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## MEDIATION WITHIN THE HEALTH CARE INDUSTRY: HURDLES AND OPPORTUNITIES

Marc R. Lebed & John J. McCauley\*

### INTRODUCTION

The health care industry is, by nature, prone to conflict. Moreover, as medicine has become more complex, developed more new technologies, and—with an increasingly aging population—faced more daunting challenges of resource distribution, the number and variety of disputes in the industry has risen at an alarming rate.<sup>1</sup> One might think that the health care industry would follow the national trend and adopt mediation as a significant vehicle for resolving disputes, but it has not.<sup>2</sup> Instead, the health care industry litigates its disputes either in arbitration or in court.<sup>3</sup> Attempts to introduce mediation as an alternative to litigation have been met with resistance and skepticism.<sup>4</sup> The question is: “Why?”

It is not that litigation actually meets the needs of health care providers. That mode, adversarial by its nature, imperils two things that physicians highly value: their ability to maintain control over the manner in which they practice, and their ability to maintain good relationships with colleagues and patients.<sup>5</sup> For this reason, it is a special mystery that there is a high comfort level with the current

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1. See generally Kenneth DeVille, *Medical Malpractice in Twentieth Century United States: The Interaction of Technology, Law and Culture*, 14 INT’L J. TECH. ASSESSMENT HEALTH CARE 197 (1998) (concluding that “widespread medical malpractice suits are the result of a combination of short-term topical causes and long-term cultural preconditions.”). *Id.* at 197.

2. Rob Robson & Ginny Morrison, *The Final ADR Frontier: Conflict Resolution in Health Care*, ACRESOLUTION, Spring 2003, at 20, 20-21.

3. See generally Thomas B. Metzloff, *The Unrealized Potential of Malpractice Arbitration*, 31 WAKE FOREST L. REV. 203 (1996) (explaining that litigation is predominant).

4. See David M. Joseph, *The Role of Health Care ADR in Reducing Legal Fees*, PHYSICIAN EXECUTIVE, Nov. 1995, at 26, 28 (discussing physician resistance to mediation of disputes with patients).

5. David M. Studdert, et al., *Medical Malpractice*, 350 NEW ENG. J. MED. 283 (2004).

system, and that the best escape from litigation—alternative dispute resolution (ADR), including mediation—has, to date, been poorly received in the field of medicine.<sup>6</sup>

Although many articles and texts on the topic of mediation and resolution of health care disputes have begun to appear in the medical, legal, and ADR literature, only one, to our knowledge, addresses the fundamental issue of identifying the hurdles to health care professionals' willingness to use mediation for such disputes.<sup>7</sup> That welcome contribution is the 2003 article by Rob Robson and Ginny Morrison, *The Final ADR Frontier: Conflict Resolution in Health Care*, which we will examine in Part I of this Article.<sup>8</sup> In Parts II and III, the hurdles identified in Part I will be expanded upon, looking at additional hurdles and focusing on the special case of medical malpractice actions. Finally, in Part IV, this Article will discuss other arenas within the health care field where mediation would be beneficial.

#### I. THE HURDLES IDENTIFIED BY ROBSON AND MORRISON

In their article, Robson and Morrison attribute the health care industry's resistance to mediation to four factors: (1) the existence of "widely divergent 'cultures' and value-systems" between plaintiffs and defendants in the typical health care dispute; (2) the existence, in health care institutions, of "complex adaptive systems"; (3) issues of "widespread inequalities and imbalances of power"; and (4) the lack of education about the availability and benefits of mediation.<sup>9</sup> In short, not enough people know about mediation, and those that do are discouraged by their sense that health care is indeed a special case,

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6. See Metzloff, *supra* note 3, at 204.

7. See, e.g., NANCY NEVELOFF DUBLER & CAROL B. LIEBMAN, *BIOETHICS MEDIATION: A GUIDE TO SHAPING SHARED SOLUTIONS* (2004); LEONARD J. MARCUS, ET AL., *RENEGOTIATING HEALTH CARE: RESOLVING CONFLICT TO BUILD COLLABORATION* (1995); Debra Gerardi, *Using Mediation Techniques to Manage Conflict and Create Healthy Work Environments*, 15 AACN CLINICAL ISSUES 182 (2004); Tim Porter-O'Grady, *Constructing a Conflict Resolution Program for Health Care*, 29 HEALTH CARE MGMT. REV. 278 (2004).

8. Robson & Morrison, *supra* note 2.

9. *Id.*

burdened with a combination of challenges that make its disputes relatively resistant to the power of mediation.

We agree with Robson and Morrison's premise; health care does indeed present an especially challenging case for mediators, for reasons that include the very factors they identify. But we take this insight in the following direction: Those special factors necessitate a special form of mediation. Not just any mediation will do. Further, if there is a need for more education about mediation, the message to be spread is not so much about the existence of mediation, but about its plasticity. Mediation, in short, can be shaped to meet the challenge.

*A. The Existence of "Widely Divergent 'Cultures'"<sup>10</sup>*

We certainly agree that cultural differences between physicians and their patients exist and that these differences are major factors in both the onset and the resolution of conflicts.<sup>11</sup> For this reason, health care conflict mediation, at least for disputes between physicians and their patients, is akin to cross-cultural mediation.<sup>12</sup> It may well be that potential users of mediation are daunted by the recognition that it would take special sophistication to resolve such disputes, and may simply conclude that the field of mediation is not up to the task.

The reality is that mediators with the proper tools can meet this challenge. In fact, the health care industry stands in greater need of such mediators to resolve its disputes than do most industries. In a typical business-to-business dispute, for example, the parties are already "speaking the same language," while in a health care dispute, there is often a significant disconnect in communication between or

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10. *Id.*

11. In fact, in an ongoing, randomized prospective study using modified Hofstede cultural dimensions (power distance, uncertainty avoidance, individualism, and masculinity), along with temporal considerations and contextual levels, we have demonstrated that physicians are markedly disparate to their host population, their patients. Preliminary data from a pilot study of physician/patient cultural differentiation, on file with the authors. For a discussion of the Hofstede cultural dimensions, see Geert Hofstede, *Motivation, Leadership, and Organization: Do American Theories Apply Abroad?*, 9 ORGANIZATIONAL DYNAMICS 42 (1980).

12. Cross-cultural mediation involves conflicts across cultural lines, typically among people from differing backgrounds or nationalities. See generally DAVID W. AUGSBERGER, *CONFLICT MEDIATION ACROSS CULTURES: PATHWAYS AND PATTERNS* (1992).

among the participants.<sup>13</sup> Thus, the very circumstances that may be discouraging the health care industry from using mediation—the inherent difficulty of resolving disputes among culturally diverse parties—is the circumstance that should create the largest demand for mediation.

The rub is that the tools needed are not just generic mediation skills. Medical mediation, more so than most other areas, requires substantive familiarity with the subject matter. To be effective at all, the medical mediator must be learned in medical matters, including medical culture. The medical industry is not generally receptive to mediator generalists, but if the mediator has this substantive familiarity and is otherwise trained in cross-cultural mediation, the health care industry's objective need for his or her services is extraordinarily high, and the likelihood of ultimate acceptance of those services should, therefore, be great.

#### *B. Health Care as a "Complex Adaptive System"*<sup>14</sup>

We also agree with Robson and Morrison that the health care industry represents a "complex adaptive system," which they describe as "one characterized by fluid linkages, flexible rules that are heavily reliant on system history, constant change, a huge volume of data, and multiple feedback loops but limited access to others' information."<sup>15</sup> Recent trends in medicine—including the adoption of patient safety programs to reduce errors, team building, and innovations such as the application of aviation safety models to operating room settings—have intensified the complexity.<sup>16</sup> Potential

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13. See Philip J. Moore, et al., *Medical Malpractice: The Effect of Doctor-Patient Relationships on Medical Patient Perceptions and Malpractice Intentions*, 173 W. J. MED. 244 (2000) (concluding that patients who have negative perceptions of their communication with physicians are more likely to sue in the event of a bad outcome); Zeev V. Neuwirth, *An Essential Understanding of Physician-Patient Communication, Part I*, J. MED. PRACTICE MGMT., July/Aug. 1999, at 14 (exploring communication problems between physicians and patients).

14. Robson & Morrison, *supra* note 2.

15. *Id.*

16. See, e.g. Joanne Fletcher, *AANA Journal Course: Update for Nurse Anesthetists - ERR Watch: Anesthesia Crisis Resource Management From the Nurse Anesthetist's Perspective*, 66 AM. ASSOC. NURSE ANESTHETISTS J. 595 (1998) (explaining that anesthesia crisis resource management (ACRM) techniques were derived from cockpit resource management in the aviation industry); Russell M. Rivers,

consumers of mediation services may look at the complexity of their field and resist mediation out of skepticism that an outsider attempting to mediate could become conversant enough with the subject at hand to be effective in resolving the disputes that arise.

The rational response to this problem, of course, is not to reject mediation, but to reject using the wrong mediator. In the hands of the right person, this complexity can be an aid, not a hindrance, to the mediation process. For those who know how to use it, complexity is the key to innovative integrative solutions. There is, simply put, “more to work with.” Moreover, participants in complex adaptive systems are more often motivated, intelligent, and educated.<sup>17</sup> This observation is generally true and is particularly true in medicine, where educational and training programs are, in many cases, mandated, and tend to be well-received and appreciated.<sup>18</sup> This trait carries with it the prospect that the task of “spreading the news”—meeting the education challenge Robson and Morrison list as the fourth impediment to the use of mediation—should be more easily accomplished than otherwise.<sup>19</sup>

### C. *Issues of “Widespread Inequalities and Imbalances of Power”*<sup>20</sup>

Robson and Morrison identify “widespread inequalities and imbalances of power” as another barrier/challenge to mediation.<sup>21</sup> Power imbalances are common in medical disputes, but that factor

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et al., *Using Aviation Safety Measures to Enhance Patient Outcomes*, AORN JOURNAL, Jan. 2003, at 158 (discussing the adoption of cockpit management methods in health care settings).

17. See Charlene A. Allred, et al., *The Assertive Community Treatment Team as a Complex Dynamic System of Care*, 32 ADMIN. & POL’Y MENTAL HEALTH 211 (2005); William A. Baumgartner & Peter S. Greene, *Developing the Academic Thoracic Surgeon: Teaching Surgery*, 119 J. THORACIC CARDIOVASCULAR SURGERY S22 (2000); Faith Hill & Chris Stephens, *Building Leadership Capacity in Medical Education: Developing the Potential of Course Coordinators*, MED. TCHR., Mar. 2005, at 145; Robert L. Helmreich, *Cockpit Management Attitudes*, HUMAN FACTORS, Oct. 1984, at 583; Daniel Maurino, *Training Needs For Advanced Technology Flight Decks*, ICAO J. (International Civil Aviation Organization, Montreal, Quebec, Canada), May 1991, at 20.

18. See, e.g., Jonathan R. Cohen, *Apology and Organizations: Exploring an Example from Medical Practice*, 27 FORDHAM URB. L.J. 1447 (2000); Catherine E. Dubé, et al., *Communication Skills for Preventive Interventions*, 75 ACAD. MED. S45 (2000); *Continuing Medical Education*, Medical Board of California, at <http://www.medbd.ca.gov/CME.htm> (last visited Feb. 14, 2005).

19. Robson & Morrison, *supra* note 2.

20. *Id.*

21. *Id.*

appears to us to have the least convincing connection to the medical industry's resistance to mediation. Such imbalances are often present in business or employment disputes, where mediation has been widely embraced. This is not surprising since, properly handled, mediation is a process that tends to ameliorate power imbalances, not exacerbate them.

#### *D. The Lack of Education Factor*

Finally, it is undoubtedly true, as represented in Robson and Morrison's article, that many, if not most, health care professionals are uninformed—or worse, misinformed—about mediation.<sup>22</sup> Education is, therefore, critical for acceptance of non-adversarial dispute management. Since an education program can conceivably be implemented, the barrier of ignorance is surmountable, particularly in health care, where a lifetime of continuing education is itself part of the “culture.” Further, we concur with Robson and Morrison that the building of alliances and increased contact within the health care industry is critical to educational programs becoming more prevalent.<sup>23</sup>

## II. ADDITIONAL HURDLES TO MEDIATION WITHIN HEALTH CARE

In addition to those challenges pointed out by Robson and Morrison, there are other unique hurdles to the acceptance of mediation in health care. The health care industry, although famous for its penchant for new technology and clinical care advances, is highly resistant to change in “non-clinical” practices and the acceptance of “outsiders” into the community of caregivers.<sup>24</sup>

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22. *Id.*

23. *Id.* at 21.

24. See Rose Gollop, et al., *Influencing Sceptical Staff to Become Supporters of Service Improvement: A Qualitative Study of Doctors' and Managers' Views*, 13 *QUALITY & SAFETY HEALTH CARE* 108 (2004); Stephen E. Prather & David N. Jones, *Physician Leadership: Influence On Practice-Based Learning and Improvement*, 23 *J. CONTINUING EDUC. HEALTH PROFESSIONS* S63 (2003); Tom Callaly & Dinesh Arya, *Organizational Change Management in Mental Health*, *AUSTRALASIAN PSYCHIATRY*, June 2005, at 120; Harry N. Mazadoorian & Stephen R. Latham, *ADR For Health Care Organizations*, *DISP. RESOL. MAG.*, Fall 2004, at 8, 10.

A great deal of money is expended on health care distribution, and today's hospitals are under extreme pressure from budgetary restrictions.<sup>25</sup> Money for outsourcing to alternative dispute resolution professionals, therefore, is very limited, and hospitals continue to rely on traditional risk management-based conflict management—a traditional approach that has limitations and high costs.<sup>26</sup> In addition, such traditional approaches to conflict do not address the growing complexity within health care organizations, necessitating conflict resolution approaches that take into account the multi-layered interests of the various stakeholders. This growing interactive complexity requires processes that are more compatible with the culture of health care than are generally used within health care institutions, at the present time.<sup>27</sup>

In conflicts with patients, the medical profession has always concentrated its conflict resolution efforts within the established litigation process.<sup>28</sup> Although the process of litigation is a painful one, and physicians' opinions about attorneys are often hostile, physicians are familiar with the system and continue to demonstrate a strong, albeit sometimes unrealistic, sense of security with traditional litigation and the judicial system.<sup>29</sup> Hence, there is a tendency for physicians to rally around and support modifications of the already existing system of litigation (*e.g.*, tort reform).<sup>30</sup> There is also a

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25. W. Richard Scott, *The Old Order Changeth: The Evolving World of Health Care Organizations*, in *ADVANCES IN HEALTH CARE ORGANIZATION THEORY*, 23(36-9); (Stephen S. Mick & Mindy E. Wytenbach, eds., 2003); Richard F. Demers, *Managing Up in Times of Financial Crisis*, 58 *AM. J. HEALTH-SYSTEM PHARMACY* S7 (2001); Donna R. Kemp, *Mental Health Crisis in California*, 18 *J. MENTAL HEALTH ADMIN.* 154 (1991); Arno Kleimenhagen, et al., *How Have Hospitals Faced the Pricing Issues of the 1990's?*, 8 *J. HOSP. MARKETING* 177 (1994); Robert J. Panzer et al., *1995 Fast Track: Cost Reduction and Improvement*, 6 *QUALITY MGMT. HEALTH CARE* 75 (1997); James C. Robinson, *Physician Organization in California: Crisis and Opportunity*, *HEALTH AFFAIRS*, July/Aug. 2001, at 81.

26. See DAVID B. LIPSKY, ET AL., *EMERGING SYSTEMS FOR MANAGING WORKPLACE CONFLICT: LESSONS FROM AMERICAN CORPORATIONS FOR MANAGERS AND DISPUTE RESOLUTION PROFESSIONALS* 75 (2003).

27. See Debra Gerardi, *The Culture of Health Care: How Professional and Organizational Cultures Impact Conflict Management*, 21 *GA. ST. U. L. REV.* 857, 858 (2005).

28. Joseph, *supra* note 4, at 27.

29. Metzloff, *supra* note 3, at 212-13.

30. See, *e.g.*, Joyce Frieden, *Texas Tort Reform Gets Mixed Reviews*, *OB/GYN NEWS*, June 1, 2005; Philip K. Howard, *Yes, It's a Mess – But Here's How To Fix It*, *TIME MAG.*, July 2, 2003, at 62, available at <http://cgood.org/healthcare-reading-cgpubs-opeds-8.html>; Kate Johnson, *Medical Liability*



widespread misunderstanding among health care professionals about litigation, especially the principles of tort law.<sup>31</sup> They tend, as a group, to underestimate the emotional, financial, and reputational damage wrought by litigation, that has been shown to be linked to the practice of defensive medicine and subsequent deteriorated physician-patient relationships.<sup>32</sup> Their own proclivities can bottleneck resolutions desired by others; for example, medical malpractice policies typically allow the insured to decline, with impunity, an offer by the plaintiff that is acceptable to the insurer.

Among physicians, there is also a resistance to relinquishing power to others, thereby losing a sense of autonomy.<sup>33</sup> This has led to frustration and anger, and in our experience, a prevailing attitude that it is up to physicians to handle their own conflicts. The position they take is, "If I can't fix it, it can't be fixed, certainly not by 'outsiders!'" In short, health care professionals, we have found, meet offers to institute dispute resolution programs with one of the following three responses: (1) "This is a great idea, but we don't have those problems"; (2) "We just don't have the resources and personnel"; or (3) "It won't work. If it would work, we would have

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*Reform Urged – Strategies Offered*, OB/GYN NEWS, June 1, 2003; Susan Marshall, *OB/GYN Group Drafting Tort Reform*, MOD. PHYSICIAN, Jul. 11, 2003; Barbara Weiss, *Malpractice: Close-Up On A Crisis*, MED. ECON., Sep. 5, 2003; available at <http://www.medicaleconomics.com/memag/article/articleDetail.jsp?id=111528>; Sharon Worcester, *Doctor Groups Call on Senate to Pass Medical Liability Reform – Cap on Noneconomic Damages*, OB/GYN NEWS, June 1, 2003.

31. See, e.g., Robert Lowes, *How to Win Your Case Before it Reaches Court*, MED. ECON., Apr. 12, 2002 (explaining common misconceptions among physicians regarding depositions).

32. Gerald B. Hickson, et al., *Obstetricians' Prior Malpractice Experience and Patients' Satisfaction with Care*, 272 JAMA 1583 (1994); Robyn S. Shapiro, et al., *A Survey of Sued and Nonsued Physicians and Suing Patients*, 149 ARCHIVES INTERNAL MED. 2190 (1989); Barry Bub, *The Nightmare of Litigation: A Survivor's True Story*, OBG MGMT, Jan. 2005, at 21; Dee McAree, *Jury in Med-Mal Case Returns Much More Than Asked*, THE NAT'L L.J., May 24, 2002; Jennifer Silverman, *Confidential Settlements: New Jersey to Open Physician Malpractice Records to Public*, OB/GYN NEWS, Mar. 15 2004; Barbara Beck, Press Release, *The Project on Medical Liability in Pennsylvania, Two JAMA Studies Indicate Malpractice System May Hurt Americans' Access to Medical Care: Physicians Practice "Defensive Medicine;" Medical Malpractice Reforms Affect the Supply of Doctors* (May 31, 2005), available at <http://mediabilitypa.org/news/index.php?NewsID=13>; Humphrey Taylor, *The Harris Poll #22: Most Doctors Report Fear Of Malpractice Liability Has Harmed Their Ability To Provide Quality Care*, at [http://www.harrisinteractive.com/harris\\_poll/index.asp?PID=300](http://www.harrisinteractive.com/harris_poll/index.asp?PID=300) (May 8, 2002).

33. Barry Silbaugh & Janet Winchester-Silbaugh, *Physician Resiliency? – Physician Executive Leadership*, PHYSICIAN EXECUTIVE, Jul.-Aug. 1998, at 30.

done it.” Or, in the alternative, they recognize the value of the suggested programs, but just never get around to instituting them.<sup>34</sup>

Physicians fear their autonomy is being threatened from many sources, such as hospital administrators, insurance companies, managed care, medical corporations, medical boards, legislative actions, and malpractice carriers.<sup>35</sup> In addition, patients are demanding more collaborative and informed relationships with historically authoritarian physicians.<sup>36</sup>

Through several interviews with hospital administrators, we believe that there is growing relational stress between the growing “corporate-minded” administrations and private medical staff, in which highly positional posturing is becoming more prevalent. However, none of these hurdles appear insurmountable. As long as the right kind of mediators are available, overcoming these challenges should only require greater awareness of their availability and greater familiarity with the processes they use. And that familiarity, in turn, can be fostered by the introduction of educational programs, especially at the medical and nursing school levels.

As is demonstrated in the next section, however, there is a remaining barrier. The good news is that that barrier applies to only a portion of the universe of health care disputes. The bad news is that the portion to which it applies is a prominent one: medical malpractice.

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34. Virginia L. Morrison, J.D., Remarks at the 2005 Georgia State University Law Review Symposium (Feb. 15, 2005).

35. Mohammadreza Hojat, et al., *Physicians' Perceptions of the Changing Health Care System: Comparisons by Gender and Specialties*, 25 J. COMMUNITY HEALTH 455 (2000); Earl R. Washburn, *The Physician Leader as Logotherapist - Physician Executive Leadership - Victor Frankl*, PHYSICIAN EXECUTIVE, Jul.-Aug. 1998, at 34.

36. See Ellen C. Annandale, *The Malpractice Crisis and the Doctor-Patient Relationship*, 11 SOC. HEALTH & ILLNESS 1 (1989); David R. Garr & Frank D. Marsh, *Medical Malpractice and the Primary Care Physician: Lowering the Risks*, 79 S. MED. J. 1280 (1986); Judith A. Hall, *Inaccuracies in Physicians' Perceptions of Their Patients*, 37 MED. CARE 1164 (1999); James C. Mohr, *American Medical Malpractice Litigation in Historical Perspective*, 283 JAMA 1731 (2000); Neuwirth, *supra* note 13; Roy Penchansky & Carol Macnee, *Initiation of Medical Malpractice Suits: A Conceptualization and Test*, 32 MED. CARE 813 (1994).

### III. THE ADDITIONAL BARRIER IMPACTING THE SPECIAL CASE OF MEDICAL MALPRACTICE ACTIONS

A final important barrier applies uniquely to the one type of dispute that we tend to associate most commonly with health care disputes: medical malpractice. That barrier is the physician's statutory obligation to report settlements of disputes involving quality of care issues to state and federal agencies. The need to report settlements often makes consensual resolution appear, from the physician's viewpoint, to be a "bad bet." What is worse, this obligation creates a barrier which, in contrast to the others discussed, is not easy surmountable.

Consider for a moment the present legislative impediments to settlement from the doctor's perspective. If even one penny is paid to a patient disputant as a result of a negotiated settlement arising out of a written claim or notice of allegations of professional negligence, the physician is reported to the National Practitioner Data Bank (NPDB), regardless of whether the physician is to blame, and even if the disputants agree the physician is not to blame.<sup>37</sup> This information, although not openly available to the public, is available to hospitals, state medical boards, medical associations, and insurers.<sup>38</sup> This can directly or indirectly negatively impact physicians' ability to maintain good standing with their malpractice carriers, providers, peers, and patients, and may even jeopardize their hospital staff privileges and medical board status.<sup>39</sup>

If a negotiated amount exceeds the state's reporting limit, then the physician is reported to the state medical board, again regardless of blame or the degree of adverse outcome associated with the claim.<sup>40</sup> This information is considered by the medical board for physician

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37. See Joseph, *supra* note 4; *Healthcare Integrity and Protection Data Bank*, National Practitioner Data Bank, at <http://www.npdb-hipdb.com> (last visited Feb. 14, 2005).

38. See Metzloff, *supra* note 3, at 205; *Access to Information*, National Practitioner Data Bank, at <http://www.npdb-hipdb.com/npdb.html> (last visited Feb. 14, 2005).

39. See Joseph, *supra* note 4; Metzloff, *supra* note 3, at 205.

40. Jeannette Martello, *Trials, Settlements, and Arbitration: The Defendant's Perspective*, CLINICS IN PLASTIC SURGERY, Jan. 1999, at 97, 98. California's reporting limit, for example, is \$29,999. *Id.* at 98.

censuring and disciplinary actions including, but not limited to, licensing restrictions, remedial mandates, and practice restrictions.<sup>41</sup> Such reports made to the state medical board, at least in California, are available to the public for review.<sup>42</sup> This reporting process can have an even greater negative impact than NPDB reporting.

As a result of this potential negative impact, for a broad range of cases, “standing firm” is arguably a tactically sound approach for physicians to take. In polling several nationally-recognized plaintiffs’ law firms, it appears that only about 10% of disputes that patients want to litigate are accepted for filing.<sup>43</sup> Although there appears to be little published data citing the attrition rate of claims, the following represent figures most commonly quoted by insurers and major medical malpractice plaintiff law firms: Approximately 75% of disputes that reach the point of being filed are eventually dismissed by the plaintiffs, often because the expected recovery is not worth the cost to litigate the case to conclusion (especially in states with statutory “caps” on damages in medical malpractice cases).<sup>44</sup> Approximately 15% of cases are resolved through negotiated settlements. Of the approximately 10% that go to trial, about 80% of cases end with the physician defendant prevailing.<sup>45</sup> Overall, “only 1.3% of all claims result in a jury award to the plaintiff.”<sup>46</sup> Thus, very few claims that are accepted by plaintiffs’ attorneys result in financial restitution. Most are either dropped by the plaintiff or the

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41. *Role of the Medical Board in California*, Medical Board of California, at <http://www.medbd.ca.gov/boardrole.htm> (last visited Feb. 14, 2005).

42. *Physician License Information*, Medical Board of California, at <http://www.medbd.ca.gov/licensever.htm> (last visited Feb. 14, 2005).

43. Interview with Barry S. Schifrin, M.D., BPM, Inc., in Los Angeles, Cal. [hereinafter Schifrin Interview] Dr. Schifrin is a maternal-fetal medicine expert and nationally-recognized medical malpractice expert witness and consultant.

44. See *The Medical Malpractice Crisis: Financial Facts*, FACT SHEET: MEDICAL MALPRACTICE REFORM (Aetna, Hartford, CT), Mar. 2003, at 1, available at <http://www.aetna.com/data/MedMalFXSH.pdf> (“More than 70 percent of tens of thousands of lawsuits are found to be without merit, but each requires a costly defense.”) [hereinafter Aetna, FACT SHEET].

45. See Thomas B. Metzloff, *Resolving Malpractice Suits: Imaging the Jury’s Shadow*, 54 LAW & CONTEMP. PROBS. 43, 49-50 (1991) (indicating that a study showed that 13.2% of medical malpractice cases went to trial, with the defendant prevailing in 81.3% of the cases); Metzloff, *supra* note 3, at 206.

46. *Medical Malpractice*, Aetna, at [http://www.aetna.com/public\\_policy\\_issues/medical\\_malpractice.html](http://www.aetna.com/public_policy_issues/medical_malpractice.html) (June 2004) [hereinafter Aetna, *Medical Malpractice*].

plaintiff's attorney, or terminated by court dismissal or summary judgment grants.<sup>47</sup> When considering the low selection percentage and case attrition rate, the physician who refuses to engage in settlement discussions even after a case has been filed has a very high chance of being spared an adverse judgment.<sup>48</sup> Malpractice insurers and defense attorneys recognize and respond to these statistics. Through our discussions with several malpractice carriers active in California, we find they are generally resistant to mediation proceedings, with the exception of eleventh hour distributive bargaining processes, when the likelihood of the physician defendant prevailing is poor. They are particularly resistant to early mediation proceedings that may "breathe life into dead cases," and are concerned that malpractice claims would skyrocket, with the certainty that the doctor will be reported for any settlement dollars paid.<sup>49</sup> The upshot of this is that only about 15% of cases settle in pre-trial negotiations or mediation, and a full 10% get resolved at trial (in our estimate, nearly four times the ordinary rate for other civil cases).<sup>50</sup>

The perverse incentive posed by statutory reporting requirements makes an already bad situation worse. There is already a resistance of health care providers to admit errors, accept responsibility for adverse outcomes, and openly discuss such matters with their patients.<sup>51</sup> Following the 2000 Institute of Medicine report, *To Err is Human*, which claimed that as many as 98,000 patients die in hospitals each year as a result of avoidable errors, patient safety issues have become

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47. See Metzloff, *supra* note 3, at 206.

48. See *id.*

49. See Troyen Brennan, et al., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION (1993); Metzloff, *supra* note 3, at 205-06; Interview with a major professional negligence insurance carrier, under conditions of anonymity (on file with the author).

50. Marc Galanter, *The Vanishing Trial: An Examination of Trials and Related Matters in Federal and State Courts*, 1 J. EMPIRICAL LEGAL STUD. 459 (2005) (explaining that, in 2002, 1.8% of civil matters nationwide were resolved by trial); Metzloff, *supra* note 3, at 206.

51. See Sarwat I. Chaudry, et al., *Detection of Errors by Attending Physicians on a General Medicine Service*, 18 J. GEN. INTERNAL MED. 595 (2003); Richard T. Penson, et al., *Medical Mistakes: A Workshop on Personal Perspectives*, THE ONCOLOGIST, Feb. 2001, at 92, 96 (stating that physicians have a moral obligation to disclose errors to patients and urging better communication between physicians and patients).

appropriately prioritized.<sup>52</sup> However, error reporting by physicians has been less than ideal, primarily as a result of deficiencies the existing reporting systems.<sup>53</sup> With the recent passing of the federal Patient Safety and Quality Improvement Act of 2005, guaranteeing anonymity for error reporting, it is hoped that physicians will be more forthcoming in reporting the errors of themselves and others.<sup>54</sup>

In the current institutional setting, overcoming this attitudinal resistance to settlement will often not be enough. Even if a physician were otherwise prepared to resolve the dispute through facilitated communication or to simply authorize the insurer to proceed to purchase the patient's offered release, that physician would suffer the pain of a generally punitive reporting system. When faced with a choice between resolving a conflict with a non-adversarial process and pursuing litigation and likely prevailing, litigation becomes a matter of professional survival. The impact of being reported is significant to a doctor's ability to practice in a market of highly competitive provider contracts, tightening institutional staff privilege standards, and rapidly escalating malpractice premiums. According to Dr. Barry Schifrin, a nationally-recognized specialist in maternal-fetal medicine and a highly respected expert in the area of medical malpractice, these circumstances give insight into the Winston Churchill-inspired "war metaphor" that is now widely applied within the medical profession.<sup>55</sup> The prevailing attitude is: "We are at war, with the very survival of the practitioner and the specialty at stake; under these circumstances, customary rules of engagement can be temporarily suspended."<sup>56</sup> Until the health care industry establishes reporting reforms and some degree of confidentiality for mediated settlements—along with providing education about the nature and

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52. INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 1 (L.T. Kohn et al. eds., 2000), available at <http://www.nap.edu/books/0309068371/html/>.

53. Chaudry, et al., *supra* note 51; Carole Schneider Houk & Barbara I. Moidel, *Integrated Conflict Management Systems in Health Care: A Practical Innovation Whose Time Has Come*, ACRESOLUTION, Spring 2003, at 30.

54. Patient Safety and Quality Improvement Act of 2005, Pub. L. No. 109-41, 119 Stat. 424 (2005).

55. Schifrin Interview, *supra* note 43.

56. *Id.*

benefits of mediation—the market for mediation in malpractice actions is destined to remain quite limited.

#### IV. OTHER AVAILABLE MARKETS FOR MEDIATION WITHIN HEALTH CARE

Although medical malpractice is, at the present time, a limited arena for mediation, there are other venues within health care that are more readily amenable to the process of mediation. The industry is presently weathering a health care crisis of historic proportions. In 2002, health care distribution costs in the United States exceeded \$1.6 trillion and continue to rise annually.<sup>57</sup> This figure is up from \$762 billion in 1991, and from \$1.4 trillion in 2001.<sup>58</sup> Costs related to medical malpractice liability have increased dramatically, estimated at \$60 to \$108 billion each year.<sup>59</sup> Even though approximately \$50 billion is spent each year on the practice of “defensive medicine,” this represents only a small portion of overall health care costs.<sup>60</sup> Of course, it must be remembered that these costs impact a very small percentage of the American population, individual physicians, and are therefore quite significant. While this additional crisis deserves considerable attention, it is certainly not the only area of “financial illness” in the health care industry. Because malpractice has become such a newsworthy and visible part of the health care crisis, people tend to think of it and its challenges as representative of the entire crisis in health care. The reality is just the contrary: Not all health

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57. Mark Sherman, *Health Care Spending Hits \$1.6 Trillion, Up 9.3 Percent in A Year*, SAN DIEGO UNION-TRIBUNE, Jan. 8, 2004, at <http://www.signonsandiego.com/news/health/20040108-1347-healthcarespending.html>.

58. *Trends and Indicators in the Changing Health Care Marketplace*, Kaiser Family Foundation, at <http://www.kff.org/insurance/7031/print-sec1.cfm> (last updated Feb. 16, 2005).

59. U.S. DEP'T OF HEALTH & HUMAN SERVS., CONFRONTING THE HEALTH CARE CRISIS: IMPROVING HEALTH CARE QUALITY AND LOWERING COSTS BY FIXING OUR MEDICAL LIABILITY SYSTEM 7 (2004); Press Release, Aetna, Statement from Ronald A. Williams, President of Aetna, on Medical Malpractice Reform (Jan. 16, 2003), at [http://www.aetna.com/news/2003/pr\\_20030116.htm](http://www.aetna.com/news/2003/pr_20030116.htm) (citing U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra*).

60. Aetna, *Medical Malpractice*, *supra* note 46. See Aetna, FACT SHEET, *supra* note 44; *Issues and Allegations: Medical Malpractice*, The American Voice 2004, at <http://www.americanvoice2004.org/health/malpractice.html#Anchor-The-47857> (Feb. 26, 2004).

care disputes are malpractice disputes, and the breadth of those non-malpractice disputes is immense.

An overview of a few developing patterns in this \$1.6 trillion industry is more telling than the numbers. According to Blue Shield of California, roughly 90% of that distribution goes to about 10% of their insured patients.<sup>61</sup> Further, a large part of that distribution is for care within the last 30 to 90 days of a patient's life, and much of that money is spent on futile care (that is, care administered without chance of survival).<sup>62</sup> Hence, bioethical conflict management and the specter of rationed care conflicts, which may be looming in the near future, are issues of increasing importance.

Roughly 44 million Americans did not have health insurance as of 2002.<sup>63</sup> An increasing percentage of these people are employed, but cannot afford the cost of health care insurance premiums, which continue to climb with percentages of increase in the double digits.<sup>64</sup> In addition, most employers can no longer pay for all or most of their

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61. Interview with Executive Board of Blue Shield of California, 2003 (on file with the author); see Press Release, The Commonwealth Fund, Consumer-Directed Health Care Plans Not Likely to Lower Health Care Costs, (Aug. 19, 2004), available at [http://www.cmwf.org/newsroom/newsroom\\_show.htm?doc\\_id=235868](http://www.cmwf.org/newsroom/newsroom_show.htm?doc_id=235868) (reporting that "ten percent of individuals account for 69% of health care costs"); see also Eric French & John Bailey Jones, *On the Distribution and Dynamics of Health Care Costs*, 19 J. APPLIED ECONOMETRICS 705 (2004), available at [www.albany.edu/~jbjones/healc32.pdf](http://www.albany.edu/~jbjones/healc32.pdf).

62. Interview with Executive Board of Blue Shield of California, 2003 (on file with the author); see Rachel DuPré Brodie & Patricia E. Powers, California HealthCare Foundation, Improving the Quality of End-of-Life Care for Californians 1 (2002), available at <http://www.chcf.org/documents/chronicdisease/ImprovingQualityEndofLifeCare.pdf> (indicating that end of life care accounts for 10-12% of total health care costs and 27% of Medicare costs); *Expenditures for End of Life Care*, Center for Advance Palliative Care, at <http://64.85.16.230/educate/content/elements/expendituresforeolcare.html> (last updated Feb. 20, 2002) (also indicating that end of life care accounts for 10-12% of total health care costs and 27% of Medicare costs); see also Eric French & John Bailey Jones, *On the Distribution and Dynamics of Health Care Costs*, 19 J. APPLIED ECONOMETRICS 705 (2004), available at <http://www.albany.edu/~jbjones/healc32.pdf>.

63. ROBERT J. MILLS & SHAILESH BHANDARI, U.S. DEP'T OF COMMERCE, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2002 1 (2003) (stating that 43.6 million Americans did not have health insurance coverage in 2002); Vicki Kemper, *Uninsured in U.S. Show the Biggest Increase in a Decade*, L.A. TIMES, Sept. 30, 2003, at A-1 (citing MILLS & BHANDARI, *supra*).

64. MILLS & BHANDARI, *supra* note 63, at 4; Kemper, *supra* note 63; Larissa Van Beurden & Leslie Stevens, *Employers Forced to Cut Health Benefits*, THE TRIBUNE (San Luis Obispo County, Cal.), Nov. 2, 2003, at A1.



employees' health care costs and are being forced to put more of this burden on the employees themselves.<sup>65</sup>

Medical advances have historically been associated with claims of malpractice, based both on an "outcome learning curve" and on the recognition of previously unknown complications associated with new technologies and medications.<sup>66</sup> As such, the present conflicts and resultant costs associated with litigation, including the protection of research and development companies from potential litigation resulting from unforeseen complications, are not insignificant.<sup>67</sup> At least to some degree, these costs are passed on to the consumer.

Financial stresses and the organizational restructuring of medical institutions and medical staff have created new areas of conflict within hospitals and staff. Among the conflicts is a growing adversarial relationship between attending physician staff and hospital administrators. Moreover, "turf wars" between different specialties remain a major source of conflict.<sup>68</sup>

The Joint Commission on Accreditation of Healthcare Organizations, Congress, the Institute of Medicine, and public pressure together have created an urgent need to address patient safety, through efficient error reporting, system integration conflict resolution, and resolution of conflicts related to institutional or organizational errors.<sup>69</sup> In addition, Lumetra, a non-profit organization designated by the federal government to oversee quality of care for California Medicare recipients, is introducing early

65. Van Beurden & Stevens, *supra* note 64.

66. See Mohr, *supra* note 36, at 1734 (describing how x-ray technology, in the years following its inception, became the most prolific source of malpractice actions).

67. See Michael Freedman, *The Tort Mess*, FORBES, May 13, 2002, at 91, available at <http://www.forbes.com/forbes/2002/0513/090.html>.

68. See, e.g. Harriet P. Lefley, *Psychologists, Psychiatrists, and Psychosis: Will Turf Battles Trump Treatment?*, in NEW DIRECTIONS FOR MENTAL HEALTH SERVICES: THE ROLE OF ORGANIZED PSYCHOLOGY IN TREATMENT OF THE SERIOUSLY MENTALLY ILL 39 (Frederick J. Frese ed., 2001); Abdelrahman A. Nimeri et al., *The Economic Impact of Incorporating Flexible Endoscopy Into a Community General Surgery Practice*, 19 SURGICAL ENDOSCOPY 702 (2005); M.L. Robinson, *Turf Battles Rock Radiology*, HOSPITALS, Nov. 5, 1989, at 46; Mary Wagner, *Ultrasound Evolution*, MOD. HEALTHCARE, Apr. 6, 1992, at 30.

69. See Patient Safety and Quality Improvement Act of 2005, Pub. L. No. 109-41, 119 Stat. 424 (2005); Editorial, *Remedy for Medical Errors*, L.A. TIMES, July 21, 2003, at B10 (discussing Congressional action on a recommendation of the Institute of Medicine calling for an error-reporting system for doctors, nurses, and other medical professionals).

intervention services to address patient satisfaction concerns and unanticipated outcomes, as are many more hospitals including, for example, the National Naval Medical Center in Bethesda, Maryland and Kaiser Permanente facilities.<sup>70</sup>

These patterns alone suggest several areas of growing social need for ADR, other than resolving malpractice lawsuits. One such area of need is medical education programs. Health care providers and medical students need to be educated in communication skills and conflict prevention and management. Another area of social need for ADR is that of intra-institutional conflict management. ADR in this area would consist of mediation, including consensus building mediation, of conflicts within medical institutions pertaining to patient safety, risk management, integrated system management, staff privilege and quality management. Further, disputes arising from the availability of and unanticipated outcomes of new drugs and new technologies would be well-served to explore mediation as an alternative to litigation.

A hierarchal system of review that is founded on remediation and patient safety is the model for a mediation system in the context of medical staff and licensing disputes. This system would include the substitution of the Judicial Review Committee (JRC) with mediation/arbitration for staff privilege disputes. Of note, California already has a binding arbitration alternative to the JRC; however, to date, it is rarely used.<sup>71</sup>

Yet another area in need of some form of ADR is professional associations. ADR in this arena would take the shape of conflict resolution and consensus building between professional associations, such as medical associations and hospital associations, and among the constituents of the associations, in conflicts pertaining to such matters as staff privileges and hospital by-law modifications.

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70. Houk & Moidel, *supra* note 53, at 31; Bob Rosenblatt, *Rx for Angry Medicare Patients: A Chance to Talk*, CAL. HEALTHLINE (Cal. HealthCare Found., Oakland, Cal.), Jan. 19, 2004, at <http://www.californiahealthline.org/index.cfm?Action=dspItem&itemID=102487>; Thomas J. Stipanowich, *CPR Perspectives: Beyond Engalla: Real-Time Resolution for Healthcare Disputes*, International Institute for Conflict Prevention & Resolution, at [http://www.cpradr.org/CPR\\_disp.asp?pg=news/column1101.htm&M=CPR%20Perspectives](http://www.cpradr.org/CPR_disp.asp?pg=news/column1101.htm&M=CPR%20Perspectives).

71. CAL. BUS. & PROF. CODE § 809.2(a) (West 2005).

Two final areas of social need for ADR are bio-ethical and rationed care conflicts. These include conflicts over restricted or rationed care, as well as conflicts over “futile care,” or care for patients who have no chance for survival (especially those who have been comatose for over three months), and quality of care conflicts involving patient satisfaction issues and unanticipated outcomes.

### CONCLUSION

Robson and Morrison have accurately portrayed many challenges to mediation in medical malpractice. However, there are other hurdles contributing to resistance to mediation in health care, especially in medical malpractice disputes. These hurdles include resistance to change, poor acceptance of outsiders, budgetary limitations, a false sense of security with the litigation and court system, resistance to relinquishing power to others, and growing relational stress between administration and private medical staff.

The majority of resistance to mediation in malpractice disputes is associated with the existing punitive reporting system, physicians’ misconceptions regarding the litigation process, the existing statistics for physicians prevailing in the litigation arena, and the recalcitrance of physicians, their insurers, and defense attorneys to stray from the comfort of a system on which they have become dependent. Essentially, even if a physician wished to negotiate a settlement, regardless of whether the care was negligent, he could not afford the consequences it may have on his ability to survive in the field and continue to practice. At the present time, mediation for medical malpractice cases will continue primarily as a tool for eleventh hour distributive bargaining.<sup>72</sup>

However, there are many areas within health care, other than medical malpractice cases, that are ripe for mediation. Although burdened with some unique challenges, they are not faced with the same hurdles as medical malpractice cases. With the present health

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72. Robson & Morrison, *supra* note 2, at 20 (stating that “[m]ediators and arbitrators are all too often viewed as the people who step in at the eleventh hour to settle a nasty labor dispute.”).

care distribution crisis at \$1.6 trillion per year and increasing, the inability to insure the population for health care costs, the specter of rationed care, and the limited availability of new and costly technology, we face many new areas of conflict that must be resolved in a timely, cost effective, and non-adversarial manner.

Health care professionals, although quick to apply new technologies, are admittedly slow to change in their “practice” behavior. However, once accepted, a new methodology is generally embraced widely and becomes a nationwide standard in a short time. Institutional markets, including hospitals, will seek out mediation more frequently when it is demonstrated that the mediation process is cost effective, non-punitive, time conserving, and effective for the resolution, not just the settlement, of health care conflicts.

Although progress will be fraught with challenges and resistance, necessity will be the mother of acceptance. As the health care crisis continues to escalate, mediation is positioned to become the preferred method of conflict resolution and consensus building in major matters.