PEPPERDINE UNIVERSITY

Pepperdine Dispute Resolution Law Journal

Volume 6 | Issue 3 Article 6

4-1-2006

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[Vol. 6: 3, 2006]

PEPPERDINE DISPUTE RESOLUTION LAW JOURNAL

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INTRODUCTION

Mediation facilitates, and often enables, creative problem solving to produce inventive solutions that can benefit both parties in a dispute. The mediator is expected to encourage communication between the parties.[1] "The process of mediation is usually informal, with no rigid or set rules except those agreed to by the parties or requested by the mediator to promote useful communications."[2] Often, a neutral third party mediator is selected by the parties jointly.[3] Although an impartial third party intervenes to create a structured and flexible forum, the parties have much greater control over the outcome in mediation than in arenas, such as litigation, where an authoritative decision-making power decides settlement issues.[4]

Mediation has been described as "assisted negotiation of a dispute settlement" or "an extension of the negotiation process."[5] Thus, good communication between the parties is imperative. However, there are key differences between traditional mediation and typical negotiation, particularly in the health care context.[6] In typical adversarial negotiations

* Sheea Sybblis, J.D., M.B.A. Associate at Stroock & Stroock & Lavan LLP in New York, NY.

1. Monica Rausch, *The Uniform Mediation Act*, 18 OHIO ST. J. ON DISP. RESOL. 603, 608 (2003).

2. Bryan A. Liang & Steven D. Small, *Communicating About Care: Addressing Federal-State Issues in Peer Review and Mediation to Promote Patient Safety*, 3 HOUS. J. HEALTH L. & POL'Y 219, 240 (2003).

3. *Id.*

4. *Id.* at 241.

5. ALT. DISP. RESOL. § 7.1 (2d ed. 2003).

6. Harold I. Abramson, *Problem-Solving Advocacy in Mediations*, 59 DISP. RESOL. J. 56, 57 (Aug.-Oct. 2004). When faced with an adversarial participant in the negotiation option, Abramson

each side generally starts with an extreme position and then makes calibrated concessions.[7] Often, in the end, the parties continue this "negotiation dance" of counteroffers until they are close enough to either split the difference or adopt an offer that is on the table.[8] "Adversarial negotiators frequently view their dispute as primarily a distributive contest over who gets the largest piece of the targeted resource (usually money)."[9] This is not consistent with mediation strategies, which generally seek to empower the parties and create solutions which often can extend beyond monetary gains.[10] Since mediation enhances communication and helps to preserve the relationship between the parties, it is often more appropriate for certain medical malpractice and negligence disputes than litigation.[11]

Mediation strives to alter the parties' adversarial posturing and instead provide an opportunity for both parties to participate in integrative bargaining.[12] Through the mediation process "parties focus on their interests instead of legal positions, overcome impediments and search for multiple options, which they evaluate and package in an imaginative way to satisfy those interests."[13] Rather than emphasize positions, or who is wrong or right, mediation allows parties to work towards a mutually satisfactory solution that meets both parties' needs. It is often referred to as "win-win."[14] As opposed to litigation, mediation does not have a "winner" and a "loser."[15] This process can develop collaborative relationships between the parties and the mediator.[16]

In the health care context, mediation can be more effective than litigation at resolving claims of medical negligence.[17] The advantages of mediating these claims include: relationship preservation, enhanced communication to improve the quality care, cost savings, and increased

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and other commentators have suggested calling a mediator to facilitate discussions. *Id.* Including a trained, neutral third party professional can assist participants to resolve disputes in which they cannot "achieve the benefits of problem solving on their own." *Id.*

7. *Id.* at 57.

8. *Id.*

9. *Id.*

10. *See generally id.* at 61. (discussing the brainstorming and problem-solving process in mediation).

11. *See generally id.* at 59.

12. James W. Reeves, *ADR Relieves Pain Of Health Care Disputes*, 49 DISP. RESOL. J. 14, 17 (Sept. 1994).

13. Abramson, *supra* note 6, at 57.

14. Rita Lowery Gitchell & Andrew Plattner, *Mediation: A Viable Alternative to Litigation for Medical Malpractice Cases*, 2 DEPAUL J. HEALTH CARE L. 421, 423 (1999); Reeves, *supra* note 12, at 17.

15. Reeves, *supra* note 12, at 16.

16. *See generally id.*

17. *See generally* Gitchell & Plattner, *supra* note 14.

efficiency.[18] The collaborative and cooperative nature of the mediation process encourages patients, physicians, and other health care providers to efficiently settle disputes.[19] The solutions that the parties are able to agree upon can include remedies that take monetary and non-monetary considerations into account.[20] The flexibility of the mediation process allows for a wider range of conflict resolution than the traditional litigation process.[21]

Part I of this paper provides a comparison of the use of litigation and mediation in the health care context. Part II explores how mediation can be used to improve many of the often criticized aspects of adjudication systems and alleviate tension between parties in health care disputes. Part III provides an evaluation of current mediation programs and studies in health care, as well as the expanding role of mediators. Part IV incorporates assessments of the potential success of mediation to resolve health care disputes in the future and provides suggestions to strengthen the process.

I. MEDIATION V. LITIGATION IN HEALTH CARE

First, to gain a better understanding of the role of mediation in the health care system, the nature of malpractice and medical error will be discussed. It is estimated that 150,000 deaths and 30,000 serious injuries are caused by physician and hospital negligence in the United States each year.[22] Medical error accounts for up to 98,000 inpatient deaths annually.[23] "Medical error can be defined as a mistake, inadvertent occurrence, or unintended event in health care delivery which may, or may not, result in patient injury."[24] Medical error is not "purposeful or reckless actions that are intended to directly or indirectly harm the patient."[25]

The dynamic, and often fast paced, nature of the health care system includes "high-level technical needs, the need for quick reaction times," long hours, and constant ongoing operations management.[26] Accordingly,

18. *Id.*
19. *See generally* Reeves, *supra* note 12; *see also* Liang & Small, *supra* note 2
20. *See supra* note 14, at 442.
21. *See generally id.* at 425.
22. *To Err Is Human: Building a Safe Health System*, Institute of Medicine, Nov. 1999.
23. *See* Liang & Small, *supra* note 2, at 219.
24. *Id.* at 222.
25. *Id.*
26. *Id.* at 223-24.

"complex systems, such as health care delivery, due to the very characteristics that make them complex, have a high potential for failures and error."[27] One author commented that considering this structure, it is remarkable that "only a small fraction of errors actually lead to adverse events."[28]

To understand the impact of mediation on the health care system, the alternative forum for dispute resolution, litigation, must be examined. Specifically, adjudication of health care disputes and the ramifications of such proceedings must be addressed. The negative aspects of the litigation process include: (1) "the inability of tort litigation to deter physician negligence;" (2) "the detrimental effect on the doctor-patient relationship;" (3) "the high emotional and financial costs to the litigants;" and (4) the procedurally inefficient, cumbersome, and time-consuming process of litigation.[29] Additionally, the current tort-based litigation system for medical malpractice has been found lacking because it does not adequately address the following: (1) compensation for patients that are injured due to negligence; and (2) encouragement of quality improvement.[30]

First, critics have argued that the "tort litigation system neither remedies injured patients nor effectively serves any useful public policy."[31] "[I]t does not encourage patients who have actually suffered injury through medical negligence to bring their claims."[32] For example, less than ten percent of the patients involved in the estimated 180,000 occurrences of negligence actually file malpractice lawsuits.[33] Critics of the current litigation system for medical malpractice contend that injured patients are not adequately compensated.[34] Litigation does not encourage patients who have injuries as a result of medical negligence to bring their malpractice claims. Additionally, litigation under-compensates patients with minor injuries and overcompensates patients with major injuries.[35]

Further, litigation often does not resolve the issue at the root of the dispute. Litigation can continue for years, yet the central points of conflict

27. *Id.* at 223.

28. *Id.* at 224.

29. Scott Forehand, *Helping the Medicine Go Down: How a Spoonful of Mediation Can Alleviate the Problems of Medical Malpractice Litigation*, 14 OHIO ST. J. ON DISP. RESOL. 907, 907 (1999); *see also* Stephen Meili & Tamara Packard, *Alternative Dispute Resolution in a New Health Care System: Will It Work for Everyone?*, 10 OHIO ST. J. ON DISP. RESOL. 23, 26 (1994).

30. Forehand, *supra* note 29, at 908.

31. *Id.* at 907; *see also* Meili & Packard, *supra* note 29, at 26-27.

32. Forehand, *supra* note 29, at 912.

33. *Id.* at 908; *see also* Reeves, *supra* note 12, at 18.

34. Forehand, *supra* note 29, at 912.

35. *Id.*

are not necessarily addressed.[36] Disputes between patients and health care providers often involve trust issues and miscommunication.[37] These issues can lead to recurring disputes and additional malpractice claims.[38]

Many scholars have suggested that alternative dispute resolution ("ADR") solves or at least ameliorates many of the problems with litigation.[39] Specifically, "it costs less money, requires less time, reduces court case loads," actively engages the parties, and supposedly utilizes fewer social resources.[40] As previously stated, the tort-litigation based system is inadequate for dealing with key issue in health care. In the extreme, one practitioner even purported that "the goals of our civil justice system are in[a]pposite to the goals of medicine."[41] Specifically, "litigation has absolutely nothing to do with healing."[42]

The process of litigation can be stressful and emotionally damaging to the participants.[43] The effect that the resolution process has on the relationship between the doctor and the patient is an important consideration. "Litigation virtually destroys this relationship."[44] Due to its adversarial nature, the litigation process tends to accelerate the deterioration of relationships rather than help rebuild them.[45] Mediation encourages cooperation, rather than adversity. "Ultimately, ADR can maintain or even improve an ongoing relationship, such as the relationship between health care consumers and their providers, plan, and alliance. Conversely, litigation tends to polarize the parties and enhance hostilities, and can disrupt ongoing relationships."[46]

Importantly, litigation can actually induce silence.[47] Specifically, the health care provider, who has significant knowledge of direct and indirect factors concerning the adverse event or circumstance at issue, is induced (and even encouraged) to refrain from speaking.[48] Communication between

36. *See generally* Reeves, *supra* note 12, at 16.
37. *See generally id.* at 15.
38. *See id.* at 16.
39. Meili & Packard, *supra* note 29, at 26.
40. *Id.*
41. Eric Galton, *Mediation in Medical Negligence Claims*, 28 CAP. U.L. REV. 321, 321 (2000).
42. *Id.* at 321.
43. *See generally id.*
44. Forehand, *supra* note 29, at 910.
45. *Id.*
46. Meili & Packard, *supra* note 29, at 27.
47. Liang & Small, *supra* note 2, at 221.
48. *Id.*

litigating parties is inhibited and important information may not be readily shared.[49] Thus, the litigation process "does not promote effective communication, information exchange, or learning to improve systems performance in health care delivery."[50] Mediation allows parties to have a more private resolution of their dispute than adjudication.[51] This factor can also assist in generating discourse and maintaining the parties' relationship.[52]

An important goal of dispute resolution systems in health care should be to increase the quality of patient care and decrease negligence. In litigation, issues necessary to improving the quality of the care delivered by providers are not addressed outside of the context of the immediate action.[53] The lack of communication between parties during litigation hinders the exchange of information.[54] Often poor or inadequate communication was involved in the events that caused the adverse event in the first place.[55] Additionally, although "[s]ometimes mistakes or poor results occur even when the utmost care is taken," communication can help alleviate some of the negative tension that arises in these situations.[56] Communication and discussion about error is fundamental to reducing mistakes and avoiding adverse health consequences.

Further, litigation does not effectively deter negligent conduct or improve the quality of care provided by health institutions.[57] The "[f]ear of punishment simply does not promote error elimination nor does it maximize system performance; instead, cooperative, nonpunitive approaches that promote communications about system weaknesses and corrective action strategies are essential for error reduction and mitigation of its occurrence."[58] While an effective balance of these approaches is necessary, discourse and candor must be encouraged to improve the quality of health care. Continuous quality improvement and management strategies require good communication and cooperative behavior between health care providers and patients.[59]

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49. *Id.* at 225.
50. *Id.*
51. *See generally id.* at 244.
52. *Id.*
53. *See generally supra* note 2.
54. *Id.*
55. *See generally* Liang & Small, *supra* note 2, at 240.
56. *See* Reeves, *supra* note 12, at 14.
57. Liang & Small, *supra* note 2, at 225.
58. *Id.*
59. *See generally id.*

Mediation encourages communication, cooperative behavior, and partnership between providers and patients.[60] By opening lines of communication and encouraging cooperative behavior, mediation promotes safe and effective quality health care.[61] This communication can reduce errors that can lead to adverse events in health care settings.[62] Information can be shared between the parties for corrective action.

In mediation, by working collaboratively, the parties try to find mutually acceptable settlement agreements.[63] Generally, the process of mediation does not result in a binding agreement.[64] However, since the parties have come to the agreement by communicating with each other, parties are more likely to comply with the resolution.[65] Even if the parties do decide to litigate, "the process of mediation has already clarified many issues, and has created opportunities for the parties to realize arguments which they could present during litigation."[66] Thus, even when mediation does not end in settlement, the process still enhances efficiency.[67] Therefore, participating in mediation can be cost effective, as well as, administratively economic.

II. THE IMPACT OF MEDIATING HEALTH CARE DISPUTES

The transformative potential of mediation in the health care system will be explored in the following contexts: (1) the communication and interpersonal relationships of the parties; and (2) cost savings and efficiency enhancements.

A. Interpersonal Considerations and Conflict Management

Mediation can maintain doctor-patient relationships in a dispute. "Mediation focuses on the future and future relationships, whereas adjudication focuses backwards by applying the rules of law only to past acts."[68] Mediation is particularly appropriate in the following cases: (1)

60. Liang & Small, *supra* note 2, at 225.
61. *Id.*
62. *Id.*
63. *See generally id.*
64. Gitchell & Plattner, *supra* note 14, at 423.
65. *See generally id.*
66. *Id.*
67. *See generally id.*
68. *Id.* at 425.

where the parties have a continuing relationship to preserve; (2) when the dispute is primarily the result of poor communication between the parties; and (3) when a creative solution is needed, particularly in complex cases.[69] In these instances mediation can facilitate communication between the parties.[70] From this discourse the parties can come to mutually acceptable solutions which are outside the scope of the type of resolution they could extract from a court proceeding.[71]

To be successful, mediation requires some degree of trust between the parties and the mediator.[72] Parties' satisfaction depends on whether or not they perceived the process as being fair, and the amount of control they had in the final decisions.[73] Mediation allows the parties to come to unique, creative, and personalized solutions, which they find mutually acceptable.[74] Since medical malpractice and negligence claims tend to be very personal and often deal with sensitive subject matters, the flexibility and adaptability of mediation enables this process to be an effective vehicle to resolve health care disputes.[75]

Parties are generally more satisfied with a dispute resolution process if they perceive it as being fair.[76] This perception is impacted by how much of an opportunity each party has to express oneself and their ability to control the final outcome.[77] Another reason that mediation may be attractive to parties in health care disputes is that it is normally voluntary.[78] The amount of participation in the actual resolution process can shape the settlement.[79] Parties do not have the same opportunity to participate in the resolution process in malpractice litigation.[80] Typically, most litigation proceedings are delegated to representatives of the parties (i.e., attorneys, insurance

69. ALT. DISP. RESOL. § 7.1, *supra* note 5.

70. *See id.*

71. *See* Gatter, *infra* note 158, at 203.

72. *Id.* Additionally, "mediators can help parties in a treatment dispute to cut through any bureaucratic and professional barriers that create opportunities for miscommunication." *Id.*

73. Forehand, *supra* note 29, at 909.

74. *See generally* NANCY N. DUBLER & CAROL B. LIEBMAN, BIOETHICS MEDIATION: A GUIDE TO SHAPING SHARED SOLUTIONS (2004).

75. *See id.*

76. *See supra* note 29, at 37; *see also* Reeves, *supra* note 12 at 16.

77. Forehand, *supra* note 29, at 909.

78. ALT. DISP. RESOL. § 7.1, *supra* note 3.

79. *See generally* Gitchell & Plattner, *supra* note 14, at 425. "Parties [in mediation] typically find value in the opportunity to participate in settling their disputes in meaningful ways. Unlike trial, they enjoy a greater degree of participation in the issue-identifying and decision-making processes, as well as being able to express themselves to each other, and their attorneys, and the mediator(s) in an informal setting." *Id.*

80. *Id.*

companies).[81] Another advantage to mediation is that the parties are "not bound by the rules of either procedural or substantive law, or by the rules of evidence."[82]

The parties' overall satisfaction depends on more than just the outcome of the dispute, and thus mediation has additional advantages over litigation. "The claimant's interests, monetary and non-monetary, may be adequately addressed, and the health care provider's interests, monetary and non-monetary, can also be protected."[83]

Medical malpractice claims often have a large emotional component which, in part, makes mediation a much more rewarding solution to the parties than litigation.[84] Patients' and their families' subjective experiences of illness can often make it difficult for them to look at a medical situation objectively.[85] Physicians are trained to make objective assessments, and as such their response to patients' needs may be perceived "as a lack of caring."[86] The mediation process allows the doctor to freely discuss why certain treatment options were selected.[87] Physicians often view a malpractice claim as a personal attack.[88] He or she may have feelings of inadequacy or incompetence which are better addressed in mediation.[89] Mediation facilitates communication in this tense situation.

Mediation techniques are also effective in bioethical consultations.[90] The distinctive character of clinical bioethics consultation is that it creates its own process by blending ethical principles and mediation skills into something unique.[91] Specifically, "[b]ioethics mediation combines the clinical substance and perspective of bioethics consultation with the tools of

81. *See id.*

82. Reeves, *supra* note 12, at 17. Both arbitration and litigation require evidence to be formally presented.

83. Gitchell & Plattner, *supra* note 14, at 442.

84. *See id.* at 425.

85. *See* Cooley *infra* note 90.

86. *See* Reeves, *supra* note 12, at 15.

87. *Id.* at 18.

88. *See generally id.*

89. *See generally id.*

90. *See generally* John W. Cooley, *A Dose of ADR for the Health Care Industry*, 57 DISP. RESOL. J. 16 (Apr. 2002). "Bioethical dilemmas are increasingly giving rise to conflicts occurring between and among members of institutional staffs, patients, and family members." *Id.* at 17. Mediation can play an important role in resolving these conflicts.

91. *See* Nancy Neveloff Dubler, *Bioethics: Mediating Conflict in the Hospital Environment*, 59 DISP. RESOL. J. 32, 35 (July 2004).

the mediation process, using the techniques of mediation and dispute resolution."[92]

> The growth of managed care and the shift from fee-for-service medicine (with its incentives for overtreatment) to capitated arrangements (with their incentives for under-treatment) have fueled a growing mistrust among patients and their families, who perceive that the integrity of the care provided may be affected by factors external to the best interests of the patient.[93]

This change "has led to increased tension between doctors and nurses," as well as conflicts with organizational administrators.[94] Additionally, efforts "to improve the profitability of the health care institution by increasing the productivity of health care providers, [and] reducing admissions to hospitals" are prevalent.[95] "As a result of these changes . . . bioethics consultation has taken on a heightened profile."[96] It has been adapted to reflect these changes and the field continues to develop.[97] The starting point in bioethics mediation is having "respect for the patient, the family and the care providers, as well as an impartial stance regarding what should be the outcome in any particular case."[98]

Unfortunately, disputes between heath care providers, subscribers, and plans are common.[99] Often these disputes involve issues of contract interpretation.[100] This includes disagreements over what types of treatments are covered and their classifications.[101] For example, disputes over the term "experimental treatment" and its applicability may be addressed using ADR.[102] Issues of assessing medical necessity and pre-existing conditions can also be addressed using mediation.[103]

Obviously multiple-defendant suits can be more complicated to mediate than single-defendant cases. "When multi-defendant suits arise, the mediation becomes more difficult, not because the conflict between the

92. *Id.*

93. *Id.*

94. *Id.* Mediation also plays a dynamic and evolving role in resolving issues between coworkers and administrators in the health care system. By being able to resolve a dispute between staff members in a shorter period of time the health care organization is able to function more efficiently, maintain good professional working relationships, and focus on patient treatment. *Id.*

95. Dubler, *supra* note 91, at 35.

96. *Id.*

97. *Id.*

98. *Id.* at 36.

99. *See generally* Cooley, *supra* note 90.

100. *Id.*

101. *Id.*

102. *See id.*

103. *See generally* Cooley, *supra* note 90.

claimant and defendants are more intricate, but because the defendants themselves will invariably dispute the guilt of each party and the levels of contribution to the settlement each is responsible for."[104] In these situations it is often necessary to mediate between the defendants as well as with the claimant.[105] The needs of patients and the concerns of health care providers are addressed in this forum. These solutions can lead to cost savings and efficiency optimization as discussed in the following section.

B. Cost Savings and Efficiency

The administrative or transactional costs of litigation are very high. Transaction costs for patients and physicians include attorneys' fees, time, and emotions spent.[106] A large number of small medical malpractice claims, that may be meritorious, are not filed due to the high costs associated with litigation.[107] It has been suggested that mediation can eliminate many of these costs and is therefore a much more efficient process.[108] Since rules of evidence and typical court requirements are not in place, the discovery costs and other associated procedural costs can be reduced.[109] Accordingly, mediation, which is generally less costly, would encourage these parties to bring their claims.[110]

Further, "[t]he high cost and enormous time commitment litigation requires to resolve disputes in the United States has prompted businesses, employers, and individual parties to choose alternative forms of dispute resolution."[111] Health care providers may not be able to "escape the high cost of litigation, either directly, by defending malpractice actions using a percentage of revenues or indirectly, by discouraging new patients from electing to receive care when bitter and protracted litigation imputes a decreased standard of care upon the health care provider."[112] However,

104. Gitchell & Plattner, *supra* note 12, at 446.

105. *See generally* Cooley *supra* note 90, at 16.

106. Forehand, *supra* note 29, at 909.

107. *See* Reeves, *supra* note 12, at 16.

108. *Id.* at 15-16. Reeves' article includes a brief discussion on the different types of "costs" associated with litigation and mediation. *Id.* Parties must consider the transactional costs of litigation, as well as financial and emotional "costs."

109. *Id.* at 17.

110. *See generally id.*

111. Gitchell & Plattner, *supra* note 14, at 421.

112. *Id.* at 442.

mediation can "alleviate the cost of litigation, can protect the reputation of the health care giver, and can keep the matter private."[113]

ADR is better suited to address smaller claims, where consumers could not afford to litigate.

> In the health care context, consumers with smaller claims frequently cannot find an attorney willing to take their case on a contingency fee basis and are unwilling to hire an attorney on an hourly basis when the attorney's total bill is likely to exceed the value of the disputed claim.[114]

Mediation is generally less expensive than litigation.[115] For example, when mediation is used early in the dispute and can effectively resolve the conflict, there is significant cost savings for both parties.[116] The use of negotiation or mediation from infancy will result in the greatest cost savings for health care providers and patients.[117]

For mediation to be successful the parties must want to reach a solution or at least be receptive to communicating to reach a solution.[118] "Unlike trial, they enjoy a greater degree of participation in the issue-identifying and decision-making processes, as well as being able to express themselves to each other, and their attorneys, and the mediator(s) in an informal setting."[119] Because of these distinct features of mediation, parties find value in the process itself, even if the outcome is less favorable than what they would have obtained in court.[120]

Mediation empowers the participants and can be less uncertain than litigation.[121] Parties have more control over the process and can even choose their own mediator.[122] Mediation can also be beneficial for providers who prefer "the finality of settlement over potential for a runaway verdict" and who would like the settlement money spent for the best treatment options for the patient.[123] Creative solutions may include setting up a trust for patient

113. *Id.* at 442-43.

114. Meili & Packard, *supra* note 29, at 28.

115. Reeves, *supra* note 12, at 15-16.

116. *Id.*

117. *Id.* at 17.

118. *Id.* at 16.

119. Gitchell & Plattner, *supra* note 14, at 426.

120. *Id. See also* Reeves, *supra* note 12, at 16 (discussion on satisfaction of outcomes).

121. Gitchell & Plattner, supra note 14, at 426.

122. *See generally* Reeves, *supra* note 12, at 16. Mediation allows people to represent their self-interests in their disputes, so parties should select a mediator with whom they comfortable. Gitchell & Plattner, *supra* note 14, at 426.

123. Gitchell & Plattner, *supra* note 14, at 424.

treatment for a child in a wrongful birth claim.[124] Directing the use of settlement funds, overseeing treatment, and the like are some of the other less traditional options that can be generated using mediation.[125]

C. Obstacles and Misconceptions

A potential obstacle to mediation involves uncertainty concerning confidentiality and privilege in some jurisdictions.[126] "Discrepancies in confidentiality protection from state to state and court to court send confusing and contradictory messages on the extent to which parties can reasonably expect their statements in mediation to remain confidential."[127] These types of discrepancies can cause patients and providers to be reluctant to cooperate, in fear that their comments may be used against them in a later court proceeding. Understandably, "if the parties believe that the mediator or opposing party will disclose or be compelled to disclose statements made in mediation, there will be significant dampening of the communication necessary to promote useful information flow."[128] An important consideration is that

> in the medical error and lawsuit context, a set of documents reporting the error, describing the facts surrounding the error, analyzing the type of patient and circumstances relating to the error, investigating what caused the error, and detailing corrective action plans in response to the error analysis, is clearly relevant to the subject matter of that particular case and thus would seem quite likely to be discoverable.[129]

This would clearly discourage mediating parties from speaking openly.[130] A related concern is whether physicians and hospitals making payments as settlements from mediation should have to report them to the

124. *Id.* at 450.

125. *Id.* at 450-53.

126. *See* Liang & Small, *supra* note 2, at 243. There is the potential for limited protection of error and safety discussions and information under the peer review and quality assurance privilege, however, these privileges are quite varied across jurisdictions since they are subject to state law. *Id.*

127. *Id.* at 243.

128. *Id.* at 240.

129. *Id.* at 228.

130. *See generally* Liang & Small, *supra* note 2. Additionally, the federal Health Care Quality Improvement Act of 1986 (HCQIA) provides for qualified immunity to participants in peer review, but does not include preventing the discovery of peer review materials. *Id.* at 236.

National Practitioner Data Bank.[131] Having to report the mediation settlements may discourage provider participation in the process and would reduce the purported privacy of the mediation process.[132]

Other common misconceptions about the use of mediation to resolve health care negligence and malpractice claims include the following: (1) incompetent providers may remain undetected; (2) patients will not be compensated as well as they are in litigation or may settle meritorious claims prematurely and be disadvantaged; (3) mediation fails or prevents the establishment of needed precedent; and (4) mediation fails to address power imbalances among parties.[133] Many of these concerns focus on the generally private and informal nature of the mediation process.

As previously noted, as opposed to litigation, mediation offers "comparative privacy, informality, and shorter resolution time," which "causes the defendant less 'trauma' than the more drawn out, public litigation process."[134] The enhanced privacy of the mediation process can be advantageous to the parties by facilitating discourse. However, it has been alleged that "[p]rivacy also harms the public at large in other health care disputes, such as those over claim denials."[135] This assertion stems from the fact that plain misbehavior may remain unknown to the public.[136] "One of the most troubling aspects associated with alternative dispute resolution from the consumer's perspective relates to the same privacy that makes it so appealing to providers."[137] Critics have emphasized this point by arguing that "individual consumers may fight the same battles over and over again."[138] For instance, the provider is less likely to lose patients who might otherwise learn of a malpractice suit in the media due to the increased privacy of the mediation process.[139] This makes the health care provider feel more secure.[140]

Notably, a "physician's reputation may be better protected through mediation[,] even if he admits he may have made a mistake in treatment by

131. The National Practitioner Data Bank (NPDB) is a central repository of information on doctors and other healthcare providers. The NPDB contains reports on malpractice payments and other adverse actions. *See generally* http://www.npdb-hipdb.com/npdb.html (last visited Apr. 15, 2006).

132. *See generally id.* Proposals suggest reform so that reported data would not be used against physicians in a court of law or in arbitration. *Id.*

133. Meili & Packard, *supra* note 29, at 26.

134. *See generally id.* at 28.

135. *Id.* at 29.

136. *Id.*

137. *Id.* at 28.

138. *Id.*

139. Meili & Packard, *supra* note 29, at 28.

140. *Id.*

apologizing to the claimant."[141] However, this may mean that "if the provider is incompetent or dangerous, the state medical examiners may not hear of the provider's behavior until after more consumers are harmed."[142] Another problem related to the issue of privacy is that resolving disputes through ADR does not develop the law or establish precedent on which other consumers can rely.[143] "Litigation is desirable when precedent needs to be set or changed."[144]

Additionally, "private dispute resolution makes it difficult for similarly wrongly-treated individuals from acting as a class against the wrongdoer."[145] Another argument is that "[o]ne adverse consequence of de-emphasizing discussion of principle and fault is that some persons may be discouraged from asserting their rights when they have been injured."[146] However, does mediation truly prevent the wider public interest from being represented? Considering the numerous benefits of mediation that were previously articulated, this is doubtful. Communication and cooperation, major focuses of the mediation process, help to further the public interest.[147] Additionally, many of the claimants with smaller meritorious interests would not necessarily litigate their claims due to the high cost of litigation.[148]

Another way that critics argue mediation can work against the public interest involves power imbalances between parties.[149] Some critics feel the mediation process may actually exacerbate social imbalances.[150] For example, feminist legal theorists have suggested that mediation puts women at a disadvantage when they participate in ADR.[151] Further, in "the health care setting, power differentials will often put women at a disadvantage because providers tend to be white, male, and professional."[152] Also, Richard Delgado, critical race theorist, suggests that "the informality of the mediation process leads to the expression of prejudice, which makes ADR

141. Gitchell & Plattner, *supra* note 14, at 443.

142. Meili & Packard, *supra* note 29, at 28.

143. *Id.* at 29.

144. *Id.* at 28.

145. *Id.* at 29

146. Trina Grillo, *The Mediation Alternative: Process Dangers for Women*, 100 YALE L.J. 1545, 1565 (1991).

147. *See generally* Liang & Small, *supra* note 2.

148. *See* Meili & Packard, *supra* note 29, at 28.

149. *See generally* Meili & Packard, *supra* note 29, at 33.

150. *Id.*

151. *Id.* at 32.

152. *Id.* at 33.

less accessible to minorities."[153] However, mediation does not maintain the status quo for the disenfranchised, but rather strives to balance parties and provides alternative solutions.[154] Still, all of these concerns must be taken into consideration when constructing mediation programs. It is important that the mediation process is seen as fair and impartial to all groups. Mediators must be trained to spot and neutralize power imbalances.

III. STUDIES AND MOVEMENTS IN MEDIATION

Mediation is a flexible process that provides parties with the opportunity to speak candidly and find creative solutions.[155] Formalizing the mediation process adds to the perception of legitimacy and may alleviate many of the concerns about the treatment of the disfranchised in the mediation process, but there are possible disadvantages.[156] Strict formality would unduly inhibit this process and may work against efforts to build trust between the parties.[157]

Trust-diminishing mediation practices, which in the short-run may resolve disputes quickly and cheaply, will in the long-run generate more disputes than classical mediation practices. One compelling argument is that "institutional bias in favor of short-run financial savings appears to undermine the long-run effectiveness of these programs."[158] Studies of institutional mediation programs and their impact on the health care system have been performed to examine such factors.[159] The institutionalization of mediation in the health care context will be examined here in terms of long and short term effectiveness.

A. Institutionalization

There are several advantages to the institutionalization of mediation. If properly implemented, institutionally sponsored programs can add legitimacy to the way that mediation is perceived.[160] These programs help educate the masses about the mediation process and alternative ways to

153. *Id.*

154. *Id.* at 30.

155. *Id.*

156. *Id.*

157. *See generally id.*

158. Robert Gatter, *Institutionally Sponsored Mediation and the Emerging Medical Trust Movement in the U.S.*, 23 MED. & L. 201, 210 (2004).

159. *See id.*

160. *See generally* Gatter, *supra* note 158, at 201 (discussing the concept of trust in medical despite disputes between physicians and patients).

resolve disputes.[161] By addressing conflicts between physicians and their patients in mediation, the parties have an opportunity to openly discuss their interests in a structured forum.[162] The sponsoring institution is also in the position to address and revise many of the policy concerns that arise in mediation.[163] Thus, mediation can "promote trust by patients in physicians and health care institutions."[164] However, institutionally sponsored programs can have the stigma of being considered biased towards the sponsoring institution.[165] Therefore, emphasis has to be placed on the need for impartiality in establishing institutionally sponsored mediation programs.

Generally court-sponsored mediation programs are instituted to serve the needs of the court system.[166] There is reason for concern that similarly, "mediation programs sponsored by health care institutions will improperly serve the interests of the sponsoring institution."[167] This perceived financial motivation can hinder the development of trust in mediations between patients and health care institutions.[168] Further, the legitimacy of medical mediation may be undermined and its potential to promote trust in medicine would be reduced.[169]

The way that institutionally sponsored mediation programs are perceived is influenced by the fact that the "programs are, by virtue of their sponsorship, 'inside' the medical establishment. Thus, the dispute resolution programs they offer affect the perceived trustworthiness of the medical establishment to assist in the fair resolution of medical disputes. If patients perceive that mediators are protecting the financial interests of the sponsoring institution," they will not trust the mediation process.[170] Patients will not perceive the process as fair. Additionally, "the emerging medical trust movement establishes that, as trust in medicine decreases, the willingness of patients to enter into disputes with physicians and institutions increases."[171] Further, it has been suggested that in the long-run patients'

161. *See id.*
162. *See id.* at 203.
163. *See generally id.*
164. Gatter, *supra* note 158, at 201.
165. *Id.* at 202.
166. *Id.* at 205
167. *Id.*
168. *Id.* at 206.
169. *Id.*
170. *See id.*
171. Gatter, *supra* note 158, at 206.

diminishing trust is likely to "generate more disputes than classical mediation practices."[172] Specifically,

> in comparison to those who have less trust in medicine, individuals with high degrees of trust in their health care providers are more likely to seek treatment when they need it, to comply with physicians' treatment orders, to feel that treatment improved their health, and to recommend their care providers to others.[173]

Several programs have been introduced in an attempt to institutionalize mediation in the health care context.[174] In a study by Farber and White in the 1990s, patients in hundreds of medical malpractice cases for a hospital had the opportunity to be resolved by a voluntary, informal complaints process.[175] The results of the study indicated that ADR could be very beneficial to parties in these types of cases.[176] Critics note that a major benefit of the Farber and White study was that mediation was used as "a first step in the malpractice dispute process."[177] This increases the efficiency of processing claims and "fleshes out" issues that may be later addressed in another resolution process, such as litigation or arbitration.[178]

Other "examples of institutionally sponsored medical mediation programs exist, including programs at Rush Presbyterian St. Luke's Medical Center, referred to as 'Rush,' at the National Naval Medical Center and at the Colorado Physician Insurance Company, known as 'COPIC'"[179] These programs were "instituted at a time when both the risk of malpractice liability among health care institutions and market pressure for those institutions to control their costs were relatively high."[180] On the assumption

> that mediation can resolve disputes quickly and at lower cost . . . health care institutions might look to mediation as a way of addressing disputes in a manner consistent with their cost containment goals. In fact, saving money rather than preserving trust [was apparently] the driving force behind [establishing] the mediation programs at Rush and at COPIC.[181]

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172. *Id.*

173. *Id.* at 207.

174. *See id.* at 201-02.

175. *See* Henry S. Farber & Michelle J. White, *A Comparison of Formal and Informal Dispute Resolution in Malpractice*, 23 J. LEGAL STUD. 777 (1994).

176. *See id.* at 803-06.

177. Forehand, *supra* note 29, at 926.

178. *Id.*

179. Gatter, *supra* note 158, at 205.

180. *Id.*

181. *Id.*

Although additional analysis is needed to make an accurate assessment, "mediation programs like those at Rush and COPIC [may be] missing an opportunity to build trust among the populations they serve and, as a result, they are foregoing the economic benefits associated with enhanced trust in medicine."[182] Still, the Rush program has been considered successful among clients and professionals in the industry.[183]

Another concern is that medical mediation in institutionally sponsored programs may have become "an adversarial competition for a favorable settlement rather than a cooperative discussion designed to defuse feelings of betrayal and establish mutual understanding."[184] Evidence in the breakdown of cooperative interaction is provided in a 1997 study which found that "in 22 percent of the cases examined, physicians did not attend any mediation session, and that, among physicians who made appearances in the other 78 percent of cases, half never spoke directly to the patient-disputants."[185] These statistics indicate that some institutionally sponsored "medical mediation sessions appear to routinely lack the kind of interaction between physician-disputants and patient-disputants that fosters cooperation and trust despite disputes."[186] For example, in the Rush program the defendant-doctor usually only appears through his or her lawyer.[187] This phenomenon is particularly disturbing because communication between the parties is necessary to foster the ongoing relationships that mediation is often intended to preserve.

It has been suggested that, to avoid the appearance of bias in institutional programs and promote the development of trust between the parties, these programs could be assessed in terms of "quantifiable increases in medical trust generated by these programs."[188]

> [T]he emerging medical trust movement in the U.S. [has led to] the creation of surveys designed to quantify interpersonal trust in health care professionals and institutions. The surveys purport to measure medical trust on a five-point scale based on about 10 questions. There are surveys measuring trust in the medical profession generally and . . . trust in one's health insurer.[189]

182. *Id.* at 207-08.
183. *See generally id.*
184. *Id.* at 205-06.
185. *Id.* at 206.
186. *Id.*
187. Gatter, *supra* note 158, at 206.
188. *Id.* at 208.
189. *Id.* at 208-09.

These surveys could also be modified to assess other components of the mediation process, such as mediator performance.[190]

B. Uniformity

Concerns about institutionalizing the mediation process include the necessity of uniformity within the profession and uncertainty about the impact of formality on the mediation process.[191] Major attempts at encouraging uniformity in the mediation process have lead to the development of the Uniform Mediation Act ("UMA").[192] The "Act applies to mediation in which the parties formally agree in a record to mediate or are required by statute or referred by a court, government entity, or arbitrator to mediate."[193] The UMA codifies efforts to promote the parties to speak candidly and encourage efficient resolution of disputes.[194]

Specifically, the admissibility of certain statements made during mediation, as well as other disclosures, is impacted by the UMA and other attempts at standardizing mediation.[195] The UMA also includes optional model provisions requiring mediators to disclose conflicts of interest to the parties and compelling mediators' to disclose their qualifications if asked.[196] Additionally, there is an ongoing debate about whether attorneys are better able to represent parties in a mediation proceeding.[197] This requirement would add to standardizing the mediation process, but may be unnecessary.

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190. *Id.* at 209.

191. *See* Gatter, *supra* note 158 (pointing out the impact of traditional methods in the mediation process).

192. The UMA attempts to impose uniformity the mediation process. The UMA's provisions will apply to nearly all types of mediation, excluding those involving labor unions, student peer mediations, and judicial settlement conferences. The UMA was approved by the National Conference of Commissioners on Uniform State Laws in 2002. *See* ALT. DISP. RESOL. § 7.1, *supra* note 5.

193. *See* Rausch, *supra* note 1, at 607 (citing Unif. Mediation Act (Annual Meeting Draft, June 5, 2001, § 4(a), *available at* http://www.law.upenn.edu/bll/ulc/ulc_frame.htm (last updated Jan. 31, 2003).

194. *Id.* at 605.

195. *See generally id.* at 607. The UMA bars mediator disclosures to courts, administrative agencies, and other government entities. *See* Uniform Mediation Act § 8(a)-(c). Pursuant to the UMA, anyone who participates in mediation will be able to prevent statements that they make from being used against them in later court proceedings. ALT. DISP. RESOL. § 7.1, *supra* note 5. Exceptions to the privilege include the following: disclosures of threats of bodily harm, reports of abuse and neglect, and demonstrating that mediation was used as a pretext to further a crime. *Id.* Under the UMA "mediation communications" include discussions held during mediation as well as communication when the parties are considering or initiating mediation. *See* Rausch, *supra* note 1, at 605-06.

196. Uniform Mediation Act § 8(d)-(f).

197. Gitchell & Plattner, *supra* note 14, at 425-26.

C. Current ADR Programs in the Health Care System

In response to the problems articulated with respect to litigation in the health care system, some states have instituted ADR programs.[198] However, many states still have not adopted the UMA.[199] Generally, states have different requirements and standards for mediation programs.[200] While some states certify mediators and require certain educational backgrounds for individuals to qualify as a mediator, others do not.[201] "Mediator qualifications vary from state to state, frequently including advanced degrees and/or specialized mediation training."[202] For example, Florida specifies qualifications for types of mediators and certifies attorneys, mental health professionals, and accountants as mediators.[203] In contrast, other state programs have more general training requirements, but do not require a particular or strict educational background. For example, programs in states such as California, North Carolina and Utah require 40 hours of mediation training, while in other states such training is discretionary.[204]

Michigan's mandated mediation program has several distinctive features.[205] In Michigan, a panel performs health care dispute mediation.[206] The parties can designate the health care professionals who will serve on the panel.[207] Specifically, the program "requires a five member panel, made up of lawyers and health care professionals, to hear 15 minutes of testimony from the plaintiff's and defendant's attorneys and to determine the amount of recovery, if any. If both parties accept the mediation evaluation, the case

198. *See* Walter Orlando Simmons, *An Economic Analysis of Mandatory Mediation and the Disposition of Medical Malpractice Claims*, 6 J. LEGAL ECON. 41, 41 (Fall 1996).

199. *See* http://www.adr.org/sp.asp?id=26600 (last visited Apr. 17, 2006).

200. *See generally* A. Thomas Pedroni and Ruth F. Vadi, *Mandatory Arbitration or Mediation Of Health Care Liability Claims?*, 39 APR MD. B.J. 54 (2006).

201. Norma Jeanne Hill, *Qualification Requirements of Mediators*, 1998 J. DISP. RESOL. 37, 37 (1998).

202. Bobby Marzine Harges, *Mediator Qualifications: The Trend Toward Professionalization*, 1997 B.Y.U. L. REV. 687(1997)

203. *See* http://www.flcourts.org/gen_public/adr/index.shtml (last visited Apr. 16, 2006). The Supreme Court of Florida certifies at least four different categories of mediators—county court, family, circuit court, and dependency. There are specific minimum qualifications for each category. *Id.*

204. Harges, *supra* note 202, at 694.

205. *See* Simmons, *supra* note 198, at 41.

206. *See id.* (describing the panel and the dispute resolution process it utilizes).

207. *Id.*

is settled by mediation."[208] Obviously, this system is not typical of the classic mediation process. "Some observers even maintain that the mediation system in Michigan is not mediation as traditionally understood. For example, Fleming described the process as 'an advisory opinion, and not mediation.'"[209] Though efficient, the process may be sacrificing long-term benefits.[210]

Classic mediation practices provide "significant potential for promoting communications and information exchange."[211] This practice engages parties and encourages communication, providing an opportunity for efficient conflict resolution in health care.[212] In many mandatory programs this opportunity to improve communication between the parties and encourage collaboration is not being fully utilized.[213] In areas that have mandatory mediation programs, the criteria for assessing which cases may be resolved by mediation needs to be critically assessed.[214]

D. The Future of Mediation in Health Care

The importance of incorporating mediation to resolve health care disputes is obvious. Congress has even recognized the importance of ADR to facilitate health reform.[215] Mediation is "used in a variety of medical settings to deal with disputes between residents and staff in nursing homes, disputes over Medicare reimbursement, quality-of-care complaints involving Medicare and Medicaid, and medical malpractice claims and bioethics disputes."[216] The health care system is complex and mediation can be adapted to suit all of these scenarios.

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208. *Id.*

209. *Id.* at 44 (internal date omitted).

210. *See* Gatter, *supra* note 158, at 208.

> [I]nstitutionalized medical mediation programs that employ classical mediation techniques are likely to experience fewer disputes in the future. In other words, policies encouraging classical mediation are a long-term investment in the efficient management of medical liability risk, and the emerging medical trust movement in the U.S. can be used to persuade mediators, physicians and health care institutions of this point.

Id.

211. Liang & Small, *supra* note 2, at 239.

212. *Id.*

213. *See generally id.*

214. Richard Morley Barron, *Which Cases Are Most Suitable For Court Ordered Mediation* (Oct. 2004), *available at* http://www.mediate.com/articles/barronMR1.cfm. The article provides ten factors that may be reliable indicia that a case is likely to be resolved by mediation. These factors include the complexity of the case and whether there is a continuing relationship at issue.

215. Meili & Packard, *supra* note 29, at 23-24.

216. Dubler, *supra* note 91, at 35. For example, mediation is used by Montefiore Medical Center in its program.

Mediation is a flexible alternative to litigation. It enables the people best suited to resolve complex health and emotional issues to problem solve – the parties themselves.[217] Mediation should be the first step in resolving medical malpractice claims. Mediation would act as "a gatekeeper to the litigation system."[218] This would increase the efficiency of the process, reduce courts' case loads, and it has been suggested that the funds that are saved may be applied to providing quality, timely treatment for the patient-claimant.[219] By using the mediation process early in a health care dispute, the parties are better able to preserve the doctor-patient relationship and work towards a collaborative solution.[220] While the comment that "[o]ften, in medical negligence cases, resolutions are found in the hearts, minds, and interests of the participants" may be overly optimistic, it is accurate.[221] Mediation empowers parties and facilitates settlement.[222] As the first step in resolving medical malpractice claims, it can clarify issues and increase efficiency.[223]

The mediation process opens up the lines of communication between the parties. Thus, even if the parties do not decide to settle in mediation, going through the process has usually made them more receptive to settling or entering into negotiation discussions in the future.[224] Additionally, mediation allows the parties to address multiple complex issues, which typically extend beyond monetary considerations.[225] Disputes in the health care system usually encompass monetary and non-monetary issues.[226] Often emotional issues, medical coverage, and treatment options need to be addressed in a malpractice claim.[227] Litigation is often able to adequately address pure monetary issues, but is less rewarding when dealing with other qualitative concerns.[228] Additionally, traditional procedures for addressing medical malpractice claims, such as litigation and settlement negotiations,

217. *See generally* Meili & Packard, *supra* note 29, at 28.
218. *Id.*
219. *See* Gitchell & Plattner, *supra* note 14, at 453
220. *See* Liang & Small, *supra* note 2.
221. Galton, *supra* note 42, at 321.
222. *See generally* Meili & Packard, *supra* note 29, at 28.
223. *See id.*
224. *Id.*
225. *See generally* ALT. DISP. RESOL. § 7.1, *supra* note 5; *see also* Meili & Packard, *supra* note 29.
226. *See id.*
227. *See* Meili & Packard, *supra* note 29, at 27.
228. *See id.*; *see also* Gitchell & Plattner, *supra* note 14.

have not been effective at promoting patient safety.[229] The "negotiation dance" or strategic salience of litigation can be counter-productive to patient treatment and detract from the quality of care provided.[230]

It is important that mediation remain a voluntary and flexible system to ensure that the disputants feel free to communicate and explore options. Mandatory mediation is effective at quickly educating the masses about the process, but should not be sustained.[231] Hospital administration and staff must be trained so that they are well versed in the mediation process and can explain the programs to patients.[232] Even limited mandatory mediation programs should be carefully structured. Mandatory mediation must remain true to the classic notions of mediation. Mandatory non-traditional mediation plans, such as Michigan's program, may be effective at resolving the immediate issues that the parties have and provide short-term solutions. However, since the parties do not have an opportunity to enter into flexible sessions to discuss their concerns, these programs may not be maximizing possible long-term benefits that mediation can provide. For example, mediation can lead to internal policy changes which reduce the number of patient complaints and reduce the likelihood of negligent care in health care settings.[233]

IV. CONCLUSION

Ideally, a medical malpractice ADR or mediation system should: (1) compensate for patients that are injured due to negligence; (2) motivate doctors and hospitals to reduce medical negligence and improve the quality of care; (3) preserve the doctor-patient relationship; and (4) optimize cost efficiency. To be fully effective, dispute resolution system in health care needs to at least meet these four goals. Additionally, it is necessary to implement a system that helps to resolve a majority of disputes early in the life of the conflict.

Mediation provides the opportunity to use creative solutions to often complex conflicts in health care. The mediation process goes beyond traditional adjudication methods to generate innovative alternatives that address the concerns of the parties. It promotes communication and

229. Edward A. Dauer, et al, *Transformative Power: Medical Malpractice Mediations May Help Improve Patient Safety*, DISP. RESOL. MAG. at 9 (Spring 1999).

230. *See generally* Meili & Packard, *supra* note 29, at 28.

231. *See generally* Simmons, *supra* note 198 (discussing concerns about mandatory mediation).

232. Hill, *supra* note 202, at 45. Training and experience are "widely accepted as valid criteria for selecting mediators." *Id.* This training makes mediators more effective and is regarded as "indispensable to the success of any mediation program." *Id.*

233. *See generally* Liang & Small, *supra* note 2, at 219.

cooperation. Particularly in health care, communication and collaboration is needed to prevent errors and adverse events. Mediation may not be a "cure all," but its flexibility allows it to be an adaptable medium – a malleable band-aid that helps the parties come together and sets the stage for the healing process to begin.