hopeful expectations that the doctor will not only relieve their physical suffering but also assist them in being more fully in charge of themselves once again.[30]

Patients, and the public in general, maintain an image of physicians that includes a "myth of medical perfection." [31] The patient's very life may depend on the physician.[32] In addition, the patient has no where else to turn, since biomedicine has a virtual monopoly on health care.[33] High technology and "medical miracles" make the idea of error intolerable.[34] Television programming presents an image of the selfless, warm, sensitive

26. *Id.* at 56.
27. Zola, *Studying the Decision to See a Doctor*, 8 ADVANCES IN PSYCHOSOMATIC MEDICINE 216, 219-220 (Z. Lipowski ed., 1972).
28. J. KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT 209 (1984).
29. *Id.*
30. *Id.*
31. Press, *supra* note 15, at 55.
32. *Id.*; J. KATZ, *supra* note 28, at 213.
33. Press, *supra* note 15, at 55.
34. *Id.* (quoting B. MARKS, THE SUING OF AMERICA 21 (1981)).

and perfect physician.[35] Lastly, as will be discussed later, the medical profession also perpetuates this notion of medical infallibility.[36]

This "deification" of physicians is helpful to the extent that it increases patient trust. The physician-patient relationship is predicated on trust, and lack of trust can result in poor outcomes.[37] To the extent, however, that this deification leads to unreasonably high expectations on the part of the patient, it constitutes a pitfall for physicians.[38]

When a patient seeks the services of a physician he enters the health care system. The system itself, especially if the patient is hospitalized, often proves dehumanizing and anxiety provoking. The patient enters an unfamiliar environment, his routine is upset, and he further loses control. The patient must interact with a large number of health care personnel and is subjected to often poorly understood and sometimes painful procedures.[39]

A patient comes to a physician with an illness, which he perceives through a unique filter of culture, background and explanatory models. His well-being and self esteem are threatened by his illness. He expects the physician to "make it *all* better," with the "all" including much more than his physical complaints. Entry into the health care system, however,

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35. Press, *supra* note 15, at 55.

36. J. KATZ, *supra* note 28, at 198-199; *see also infra* notes 46-52 and accompanying text.

37. Sommers, *Malpractice Risk and Patient Relations*, 20 J. FAM. PRAC. 299 (March 1985).

38. Press, *supra* note 15, at 55.

39. A dramatic description of this phenomenon is:

> Just when the miseries and anxieties of serious illness make a person need most the comfort and reassurance that familiar surroundings can provide, he is abruptly deposited, like Alice falling down the rabbit hole, into an entirely foreign place, peopled by a citizenry who rush about in strange (but uncolorful) costumes, muttering a language that is only sometimes familiar, . . . who make it perfectly clear that he is expected to conform to their apparently arbitrary customs without benefit of any explanation. . . . The patient's loss of his familiar surroundings is rapidly followed by the loss of most of those personal belongings that symbolize his identity—clothes, jewelry. . . . In exchange he acquires . . . a plastic identification bracelet. . . . His privacy and his ability to exert some control over what he does and what is done to him have been sacrificed. . . . His room is constantly invaded by total strangers who . . . poke and probe, insert assorted substances into his body via assorted routes and extract assorted other substances via assorted other routes, and determine his waking and eating habits and most other details of a life that is no longer his own. His senses are subjected to abrasive noises, harsh light, and unpleasant odors, all of which he is powerless to banish.

L. LANDER, DEFECTIVE MEDICINE—RISK, ANGER, AND THE MALPRACTICE CRISIS 19-20 (1978).

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brings further assaults to his identity and self-control. The patient may be left anxious, fearful, and dependent.

III. The Physician's Perspective—Disease

"While the patient presents with illness, clinical medicine looks exclusively for disease."[40] The practice of medicine requires the gathering of information about symptoms, labeling or diagnosing the disease, and prescribing treatments to ameliorate the symptoms or remove the disease. "The [medical] practitioner, looking from his professional vantage point, preserves his detachment by seeing the patient as a case to which he applies the general rules and categories learned during his protracted professional training."[41] The modern physician has been described as an "expertly trained mercenary" who "wages battle" against an "invasion of microbes or some other alien elements."[42]

The physician's view of his role often becomes narrow in focus. "[P]hysicians . . . are so completely preoccupied with the complex liturgy of molecular biology, biochemistry and pathophysiology that they tend to look upon the patient as a curious vessel for the containment of interesting pathology."[43] The modern physician uses a cadre of diagnostic procedures, laboratory and X-ray machines, pharmacological agents, and surgical techniques.[44] The reality remains, however, that medicine is less "scientific" than many people believe. Not all diseases can be diagnosed easily and mistakes are inevitable, even with the utmost care. This possibility of imperfection raises fear in physicians.[45]

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40. Press, *supra* note 15, at 56.

41. Freidson, *Dilemmas in the Doctor/Patient Relationship*, in A Sociology of Medical Practice 285, 286 (1975).

42. L. Lander, *supra* note 39, at 89.

43. Moser, *Psychosemantics (On Speaking to Patients)*, in Diseases of Medical Progress: A Study of Iatrogenic Disease 809, 809-10 (3d ed. 1969).

44. *See generally* L. Lander, *supra* note 39, at 34-56 (discussing the "tools" of modern medical practice).

45. This lack of scientific precision and the resulting fear has been described.

> Clinical diagnosis . . . obeys the law of diminishing returns. By taking reasonable care a doctor can spot, say, 75 per cent of cases of some potentially dangerous disease among patients coming to consult him; and another 20 per cent by being scrupulously careful. The remaining 5 percent, it must be admitted, are often not recognized at a first visit. Occasional mistakes are in fact inevitable. . . . In most cases [the doctor] can rely on his often quick assessment of a mental or physical state, based on what his patient tells him and what he finds on examining him, as a reasonable basis for action. Many conditions are obvious at sight. Or anyhow not much thinking is required. And, of course, until recently, even in a difficult case, this was all a doctor had to go on. But now, as

The physician's emphasis on the "scientific" is, in part, a mechanism to deal with this fear. Physicians must learn to cope with uncertainty as they practice their profession.[46] This uncertainty stems from feelings of personal inadequacy at mastering the "vastness of medicine" and from the fact that there are limitations in current medical science.[47] Through the socialization process of medical school, the medical student:

> adopts a *manner* of certitude, for he has come to realize that it may be important for him to "act like a savant" even when he does not actually feel sure. From his instructors and patients alike a student learns this lesson: that if he is to meet his clinical responsibilities, he cannot allow himself to doubt as openly or to the same extent that he did during his preclinical. Instead, he must commit himself to some of the tentative judgments he makes, and more decisively on behalf of his patients. . . . The . . . student learns from his instructors that too great a display of unsureness on his part may elicit criticism; from his patients he learns that it may evoke alarm.[48]

Specialization in medical practice further contributes to the "flight from uncertainty" because it "tends to narrow diagnostic vision and to foster beliefs in the superior effectiveness of treatments prescribed by one's own specialty."[49]

Physicians' attitudes of certainty, in spite of their internal fears, serve several functions. Physicians may be "powerful therapeutic agents" in their own right, and their unwavering confidence in their ability may act as a placebo to their patients.[50] "Deep in patients' unconscious, physicians are viewed as miracle workers, patterned after the fantasied, all-caring parents of infancy. Medicine, after all, was born in magic and religion, and the doctor-priest-magician-parent unity that persists in patients' unconscious cannot be broken."[51]

In addition, "[p]rofessing certainty serves purposes of maintaining professional power and control over the medical decision-making process

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> the result of the application of the techniques of scientific research to clinical problems, it is usually possible to confirm, extend or disprove a clinical diagnosis by X-rays, blood tests, biopsies, microscopic examination, chemical analyses, electrical recordings and other methods, collectively known as investigations, or exclude some fear haunting the back of a doctor's mind. For doctors suffer from fear.

A. CLARK-KENNEDY, *supra* note 24, at 162-63.

46. Fox, *Training for Uncertainty*, in A SOCIOLOGY OF MEDICAL PRACTICE, *supra* note 41, at 87.

47. *Id.* at 88.

48. *Id.* at 103.

49. J. KATZ, *supra* note 28, at 188.

50. *Id.* at 192.

51. *Id.*

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as well as maintaining an aura of infallibility."[52] Fear that patients will resort to quacks and economic concerns about the cost of more honest dialogue between patient and physician are two additional reasons cited for maintaining the mask of certainty.[53]

In addition to the status conferred on physicians by patients through the transference of infancy-dependency feelings triggered by illness, physicians enjoy a latent status as a result of their prestige in the lay community.[54] This "latent status has no necessary relationship to his technical qualification to be an expert, but obviously impinges upon his relation to his patients. Indeed, latent status seems crucial for sustaining the force of manifest or professional status."[55]

Physicians' expert knowledge of the science of medicine, their air of certitude, their latent status in the community, and the parental roles in which patients cast them combine to confer authority. This authority is imposed on the public as the profession maintains "control over [its] practices through exclusive licensure laws . . . and freedom from lay control."[56] This same authority enters the examining room when the physician encounters a patient.

> The doctor . . . expects his prospective clients to be "well informed citizens" in so far as the decision to seek medical aid is concerned. . . . However, this role prescription for the "proto-patient" contrasts with an opposite role prescription for patient behaviour, where the patient is expected to defer to the opinion of the doctor.[57]

The top two complaints, voiced by physicians about patients, are that patients too often consult them for trivial conditions, and that after the consultation, patients don't follow orders.[58] Patients and the public not only confer authority on physicians, but physicians come to expect it.

This press for authority is not necessarily motivated by a desire for raw power. Physicians, with their expert knowledge, altruistically believe that they are in the best position to make decisions regarding medical care.[59] In addition, they may wish to protect patients from the burden of making complex choices.[60] This altruism translates into an expectation

52. *Id.* at 198.
53. *Id.* at 199-200.
54. Freidson, *supra* note 41, at 294.
55. *Id.*
56. J. KATZ, *supra* note 28, at 29.
57. Bloor & Horobin, *Conflict and Conflict Resolution in Doctor/Patient Interactions*, in A SOCIOLOGY OF MEDICAL PRACTICE, 271, 277 (1975).
58. *Id.* at 276.
59. J. KATZ, *supra* note 28, at 88.
60. *Id.* at 91.

that patients trust the physician, since the physician is doing his best for the patient.[61]

The foregoing discussion of physicians' culture, focus, motivations, and coping mechanisms is not complete without reference to the time constraints and pressures the physician brings to any patient encounter. Physicians are not only professionals, the majority of them are entrepreneurs.[62] In addition to dispensing medical care, they must deal with the management of a business and attend to billing, insurance forms and employee relations. They must also interact with and coordinate the activities of other medical specialists and a host of health care workers.[63] They must be available for emergencies. They must remain current with burgeoning medical literature and become proficient with new technology. The popular image of the "harried doctor" is far too often real.

One final element of the physician's perspective is a generalized fear and mistrust of patients, fueled by the "malpractice crisis." In the back of the physician's mind lurks the worry that the patient may be a potential adversary.[64] This concern may color the physician's approach to the patient on both interpersonal and professional levels. "Defensive medicine," defined as practices that would not have occurred in the absence of a malpractice threat, takes the form of excessive diagnostic laboratory tests and X-rays, unnecessary hospitalization, and refusal to undertake procedures or treat patients whom the physician believes pose a risk of suit.[65]

IV. Fertile Ground For Conflict—The Clash Of Perspectives

There is a built-in opportunity for conflict, and resulting anger, in every physician-patient relationship. "Differences in orientation mean that a false consensus prevails between the doctor and the patient."[66] This clash of perspectives may be inherent in any professional-lay person encounter.[67] The professional approaches a problem from a different van-

61. *Id.* at 89.
62. L. Lander, *supra* note 39, at 68.
63. *Id.* at 63.
64. *Id.* at 141.
65. P. Danzon, *supra* note 3, at 146.
66. Fabrega, *The Need for an Ethnomedical Science*, 189 Science 969, 973 (Sept. 19, 1975).
67. The inherent differences in professional and lay perspectives have been the subject of discussion.

> The client, being personally involved in what happens, feels obliged to try to judge and control what is happening to him. Since he does not have the same perspective as the practitioner, he must judge what is being done to him from other than a professional point of view. While both professional worker and client are theoretically in accord with the end of their relationship—solving the client's problems—the means by which this solution is to be accomplished and the definitions of the problem itself are sources of potential difference.

Freidson, *supra* note 41, at 286-87.

tage point than the client. These differences in approach and problem definition may lead to conflict.

The patient consults a physician expecting relief from the human suffering of illness, while the physician stands ready to offer a scientific approach to the cure of disease. The biomedical model assumes that "disease reflects disordered biological mechanisms that can ultimately be described in terms of chemistry and physics and that are independent of social behavior or intrapsychic processes."[68] The patient's subjective experience of illness, including his anxieties and explanatory models, may be overlooked or ignored.[69] The patient feels "psychologically abandoned," and is disappointed when his physician doesn't "deliver on the promise of total care-taking."[70]

The nature of medical practice requires the physician to classify patient symptoms into a limited number of categories, reducing patients to members of a class.[71] What is unusual and anxiety-provoking to a patient is often ordinary and routine to the physician.[72] The risks of medical treatment are expressed in percentages by medical practitioners, while frequency of maloccurences are of little assurance to patients. "Even if failure occurs once in ten thousand cases, the question for the patient is whether or not he is who is to be that one case."[73] Thus, while sickness presents a personalized threat to a patient, the physician approaches it as "business as usual." Patients can experience their physician's lack of alarm, commensurate to their own fear, as a lack of caring.

The clash of physician's and patient's culture and education culminate in patient's expectations not being met.[74] Patients' explanatory models lead them to anticipate a particular reason for their illness with a resulting expected approach to it by the doctor. "Instead of prescribing what seems to the patient to be a good sensible remedy like . . . penicillin, the physician suggests that the patient go on a dietary regimen or simply take aspirin. . . . The patient's culture leads him to expect what the doctor's culture does not suggest."[75] The patient may be disappointed in the result of treatment and lose faith in the physician.[76]

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68. L. LANDER, *supra* note 39, at 79.
69. Press, *supra* note 15, at 57.
70. J. KATZ, *supra* note 28, at 226.
71. Freidson, *supra* note 41, at 287.
72. *Id.*
73. *Id.* at 289.
74. *Id.* at 291.
75. *Id.*
76. There is a connection between patient disappointment and the malpractice crisis.

The objectives of health and cure that supposedly unite physician and patient in a common pursuit can rarely be fully realized. Further-

Lack of effective communication often plagues the physician-patient relationship.[77] Society grants physicians authority based on the assumption that "only physicians, with their specialized training, know medicine. . . . The patient, however, knows nothing."[78] Physicians may not provide information to patients, since patients do not have the knowledge to evaluate it properly. Patients may be intimidated and unable to articulate questions. "Information-providing often occurs only as part of the mandated informed consent. As such, it is usually one-way, with the [physician] selecting the agenda."[79] Lack of communication may make "patients feel disregarded, ignored, patronized, and dismissed. . . . Without a sharing of . . . vital information, physicians and patients become estranged from one another; recommendations become orders and advice becomes command."[80]

The patient's lack of information, his dependence on and deification of the physician, combined with the physician's expert and professional status contribute to an imbalance of power. "[P]atients' childlike wishes and needs to be relieved of all responsibility for their care" collide with "their adult wishes and needs to be informed, heard, and consulted."[81] Physicians tend to respond more to patients' childlike needs "engendered by suffering and fear" and disregard "the fact that patients are adults as well."[82] Physicians are reluctant to involve patients in "the process of thinking about choices and of making final decisions jointly."[83] "The result for the patient can be confusion and resentment. . . . [H]e must relinquish control over his own sickness and medical management."[84] "[P]atients resent physicians' lack of trust of their capacities to participate

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> more, these objectives can be pursued in a variety of ways, each with its own risks and benefits. The physician's personal and professional ethics and experience may dictate one course; the patient's needs, wishes, priorities, motivations, and expectations may indicate another one. Thus, health turns out to be an ambiguous state about which doctors and patients may have conflicting expectations. Physicians, in not appreciating that fact and not clarifying differences in expectations, have contributed to patients' disappointments about outcome and, in turn, to the "malpractice crisis" spawned by such disappointments.

J. KATZ, *supra* note 28, at 98.

77. *See generally* J. KATZ, *supra* note 28.

78. Press, *supra* note 15, at 57.

79. *Id.*

80. J. KATZ, *supra* note 28, at 210, 212.

81. *Id.* at 207. The conflict between the childlike and adult needs of patients are not limited to lay persons. Physicians experience the same internal conflicts when they become patients. *See* Freidson, *supra* note 41, at 293.

82. J. KATZ, *supra* note 28, at 209.

83. *Id.* at 208.

84. Press, *supra* note 15, at 58.

in the decisions that are so crucial, so personally important, to patients' future well-being."[85]

These potential conflicts—divergent approaches, expectations and values, and an imbalance of power—undermine a positive physician-patient relationship, and increase the malpractice risk.[86] "The less trust a patient has in the physician, the more liability becomes a factor."[87] Patient feelings of abandonment, confusion, resentment and suspicion may be predisposing factors that "condition the patient to expect negative events or to search for them."[88]

If patients' recoveries from illnesses are uneventful and complete, these feelings may be disregarded.[89] If, however, the "outcome or the treatment process itself . . . does not agree with patients' fantasied or realistic expectations, they . . . become more aware of [these] feelings."[90] "[Questions] become pressing when the [illness] assumes what seems to be serious proportions," such as "when the diagnosis seems implausible, when the prescription seems intolerable and unnecessary, and when cure is slow or imperceptible."[91]

V. Conflict Becomes Dispute—It's Off To Court We Go

Conflicts between physicians and patients may ultimately lead to charges of medical malpractice. "If understanding between physician and patient is not commensurate with the necessary diagnostic and therapeutic activities, there is a strong possibility of a failure of treatment, collapse of the relationship, or both. If both occur at about the same time, chances for a lawsuit are high."[92] While a medical injury or unhappy outcome is a prerequisite for filing suit, "injury by itself does not translate into the intense hostility that a lawsuit expresses." [93]

> [T]he injury, the objective sign that something went wrong, is not sufficient. . . . That objective sign must be joined with the subjective state of being angry. . . . What distinguishes the injuries that do not become malpractice claims from the injuries that do, and what even colors the patient's perception of what constitutes an injury, is the subjective element of patient anger; without anger, an act as hostile as a lawsuit, particularly against as well-established an authority figure as a physician,

85. J. Katz, *supra* note 28, at 212.
86. Sommers, *supra* note 37, at 299.
87. *Id.* at 299-300.
88. Press, *supra* note 15, at 55.
89. J. Katz, *supra* note 28, at 212.
90. *Id.*
91. Freidson, *supra* note 41, at 290.
92. D. Louisell & H. Williams, Medical Malpractice 137 (1960).
93. L. Lander, *supra* note 39, at 4.

> is impossible to contemplate. Thus, while for legal purposes medical malpractice represents the intersection of patient injury and physician negligence, for social purposes a malpractice claim represents the intersection of patient injury and patient anger.[94]

Thus, patient injury is the precipitating factor that motivates patients to seek a malpractice claim, but anger and other factors predispose patients to bring suit.[95] Incidents are transformed into lawsuits through a social-emotional process.[96]

Patients, as lay persons, are rarely in a position to determine, unaided, whether a particular injury is the result of their physicians' breaching a medical standard.[97] Patients can assess the physicians' efforts, the effective dimensions of the physician-patient relationship, and the degree to which the physicians' role performance corresponds to expectations. Studies have shown that these are the factors patients use in evaluating medical care.[98] To patients, how a physician "treats" them on an interpersonal level is often more important than the medical treatment received.[99] One study found that physicians' failure in communicating dianoses and affronts to patients' values were significantly related to a patient's decision to consult a lawyer about a medical incident.[100] Patients also examine how the physician treated their family, when weighing the decision to sue.[101] Physician indifference to family members during their time of stress can be a deciding factor.[102] "The patient's personal relationship with the physician is a major determinant of whether the patient will sue the physician."[103]

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94. *Id.* at 4, 6-7.

95. Press, *supra* note 15, at 54.

96. Felstiner, Abel, & Sarat, *The Emergence and Transformation of Disputes: Naming, Blaming and Claiming. . .*, 15 LAW & SOC'Y REV. 631 (1980-81).

97. R. KLEIN, COMPLAINTS AGAINST DOCTORS 50 (1973).

98. Press, *supra* note 15, at 54.

99. R. KLEIN, *supra* note 97, at 44.

100. M. MAY & L. DEMARCO, PATIENTS AND DOCTORS DISPUTING: PATIENTS' COMPLAINTS AND WHAT THEY DO ABOUT THEM 24 (1986) [published by the Institute for Legal Studies as DISPUTE PROCESSING RESEARCH PROGRAM—WORKING PAPERS SERIES 7].

101. Press, *supra* note 15, at 54.

102. *Id.*

103. E. RICHARDS & K. RATHBUN, MEDICAL RISK MANAGEMENT—PREVENTIVE LEGAL STRATEGIES FOR HEALTH CARE PROVIDERS 294 (1983). These authors go on to say:

> Well-liked physicians are seldom sued, irrespective of their professional competence. In most cases, patients will sue physicians they like only if they suffer a major injury that is clearly due to negligent treatment. On the other hand, competent physicians with poor "bedside" manners may be sued over minor mishaps that a better-liked physician would not be

A physician's response to an untoward medical outcome can further accelerate patients' reactions. For example,

> The doctor who *wants* to get in trouble after an incident of actual malpractice can do so easily. All he has to do is avoid the patient, blame the patient for the bad result, refuse to talk to the family, refuse to apologize, refuse to listen in humility to patient castigation, and then to send his bill as usual. The doctor who wants to guarantee a breakdown in the relationship does not have to do *all* of the foregoing, just a few will suffice. The doctor who does not want to be sued will avoid these traps and will face the patient with humble sympathy and courage for the truth.[104]

Patients pursue malpractice claims out of anger. They often have strong "get-even, or revenge" motives.[105] This anger, and desire for compensation for physical *and* emotional "hurts," propel patients to an attorney's office.[106] Lawyers further transform physician-patient disputes into lawsuits by focusing on the precipitating injury, rather than the underlying emotions and needs.[107] The elements of a negligence claim become the focus as the attorney prepares for litigation. If the lawyer is successful, the patient will receive monetary damages, either in the form of a settlement or a court judgement.

The litigation process does not resolve the "hurts" however. Patients do not necessarily "want to sue for money. What they really want [is] a chance to be alone in the room with the defendant doctor for about fifteen minutes."[108] The anger that brought the patient to court in the first place

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> sued for. . . . As long as the patients feel physically better, the well-liked and disliked physician are in the same position. When the patient does not physically improve, that patient's state of mind becomes much more important in determining whether or not to sue the physician.

Id.

104. R. Blum, The Management of the Doctor-Patient Relationship 253 (1960) (emphasis in original).

105. L. Lander, *supra* note 39, at 7.

106. The nexus between patient anger and a malpractice suit stems from a rejection of the passive patient role.

> If the doctor fails to fulfill the patient's expectations of his role—if he treats the patient's sickness not as a human condition but as an isolated entity—then the patient in his anger feels free to violate the proscriptions of the patient role. If being passive and submissive, as a 'good patient' is expected to be, has brought a person grief, then he may look for a way to right this wrong that is active and aggressive; bringing a lawsuit, whatever its drawbacks, is at least that.

Id. at 14.

107. *See generally* Menkel-Meadow, *The Transformation of Disputes by Lawyers: What the Dispute Paradigm Does and Does Not Tell Us*, 1985 Mo. J. Disp. Res. 25, 31.

108. E. Bernzweig, *The Revenge Factor in Litigation*, in Medical Malpractice: A Center Occasional Paper 4 (D. McDonald, ed., 1971) (published by The Center for the Study of Democratic Institutions).

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may be mollified, but it doesn't disappear. This unresolved anger continues to affect the patient, his family and acquaintances, his physician, and society as a whole.

A malpractice suit can be devastating for a physician.[109] A physician views a malpractice suit as an extreme form of criticism, which exposes vulnerabilities.[110] Professional existence is threatened and financial security may be endangered. Despite the fact that the majority of malpractice suits are settled before trial, and of those that go to trial, the vast majority are decided in the physician's favor, the individual physician confronted with a malpractice suit experiences hurt, resentment, and emotional trauma.[111] These emotional injuries "will be left to fester, ultimately to poison the atmosphere of all the doctor's encounters with patients."[112] A vicious cycle of mistrust and defensive medicine is set into motion.

As a dispute resolution process, the malpractice litigation system fails to address the emotional injuries of patients and inflicts emotional injuries on physicians. It also fails to accomplish other objectives. Deterrence of physician incompetence, a basic function of malpractice law, is not accomplished because not all patients sue or are able to sue. Insurance coverage insulates physicians from personal liability, and physician discipline mechanisms do not necessarily coordinate with the tort system.[113] As a method of compensating injured patients, malpractice law "fail[s] miserably":[114] few injured patients ever bring claims; the costs of litigation and malpractice insurance are high when compared to compensation paid; awards allegedly correspond poorly with the extent of actual injury; and compensation is often long-delayed.[115] The system's reliance on traditional medical standards of practice may perpetuate inappropriate or inefficient treatment and inhibit alternatives.[116]

These shortcomings of the malpractice litigation system flow from the confines of tort law in general. Courts are limited in the types of relief they can offer. Damages in civil suits are sometimes substitutes for alternative forms of relief, such as an apology, which courts cannot grant.[117]

109. *See generally* AMA Report, *supra* note 1, at 20.
110. L. Lander, *supra* note 39, at 132.
111. *Id.*
112. *Id.* at 133.
113. Law, *supra* note 10, at 310-11.
114. Bovbjerg, *Medical Malpractice on Trial: Quality of Care is the Important Standard*, 49 Law & Contemp. Probs. 321, 326 (Spring 1986).
115. *Id.* at 326-28.
116. Havighurst, *Altering the Applicable Standard of Care*, 49 Law & Contemp. Probs. 265, 266-67 (Spring 1986).
117. Abel, *Critique of American Tort Law*, 8 Brit. J. of L. & Soc'y 199 (1981).

VI. Apology—A Practical, But Non-Legal, Remedy

"Apology is a social lubricant used every day in ongoing human relationships. People constantly utter words of apology . . . to seek indulgence for a minor social breach, to ask for permission to violate conventional rules, or to express sympathetic regret for a mishap."[118] Apology is also offered after "one person does substantial physical, economic, social, or psychic harm to another" and "serves the crucial function of repairing relationships after injury."[119] "[A]pology is an important ingredient in resolving conflict."[120]

While apology is a common occurrence in everyday life, it has not been incorporated into American legal doctrines.[121] American law is based on an "assumption of individual autonomy and choice, which implies that individuals' interests are to be viewed in isolation and often in competition with those of others. . . . [The] role of law is to deal with the tensions and troubles that are a dominant feature of relations among people."[122]

Apology can have an impact in preventing litigation.[123] "[C]omments made by trial lawyers experienced in medical malpractice suits [suggest] that a physician's failure to express sympathy and concern for the patient or the family promptly after an adverse operation or treatment significantly increases the likelihood of litigation."[124] One attorney made an empiric observation that patients never file malpractice cases if "the doctor said he was sorry or made an effort to show concern for the feelings of the patient and the family."[125]

A sincere apology serves three functions. First it expresses the subjective state of mind of the apologizer—remorse and non-hostility.[126] Sec-

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118. Wagatsuma & Rosett, *The Implications of Apology: Law and Culture in Japan and the United States*, 20 Law & Soc'y Rev. 461 (1986).

119. *Id.* at 462.

120. *Id.* at 493.

121. *Id.*

122. *Id.* at 495. The authors further describe the emphasis in American law.

> [I]ndividualistic values—most notably compensation, declaration of right, punishment, professional self-interest, and administrative convenience—have been elevated at the expense of the restorative capacity of law and social ceremony. The American lawsuit is designed to deal with claims of economic loss; indeed, its lawyer-dominated, adversarial structure is not suited to resolve other kinds of issues. The legal system tends to reduce disputes to the type it is comfortable handling. Claims for personal injury are treated as if the issue is how to put a dollar price on pain and suffering.

Id. at 494.

123. Haley, *Comment: The Implications of Apology*, 20 Law & Soc'y Rev. 499, 504 (1986).

124. *Id.*

125. *Id.* at 504-5.

126. Wagatsuma & Rosett, *supra* note 118, at 469.

ond, it indicates an intent to compensate the injured party.[127] Third, if the apology is accepted and "responded to by at least the beginnings of forgiveness," the injured person's hostility toward the wrongdoer is ameliorated.[128] This sets the stage for a peaceful resumption of relations.[129]

The American legal system is "weakest in dealing with ongoing relations and strongest in dealing with isolated transactions."[130] This tendency to break everything into separate transactions, in part, explains why the importance of apology is downplayed in our legal tradition. In addition, since a major component of apology is a subjective state of mind, we shy away from reliance on this social custom as a foundation for our legal structure.[131] Under common law tradition, a sincere apology is treated as an admission of liability, unless it is uttered in the narrow confines of a settlement conference.[132] This is a strong deterrent to tendering an apology.

By failing to acknowledge apology, the American legal system misses an opportunity to fully remedy some types of disputes.

> The important point here is that while there are some injuries that cannot be repaired just by saying you are sorry, there are others that can *only* be repaired by an apology. Such injuries are the very ones that most trouble American law. They include defamation, insult, degradation, loss of status, and the emotional distress and dislocation that accompany conflict. To the extent that a place may be found for apology in the resolution of such conflicts, American law would be enriched and better able to deal with the heart of what brought the controversy to public attention. It would also be relieved of some of the pressure to convert all damages into dollars—a pressure that produces absurdly large punitive damages judgments when a trier of fact sympathetically identifies with the claim of degradation and emotional distress but the economic loss is fictive. More to the point, society at large might be better off and better able to advance social peace if the law, instead of discouraging apologies in such situations by treating them as admissions of liability, encouraged people to apologize to those they have wronged and to compensate them for their losses. Lawsuits may never be filed in such situations.[133]

VII. Implications For Change

The legal system and proposals for medical malpractice reform have focused almost exclusively on technical medical errors and adjustments

127. *Id.*
128. *Id.* at 477.
129. *Id.*
130. *Id.* at 478.
131. *Id.* at 469.
132. *Id.* at 479.
133. *Id.* at 487-88.

in the tort system to limit access or control compensation. An additional approach is needed that addresses the contribution of anger in patient-physician relationships to the malpractice crisis. While there is much that physicians, and patients, can do to prevent inherent tensions from accelerating to open hostility, the malpractice system and the legal profession can also shoulder part of the task of resolving disputes in a productive manner.

Physicians certainly do not hold a monopoly as the only professionals that have a narrow focus and fail to address clients in a holistic fashion.[134] Lawyers, just like physicians, can be guilty of failing to communicate openly with clients and of excluding them from decision making processes.[135] When the angry patient brings his dispute to the lawyer's office, the underlying emotions and values are often ignored. An adversarial stance and rules of law are stressed.[136] Defense attorneys take much the same approach, as evidenced by the following excerpt advising physicians about malpractice suits: "Your attorney is your modern-day knight, your champion. He must fight your battle for you in court. He will decide strategy, tactics, and means to destroy the plaintiff's claims."[137] The "trained mercenary" label previously applied to physicians seems equally applicable to attorneys.[138]

Both plaintiffs' and defendants' attorneys counsel their clients to refrain from all direct contact with the other party, opposing counsel, and officers of the court.[139] In their zeal to protect their clients and prepare for litigation, attorneys forestall any opportunities for apologies and reconciliation. Even in settlement conferences, the emphasis is on what the probable result would be at trial.[140] Alternatives to litigation or lawsuit-based settlements are overlooked.

As previously discussed, the legal system also discourages apologies by labelling them as admissions of liability in most cases.[141] The purpose of a malpractice suit is to assign fault and determine damages, not to foster reconciliation in relationships or decrease hostilities. While proceeding through the process, the physician and patient may become further polarized and angrier.[142]

134. *See generally* Menkel-Meadow, *supra* note 107.

135. D. Rosenthal, Lawyer and Client: Who's in Charge 18-20 (1977).

136. *See generally* Riskin, *Mediation and Lawyers*, 43 Ohio St. L. J. 29, 43-48 (1982) (discussion of the "lawyer's standard philosophical map").

137. W. Alton, Malpractice: A Trial Lawyer's Advice for Physicians (How to Avoid, How to Win) 143 (1977).

138. *See supra* note 42 and accompanying text.

139. W. Alton, *supra* note 137, at 125-34, 218.

140. *Id.* at 161-65; *see also* Menkel-Meadow, *supra* note 107, at 32.

141. *See supra* note 132 and accompanying text.

142. J. Folberg & A. Taylor, Mediation: A Comprehensive Guide to Resolving Conflicts Without Litigation 10 (1984).

Current alternatives to litigation, such as arbitration and pre-trial screening mechanisms, have not proven widely successful.[143] In addition, these alternatives are based on a litigation-like model and do not offer opportunities for reconciliation of the parties. What is needed is an adjunct to the current malpractice system that can help the parties to diffuse their anger and repair their relationship.

> [I]t might be possible to lay down a specific obligation on both complainants and doctors to go through a conciliatory stage. . . .
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> . . . .
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> [T]he conciliation would be carried out by an official who can be seen to be neutral as between patient and doctor. . . . [T]he emphasis will have to be put not, as in the past, on the freedom of the two parties to end their relationship but on the need to mend matters when there is a dispute.[144]

Essentially, what is called for is a system of mediation. Mediation is defined as a "process by which the participants, together with the assistance of a neutral person or persons, systematically isolate disputed issues in order to develop options, consider alternatives, and reach a consensual settlement that will accommodate their needs."[145] Bringing the patient and physician together to mediate their dispute opens the doors for different, and perhaps better solutions to their problems.

> Mediation tends to diffuse hostilities by promoting cooperation through a structured process. . . . The adversarial process, with its dependence upon attorneys on behalf of the clients, tends to deny the parties the opportunity of taking control of their own situation and increases their dependence on outside authority. The self-esteem and sense of competence derived from the mediation process are important by-products that help to provide self-direction and lessen the need for participants to continue fighting.[146]

Mediation also offers the benefit of saving time and money if the dispute can be resolved without litigation.[147] Even if all aspects of a physician-patient dispute are not resolved, mediation offers the possibility of helping the participants to understand the underlying conflict and reduce it to a manageable level.[148] For instance, certain parts of the potential

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143. *See* Henders, *Agreements Changing the Forum for Resolving Malpractice Claims*, 49 LAW & CONTEMP. PROBS. 243 (Spring 1986).

144. R. KLEIN, *supra* note 97, at 143-45.

145. J. FOLBERG & A. TAYLOR, *supra* note 142, at 7.

146. *Id.* at 10-11.

147. *See* Pearson, *An Evaluation of Alternatives to Court Adjudication*, 7 JUST. SYS. J. 420, 435-37 (1982) (discussing time and cost savings of divorce mediation and court annexed mandatory mediation projects).

148. J. FOLBERG & A. TAYLOR, *supra* note 142, at 8.

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lawsuit could be settled, while others, such as the amount of damages, could be identified and resolved through court action.[149]

Apology is also possible through the process of mediation. Since rules of evidence and remedial restrictions do not apply in mediation, it is a perfect forum for including apologetic behavior.[150] This could further help reduce anger and hostility between the parties.

Mediation, however, would not be a panacea. If it is to be used, mechanisms to insure confidentiality must be developed. Open discourse would be inhibited if statements made during mediation sessions could later be used as admissions in court. Mediation would have to be structured to overcome the imbalance of power between the physician and patient, and to eliminate the possibility of insincere apologies given in an attempt to manipulate compensation.[151] The qualifications of mediators and their ability to remain neutral and ensure fairness need to be explored.[152]

The potential avenues for establishing mediation programs are numerous. Attorneys could suggest and facilitate private mediation. Existing dispute resolution centers could expand their services to include physician-patient disputes. Health care institutions, medical organizations, and the bar could develop programs. Government agencies and the courts could offer ombudsmen-mediator services. Medical consumer groups and insurance companies could assist in implementing procedures.

VIII. Conclusion

Given the recurrent nature of the medical malpractice crisis, the time has come to examine the underlying conflicts that lead to patient-physician disputes, and the way the legal system attempts to handle these disputes. The current system of court adjudication puts a band-aid of dollars on festering wounds of anger and hostility. While compensation is an essential ingredient in the malpractice arena, attention must also be directed to the repair of relationships and the diffusion of animosity.

Adapting mediation techniques to physician-patient disputes represents a return to the basic values of personal autonomy and self-determination that are the foundation of our legal system and society. Bringing physicians and patients together to work out their own difficulties, where possible, can increase accountability and awareness and improve future relationships. The legal profession has an obligation to address societal

149. E. Richards & K. Rathbun, *supra* note 103, at 294.

150. J. Folberg & A. Taylor, *supra* note 118, at 496.

151. Wagatsuma & Rosett, *supra* note 118, at 496.

152. *See generally* Riskin, *Toward New Standards for the Neutral Lawyer in Mediation*, 26 Ariz. L. Rev. 329 (1984).

problems, such as the medical malpractice crisis, by adopting new approaches designed to meet needs. In addition, since lawyers share many of the attributes and shortcomings of professional practice that plague physicians, solving the medical malpractice crisis may ward off a similar "crisis" for attorneys.

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