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The Future of ADR

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ADR in health care has a long way to go, a lot to do, and a past to live down.

A comprehensive survey of the use of ADR in health care was undertaken in 1990[1] and selectively updated in 1997.[2] The results on both occasions were surprising: ADR has been less frequently employed in health care than the situation in that field would warrant. There was certainly an increased usage between the dates of the two surveys, and there has been further evidence of its acceptance since the latter of the two;[3] but it seems still to be the case that health care has come to ADR cautiously at best.

Without knowing these data, one might have predicted quite the contrary. Health care is undergoing rapid and often wrenching change. From an economic microsystem in which the major flaws were over-consumption and an absence of competition, it has become, in only about a decade, nearly the opposite of what it used to be. Health care is now a highly competitive environment structured to achieve economies while delivering efficient levels of service.[4] Providers, who once earned more by doing more, may now earn more by doing less. Comfortable arrangements among suppliers and payors that once abounded are being undone as payors reduce costs to compete for the business of the larger employers. Physicians compete for appointments within groups and plans, and payors compete to attract profitable providers. The alignments among patients, providers, payors and employers have changed in ways that would not have been recognizable less than a generation ago.

Change creates conflicts, since conflicts so often arise from unmet expectations, about advantage, status, and place. The 1990 CPR survey identi-

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1. The 1990 study was conducted by the CPR Institute for Dispute Resolution, with the support of a grant from the Kellogg Foundation. The author of this part of this article served as chair of that effort. The results of the CPR work appear in E. A. Dauer et al, Health Industry Dispute Resolution: Strategies and Tools for Cost-Effective Dispute Management (CPR 1993).

2. The 1997 update was also conducted by the present author, with the support of a grant from the Robert Wood Johnson IMPACS program. The results of that work have not been published apart from a report to the Foundation.

3. See e.g. E. Rolph et al, *Arbitration Agreements in Health Care: Myths and Reality*, 60 L. & Contemp. Prob. 153 (1997)

4. See generally Clark Havighurst et al., Health Care Law and Policy (2nd Ed. 1998).

fied more than 50 kinds of disputes in which health care entities were engaged,[5] many of them being unique to that field. Physicians, for example, have conflicts with health plans over matters of inclusion and deselection; patients have conflicts with physicians about access, quality and service; patients dispute with insurers over benefits and coverage. There are, among many others, reimbursement disputes between payors and providers, and quality-focused conflicts between providers and their regulatory agencies. All of these occur in addition to the more common problems that arise in the normal lives of contracting and employment, supply and competition, and such other activities as any business or profession encounters.

The disputes are happening, yet (with the exception of court-annexed procedures) there has been less use of ADR in these disputes than experience elsewhere would suggest. It is a mystery why this is so. Perhaps health care managers and professionals, linked as they are to the empirical traditions of the health sciences, have been waiting for sufficient data about ADR's successes and failures before they will adopt it as a nostrum for themselves. Maybe the changes in the industry have made the stakes too great or the new rules of the road too unpredictable to allow for confidence in private resolutions. For some new problems authoritative intervention may be required, which ADR does not provide. In one particular area the 1997 investigation found that at least some of the resistance to ADR came from the insurance industry, which is not only the principal stakeholder in health care but is also an industry whose conservatism is in many ways demonstrable, though not altogether inappropriate.[6]

The usage rate of ADR in medical malpractice remains depressed,[7] despite some notable private initiatives.[8] Here, however, the gap between need and usage is more readily understood. ADR in medical malpractice had a bad false start, the effects of which have been discernible for over a decade.

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5. There are others that were not identified by the CPR surveys, such as end-of-life decisions.

6. Not all insurers fit this description. Some, such as CIGNA and the COPIC companies, have long been at the forefront of developments in ADR. But many are reluctant to change what has been successful for them. For further discussion see E. Dauer et al., *Prometheus and the Litigators: A Mediation Odyssey*, in 21 J. Legal Med. 159 (2000).

7. A private survey was conducted by the Physician Insurers' Association of America in 1999, which measured the usage rate of mediation among its member companies. The results showed only a modest use of mediation in malpractice disputes; and, where mediation was employed, its use by medical liability insurers is most often at a very late stage in the management of a claim. The PIAA study is on file with the author.

8. One example is the program at Rush-Presbyterian Hospital in Chicago, described in R. Gitchel et al., *Mediation: A Viable Alternative to Litigation in Medical Malpractice Cases*, 2 De Paul J. Health Care L. 421 at 447 (1999).

There were two periods in recent history that were known as the "insurance crises." In 1974-75 and again in 1985-86, liability insurance became expensive and in some sectors virtually unavailable. The disruptions that caused were highly visible. The news media were full of stories such as those of rural physicians who refused to deliver babies because their malpractice carriers would not cover the liability risks. The crisis was not limited to health care, but some in health care were poised to seize on it, describing the insurance crisis as the consequence of a legal system gone awry.[9] It may or may not have been the case that the liability system was in need of reform,[10] but that is exactly what it got. Those same years were the peaks of legislative efforts in tort reform. A good deal of the statutory changes in tort law that occurred in the past generation were put in place during those two brief periods of time.

Many of the tort reforms of 1974-75 and 1985-86 were directed at malpractice liability in particular. Much of the rest of it affected malpractice liability along with everything else. Caps on pain and suffering, for example, were widely enacted, along with repeal of the collateral benefits rules. Some of the reformers' initiatives, however, were just too far a departure to be politically viable. Efforts to impose caps on plaintiffs' attorneys' fees and other devices such as fee-shifting, which would have created disincentives for plaintiffs to bring their claims to court, were successfully resisted. Thus ADR was widely introduced as part of the entire reform package. It was not introduced, however, to achieve better resolutions, as the cognoscenti of the field would have preferred. It was embraced instead as an alternative way to limit access to the courts — a goal the reformers were unable to accomplish through substantive legal changes alone. About half the states enacted devices known as "screening panels." Others adopted mandatory pre-trial mediation; some tried mandatory (albeit non-binding) arbitration. All of these were

9. It was the case that the severity of medical malpractice claims had grown rapidly in the decades just before. For a contemporary discussion of the tort reform agenda during the second "insurance crisis," see generally *Symposium*, 64 Den. U. L. Rev. 613 (1987).

10. There is reason to believe that the two insurance crises were the result of endogenous features of the insurance industry rather than of any changes in the legal environment. For nearly fifty years, insurance prices and insurance availability had shown a cyclical pattern with a period of almost exactly eleven years, thus peaking in 74-75 and again in 85-86. Unpublished research on file with the author, who served as Chair of the Colorado Tort Reform Commission during the 1985-86 cycle.

meant to serve as barriers, or at least as diversions away from the courthouse itself.

Predictably perhaps, none of this worked very well. Screening panels have been a failure almost everywhere they were tried.[11] Mandatory mediation became a side-bar form of settlement conference negotiation. Mandatory arbitration in some states actually added a layer of expense without achieving either the efficiencies or the diversions its proponents expected.

The reasons for these failures are not hard to understand. ADR works well when it is used for what it is designed to do: to improve the management of conflicts and achieve better outcomes, not to serve as a surrogate for politically unsaleable substantive change. Lawyers dislike being told what to do. Mandatory procedures operating on an institution's sense of the calendar do not command much support, and court-based reforms that address matters only after they have become lawsuits do not prevent lawsuits. Perhaps most important is the now well-known fact that in ADR there is no such thing as "once-size-fits-all." The characteristics of cases that make them appropriate matters for one form of resolution rather than another are complex and not limited to the legal label that may be placed on the claim. Many of the ADR procedures grafted onto the tort reform initiatives recognized little if any of these finer points. The results were neither what was expected, nor what they otherwise could have been.

The consequences of the tort-reform misadventure have had a long persistence. In medical injury in particular, ADR got a bad name. Not many people fully appreciated the differences between well-crafted private mediation and the court-annexed haggling that became known as mediation. Even today the phrase "mediation" conjures in the minds of liability insurers an image of a facilitated settlement conference with its single-axis focus on dollars alone – a procedure most often employed only after the decision to pay has been made, leaving for resolution only the question of how much.

It was a bad start. Whether the failed experiment in malpractice also affected the reputation of ADR in other areas of health care cannot be as easily determined. Two things, however, are certain. First, this false start did retard the applications of ADR in one important and very visible part of health care; and second, the rest of health care is behind where it should be on the ADR usage curve. Health care underutilizes ADR, and ADR has a long way to go in health care.

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11. See e.g. Jona Goldschmidt, *Where Have All the Panels Gone? : A History of the Arizona Medical Liability Review Panel*, 23 Ariz. St. L. J. 1013 (1992).

There is a certain irony in this situation. In health care in particular, ADR may be able to contribute a great deal, some of it qualitatively different from what it has been able to accomplish elsewhere. This unusual potential is in fact the more interesting of the challenges ADR faces as it moves into the new millennium.

The benefits ADR can bring to health care disputes are at first glance not very different from those that appear elsewhere: economy in dispute management, reduction of adversariness, streamlining of the otherwise ponderous processes of the courts. Another benefit, when ADR is used preventively, is its potential to prevent disputes from becoming lawsuits at all. A problem can remain a problem, capable of being solved as such rather than maturing into a lawsuit that allows solutions crafted only from the limited argot of that genre. I believe, however, that the potential for ADR in health care is far greater than that. I will focus again on the malpractice setting, though I believe similar descriptions could be offered for benefits disputes, physician deselection conflicts, and many others.

Briefly, we now know that there is little if any correlation between incremental liability for medical accidents and incremental patient safety. Conventional analysis predicts that if doctors pay more when they make mistakes, they will be less likely to make mistakes. In fact, it doesn't seem to work that way.[12] More deterrence seems not to follow from the imposition of more liability. Along with Marcus, Passineau, Thomasson and others, I have been pondering this phenomenon, and have developed the hypothesis that the *process* by which medical liability is imposed may be the culprit. That process is, conventionally, litigation and its associated procedures.

As Passineau has shown, physicians who have been sued for a medical error are *more* likely to make another error during the pendency of that suit, rather than less.[13] Why is this so? Leape[14] and others have described what needs to be done to help an error-producing system improve. Almost all of what ought to happen in error-reduction is inconsistent with almost all of

12. The most recent study that searched for and found no effect of incremental liability on incremental patient safety is Douglas Conrad et al., *The Incentive Effects of Malpractice Liability Rules on Physician Behavior*, 36 Med. Care 706 (1998)

13. See Passineau, *Why Burned-Out Doctors Get Sued More Often*, Med. Econ. 1998; Thomasson, "Patient Safety Implications of Medical Malpractice Claims Resolution Procedures," in Enhancing Patient Safety and Reducing Errors in Health Care (AAAS 1998).

14. Lucian Leape, *Error in Medicine*, 272 JAMA1851 (1994)

what happens in traditional litigation. For example, error-reduction requires that errors be addressed as the outputs of systems. Litigation, by contrast, focuses on the isolated activities of individuals. Error reduction requires full information about the instances and causes of errors. The risks of creating adverse evidence for litigation, however, tend to push information further underground. Error reduction requires a non-punitive environment, within which accidents can be approached as learning opportunities. Medical liability litigation is nothing if it is not punitive.

There is good reason to believe that well-crafted forms of mediation can achieve an effective link between today's medical error and tomorrow's patient safety. Mediation, for example, offers the re-establishment of communication within which expectations, flaws, and the causes of accidents can be explored. Mediation's flexible outcomes allow for corrective rather than punitive solutions. Confidentiality in mediation can allow for a much less-risky root cause analysis. All of this is in addition to the fact that mediation can in many cases respond more authentically to the needs of injured patients and their families, whom we know want rectitude, correction, and closure (and, yes, sometimes revenge) more frequently than they want cash.[15]

The details of all this are extensive and worth being explored more fully. The present point is only that the future of ADR in health care may well include, if participants in the field will help it include, a contribution to reducing future medical accidents. This may not be a familiar assignment for ADR, but it is an opportunity to achieve an important health care objective. Although we have not yet explored the same theme in other areas within health care, it seems at first glance to be a real possibility. Disputes about benefits, for example, can be opportunities for physicians to understand more about their patients, and patients to understand more deeply the whys and the ways of medical care. Better health is often the result. Adversarial conflict techniques destroy communication. ADR techniques help repair it.

Ever the optimist, I suspect we may be able to make lemonade from the lemons with which ADR in health care began. Providers, their insurers, and many health care managers have not fully embraced ADR, remaining unconvinced perhaps by its more conventional promises. If we can develop empirical demonstrations that ADR techniques may have these more far-reaching consequences, perhaps its use can be fostered explicitly on those grounds. It will be close work, and must be done with the rigor and care that health care prides itself as fostering. The results will not come overnight, but the effort

15. See e.g. Penchansky and Macnee, *Initiation of Medical Malpractice Suits*, 32 Med Care 813. (1994). G. Hickson et al. *Factors that Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries*, 267 JAMA 1359 (1992).

seems worthwhile. There is not much downside, and the opportunities on the upside are useful, important, and tantalizing indeed.