FOREWORD
SEE YOU OUT OF COURT? THE ROLE OF ADR IN HEALTHCARE

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The U.S. healthcare system has undergone dramatic changes in the past year, which will have a profound impact on American society. While the "Patient Protection and Affordable Care Act of 2010" seeks to ensure healthcare coverage for the vast majority of Americans, controversies relating to scope of coverage, cost and course of treatment chosen, quality of care rendered, healthcare staff demeanor, and bioethical dilemmas are bound to persist. Indeed, in all likelihood, these controversies will even expand with the growth in the number of healthcare recipients under the federal scheme. Moreover, the changes introduced through the U.S. healthcare reform act are far from stable, as attempts to repeal the reforms have been launched. As we can see, the healthcare arena is a volatile setting, fraught with conflict and subject to strong ideological divides.

Over the years, a recurring theme in the writing on conflict in the healthcare arena has been the potential for appropriate (or alternative) dispute resolution (ADR) avenues, in particular non-adjudicative ADR processes, to address such disputes more effectively than formal channels. Indeed, the *Law & Contemporary Problems* issues on medical malpractice published over a decade ago included research on the role of ADR in that particular context.[1] The principal insight in publications on this topic has been that ADR can be more effective and satisfactory than litigation in addressing these disputes because of the role that miscommunication (and the lack of communication altogether) plays in doctor–patient (and patient–family member) interactions. For the same reason, efforts have also been devoted to enhancing doctor communication skills and problem-solving capabilities. Despite these attempts, real change has yet to take place. As can be seen in the contributions to this issue, the reality of healthcare is one that is laden with disputes and is broadly perceived as generating costly litigation. The interest in alternatives to litigation has become all the more salient in the context of current healthcare reform efforts with the question of cost being commonly associated with medical malpractice litigation.

But the focus on malpractice can be misleading. Although medical malpractice claims have had a deep impact on the healthcare system and its

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1. *See* 60 LAW & CONTEMP. PROBS. (Winter & Spring 1997).

actors, these conflicts represent only one facet of the disputing culture in healthcare. In fact, other types of conflicts, despite their prevalence and impact, have been overshadowed by malpractice and the related focus on defensive medicine, receiving marginal attention in the literature, in policymaking, and in public debate. To better understand the manifold disputes in healthcare and the potential contribution of ADR in addressing, transforming, and preventing conflict in that setting, a broader view is needed.

This issue, entitled "*See You Out of Court: The Role of ADR in Healthcare*," seeks to fill that void by providing a comprehensive examination of ADR in healthcare. Specifically, this issue sets out to broaden the scope of disputes studied, and to offer multidisciplinary perspectives on the sources of disputes, the potential of ADR to address them, and the barriers obstructing the adoption and success of ADR in these settings. Dispute types examined include, in addition to malpractice, small-scale "non-litigable disputes," conflicts over bioethical dilemmas, disputes arising from the shift to digital medical records, and ideological debates over healthcare reform. In many of these contexts, litigation has been found suboptimal or is inappropriate altogether, and use of ADR (or ADR-based skills and tools) has been attempted or contemplated.

In studying conflicts in the healthcare setting, the contributors to this issue address such questions as: What are the sources of these disputes? What are the features of the healthcare settings that give rise to such disputes? How are the different types of disputes currently being addressed and are current avenues for addressing disputes satisfactory? What role does ADR presently play, and what role can and should ADR avenues occupy? What are the difficulties in employing ADR and are they unique to the healthcare arena? What role do law, culture, and economics play in the disputing culture and in the role of ADR? These and related questions are addressed through a rich and diverse collection of papers, that cut across geographic and disciplinary boundaries, while exploring different topics and dispute types of varying scale, ranging from individual conflicts, through organizational and community settings to full-fledged national crises.

The first two papers touch on different aspects of the healthcare reforms introduced by the Obama Administration. In her contribution,[2] Carrie Menkel-Meadow explores the extent to which experience with ADR processes could have informed the failed attempt at deliberative democracy around healthcare reform in the United States. Menkel-Meadow draws on theories of deliberative democracy and consensus-building processes in analyzing the failure of the many different town-hall meetings that were held throughout the country to generate a civilized, rich, and thoughtful debate on the reform of the U.S. healthcare system. Her vivid description of these disastrous attempts at engaging the public casts doubts on the prospects of such endeavors, or, at the

2. Carrie Menkel-Meadow, *Scaling Up Deliberative Democracy as Dispute Resolution in Healthcare Reform: A Work in Progress*, 74 LAW & CONTEMP. PROBS. 1 (Summer 2011).

very least, the adequacy of the theories underlying and supporting these efforts. Menkel-Meadow uncovers the ways in which the Obama town-hall meetings were reduced to a political procedure that required binary decisions, failing "to explore basic principles of complex voting issues . . . , and multiple-issue trading, a staple of consensus-building procedures . . . ma[king] it virtually impossible for the town-hall meetings to affect policy outcomes."[3] Indeed, by overlooking the lessons generated by the ADR field in terms of the need for "process pluralism" that would address the "principled-rational," "bargaining," and "affective" modes of human discourse, the town-hall meetings could not give rise to true deliberation.[4] Menkel-Meadow finds that principles of individually tailored ADR processes cannot be simply "scaled-up" to accommodate large numbers of participants for purposes of deliberative democracy if we are to seriously address deeply held values and strong emotions (or in Menkel-Meadow's terminology, the "affective dimensions") on the one hand, and the need for a firm factual basis and some substantive expertise on the other hand, when addressing "highly conflictual disputes at the societal, not individual, level."[5] Instead, Menkel-Meadow calls for the development of more sophisticated theories and practices that would weave together the three levels of discourse "into large-scale and complex political issues,"[6] while providing insightful guidance on what such theories and practices might require in terms of system design.

The article[7] by Ethan Katsh, Norman Sondheimer, Prashila Dullabh, and Samuel Stromberg relates to another change introduced by the Obama Administration as part of the "American Recovery and Reinvestment Act," enacted a year prior to the legislation relating to healthcare reform. As part of that bill, also known as the "stimulus bill," the government devoted the substantial sum of $19.2 billion for encouraging the adoption of health information technologies, namely, in the form of electronic health records (EHRs). As Katsh et al. eloquently demonstrate, the shift from a manila medical file to a digital medical record inevitably generates problems, complaints, and full-fledged disputes relating to the "accuracy, meaning, and content of the record."[8] Most significantly, perhaps, as Katsh et al. point out, the shift to EHRs promises to transform the doctor–patient relationship into one in which patients' healthcare is "a truly shared responsibility" through "patient engagement" allowing for "more consistent and effective flow of information among patients, physicians, and other healthcare providers."[9] As the article

3. *See id.* at 6.
4. *See id.* at 8.
5. *See id.* at 3.
6. *See id.* at 28.
7. Ethan Katsh, Norman Sondheimer, Prashila Dullabh & Samuel Stromberg, *Is There an App for That? Electronic Health Records (EHRs) and a New Environment of Conflict Prevention and Resolution*, 74 LAW & CONTEMP. PROBS. 31 (Summer 2011).
8. *See id.* at 37.
9. *See id.* at 44.

shows, the introduction of new technologies enhances patient empowerment, but at the same time creates new problems and gives rise to new types of disputes, ones for which traditional dispute resolution avenues may prove inadequate. Katsh et al. therefore advocate the adoption of online dispute resolution systems to prevent problems that may arise in the context of EHRs, and to address those that do, most notably problems relating to the amendment of digital records.

A major area shaping the healthcare arena in recent decades that has received only minor attention in the Obama healthcare legislation is that of malpractice reform. David M. Studdert, Allen Kachalia, Joshua A. Salomon, and Michelle M. Mello's article[10] advances the adoption of noneconomic damages schedules as an alternative to caps for addressing the "profound, longstanding, and seemingly intractable problem" of widely disparate jury valuations of such damages. Studdert et al. explain why caps on non-monetary damages—the most common reform proposal for addressing the problem of "jackpot" awards—are inadequate. The problem of rising insurance costs, warped deterrence signals, inequitable compensation, and reduced public trust and confidence in the system cannot be cured by caps that do not provide juries with substantive guidance as to what constitutes an appropriate award in a given case. They therefore advance damages schedules as "the next generation of tiered caps—more sophisticated, principled, and sensitive than their forebears."[11] The authors draw upon methodologies developed to grade health states in formulating a health-utilities approach to schedules for noneconomic damages in malpractice cases. Studdert et al. go beyond the development of a theoretical model by providing empirical "proof of concept" for the feasibility of their approach to be further developed and refined in "careful state-based experimentation with a health utilities-based noneconomic damages schedule."[12]

Significantly, Studdert et al.'s call for the adoption of schedules for noneconomic damages can be expected to impact not only the formal arena, but also informal negotiations and settlements, offering increased predictability and higher prospects of settlement. This is the focus of Mirya Holman, Neil Vidmar, and Paul Lee's article,[13] which explores the intricate relationship between the formal court avenue and settlements that take place in its shadow, and examines the ways in which regulatory schemes governing various ADR options shape the outcome of malpractice claims. Their empirical project provides a profile of all litigation in Florida in the last twenty years, including data on the types and characteristics of cases resolved at each stage of the

10. David M. Studdert, Allen Kachalia, Joshua A. Salomon & Michelle M. Mello, *Rationalizing Noneconomic Damages: A Health-Utilities Approach*, 74 LAW & CONTEMP. PROBS. 57 (Summer 2011).

11. *See id.* at 66.

12. *See id.* at 101.

13. Mirya Holman, Neil Vidmar & Paul Lee, *Most Claims Settle: Implications for Alternative Dispute Resolution from a Profile of Medical-Malpractice Claims in Florida*, 74 LAW & CONTEMP. PROBS. 103 (Summer 2011).

process. Indeed, the choice of Florida was not incidental. Aside from its detailed reporting requirements for medical malpractice claims, Florida has an elaborate regulatory scheme that structures (and constrains) the claiming process. These rules require a "wait period" before the filing of a malpractice lawsuit and offer informal discovery and arbitration during the pre-suit period, as well as mandating mediation and offering arbitration and settlement conferences in the post-litigation phase. The authors study the "subprofiles of the stages of resolution," for example, the characteristics of the claims resolved during each of the stages prescribed under Florida law as well as the nature of the settlements reached in each of these stages. A principal finding was that the stage in which a resolution took place affected whether a payment was made from the defendant to the claimant, with claims resolved during the pre-suit period being the strongest factor predicting that a claim would result in payment. Although the authors are in favor of a swift and non-adversarial resolution of malpractice claims, a move supported by the Florida regulatory scheme, they caution of the impact of early resolution before discovery has taken place and as long as complex questions of negligence and causality remain unclear.

Carol Liebman's article[14] further explores the potential of ADR for addressing malpractice disputes by studying the role played by mediation in this context. Her analysis provides a rich description of the experience with mediation as it emerges from two recent empirical studies of mediation programs in New York hospitals. Both studies sought to examine the potential of interest-based mediation to advance economic benefits for the parties (in the reduction of costs and time to resolution) as well as noneconomic benefits in the form of enhanced patient safety, and healing impaired doctor–patient relations. In many respects, these mediations were a success. Plaintiffs conveyed a high rate of satisfaction with the process, which allowed them to be heard in a professional setting, and mediation was found to be time efficient, although such benefit could have been maximized had parties made use of mediation to reach settlement in earlier stages, closer to the occurrence of the adverse event. However, these benefits were somewhat overshadowed by the significant opportunities missed in the use of mediation in these settings, which can be attributed to the absence of a key player—the doctors. While a high percentage of plaintiffs participated in the mediation sessions, not a single physician attended them. This was no trivial matter. The absence of physicians significantly diminished the opportunities for noneconomic gains through mediation, namely, allowing patients and physicians to reconcile and restore trust, letting the parties forgive and be forgiven, enabling physicians to have voice and restore their reputation, allowing patients and families to receive full information on the circumstances of the error, and helping the physician and

14. Carol B. Liebman, *Medical Malpractice Mediation: Benefits Gained, Opportunities Lost*, 74 LAW & CONTEMP. PROBS. 135 (Summer 2011).

hospital to gather information that could lead to the adoption of institution-wide policy changes. This last point is of real importance if the institutionalization of mediation is to be tied to increased patient safety. As Liebman aptly states: "[F]or patient safety to benefit, someone is needed at the table who has the clinical technical knowledge, appreciation for the institution's culture . . . and who has understanding of policy and procedures."[15] Why, then, do the physicians abstain? Liebman finds that their attendance in mediation sessions is actively discouraged by their attorneys who fear the emotional impact such interaction may have on their clients, and are guided by a limited understanding of the mediation process. Liebman bemoans this result, and calls for the empowerment of repeat-player defendants in malpractice claims (such as hospitals and nursing homes) vis-à-vis their lawyers, impacting their choice of lawyer, the nature of their relationship, and, ultimately, the role of ADR mechanisms in this context.

Michal Alberstein and Nadav Davidovitch in their contribution[16] draw on various case studies and research relating to the role of apology in addressing collective trauma and restoring trust in public health to enrich our understanding of apology both in the collective sphere as well as in the individual-clinical setting. The authors analyze the Tuskegee Syphilis case as a "paradigm for an enriched notion of an apology."[17] Clinton's 1997 apology took place many years after public disclosure of the study, and after a multi-million dollar settlement had been reached. The legal outcome was clearly inadequate as the "shadow of Tuskegee" continued to shape the relations between the African-American community and the American public health community, breeding distrust in the system and individual healthcare professionals.[18] The authors find that the involvement of the community in the construction of the apology, and the fact that the apology supplemented a legal course of action (and was not perceived as a substitute to such avenue), helped make this a success story. Indeed, these features of the Tuskegee apology can explain why other instances of public health apologies explored in the article have been largely unsuccessful. Based on these experiences and Yamamoto's work on social healing, the authors offer a rich understanding of the meaning of apology both for public apologies relating to collective trauma as well as individual apologies rendered in the clinical setting. With respect to the latter, they emphasize the need for a more culturally-sensitive approach, which leaves room for patient involvement, and allows for restoration of relations and prevention of future harms, beyond the apology's potential for enhanced efficiency and lower claim rates.

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15. *See id.* at 145.

16. Michal Alberstein & Nadav Davidovitch, *Apologies in the Healthcare System: From Clinical Medicine to Public Health*, 74 LAW & CONTEMP. PROBS. 151 (Summer 2011).

17. *See id.* at 164.

18. *See id.*

Alberstein and Davidovich's work also directs us to another principal area of disputing in healthcare, that of bioethics. Nancy Dubler's article[19] focuses on bioethical disputes and the possibility of addressing them through "bioethics mediation," a pioneering framework developed by her and Carol Liebman in their earlier work. In describing bioethics mediation, the article offers illuminating case studies, which vividly demonstrate the inadequacy of legal avenues and the unique contribution of the mediation process in this context. Dubler describes the contours of bioethics mediation and the important distinctions between this particular type of mediation and that practiced in other arenas. In the bioethics context, neutrality, confidentiality, expertise, and the outcome are reshaped so as to accommodate the needs of the care team and the patients and families, as well as to meet legal requirements and practical constraints. The bioethics mediator is an ethics consultant who provides a "neutral turf" for discussing bioethics cases, but at the same time is also an employee of the hospital and is therefore likely to be familiar with the medical staff. The bioethics mediator must also possess medical expertise so as to "translat[e] the ethical and legal norms of medical practice for both the family and the medical staff,"[20] bridging the linguistic and cultural gaps that exist when "[d]octors speak doctor; nurses speak nurse; and no one speaks patient or family."[21] The bioethics mediator's role is to "carv[e] time and space"[22] for discussion, in the midst of the "life and death," "time is of the essence" atmosphere. Physicians typically see the facts of the case as objective and allowing for only one "best" course of action, and mediated resolutions in this context must be "principled" in that they need to conform to legal norms and moral principles. However, "there are always multiple options for the plan of care"[23] and "what counts as a medical fact is a matter of selection and interpretation . . . reflect[ing] normative assumptions."[24]

The organizational focus in Dubler's article illuminates not only the needs of the patients but also those of the healthcare team, performing an extremely complex and exacting task under difficult conditions. This state of affairs is most apparent in Moti Mironi's analysis of the use of arbitration for the restructuring of the healthcare system and the employment structure for physicians in Israel, in the aftermath of a mediated settlement of a lengthy doctor strike.[25] Mironi was one of two mediators appointed in 2000 by former Prime Minister Barak to resolve a long-term doctors' strike in Israel. As part of the mediated resolution

19. Nancy Neveloff Dubler, *A "Principled Resolution": The Fulcrum for Bioethics Mediation*, 74 LAW & CONTEMP. PROBS. 177 (Summer 2011).

20. *See id.* at 188.

21. *See id.* at 180.

22. *See id.* at 190.

23. *See id.* at 186.

24. *See id.* at 196.

25. Mordehai (Moti) Mironi, *Experimenting with Alternative Dispute Resolution as a Means for Peaceful Resolution of Interest Labor Disputes in Public Healthcare—A Case Study*, 74 LAW & CONTEMP. PROBS. 201 (Summer 2011).

he orchestrated, the doctors agreed not to strike for a period of ten years in return for the public health employers' agreement to submit future disputes on physician remuneration and working conditions to arbitration. The mediation process was viewed as a success story, leading not only to the resolution of the strike, but also to a deeper change, setting the stage for a strategic transformation of "the landscape of labor-management and employment relations in Israel's public healthcare industry."[26] Yet the arbitration process that followed largely failed in realizing those expectations. Mironi, from his unique dual perspective as mediator–practitioner and researcher–author, provides a powerful analysis of the twists and turns that accompany the arbitration process, uncovering the deep-rooted barriers that prevented ADR from fulfilling its promise. These barriers included such factors as the economic downturn, the animosity and suspicion of some parties towards their loss of control over the outcome, and dispute system design issues such as choice and authority of the arbitrators. As a result, the "no-strike arbitration model that was praised by the court and others as being innovative, pioneering, unique, and unprecedented . . . will now rest in peace."[27]

Finally, my own piece[28] identifies two significant aspects of doctor–patient relations that have generally been overlooked in the debate over the ills of the healthcare system: the neglect of "non-litigable disputes" and the emergence of "defensive communication." Based on empirical data, the article uncovers the prevalence of small-scale conflicts that do not constitute legal causes of action (hence their name, non-litigable), but are nonetheless significant in the toll they exact from fatigued healthcare professionals on the one hand and anxious patients and family members on the other.[29] Non-litigable disputes typically stem from miscommunication (or the lack thereof altogether) and are therefore precisely the sort of problem that ADR avenues are best suited to address (or mediation-based communication skills could effectively prevent). Nevertheless, we find that attempts to introduce ADR processes for addressing patient–physician disputes or to enhance physician communication skills that have been introduced in recent years have failed to transform doctor–patient relations and bring about a deep cultural change in the hospital setting.[30] While the explanation for this failure has tended to focus on doctors' professional culture, the article points at another source: the fear of malpractice liability. The full extent of the impact of the shadow of malpractice law, therefore, extends beyond the oft-cited emergence of defensive medicine, and extends to defensive communication. Physicians actively adopt a mode of communication that is closed, hierarchical, and confrontational so as to mask their decision-making

26. *See id.* at 205.

27. *See id.* at 239.

28. Orna Rabinovich-Einy, *Escaping the Shadow of Malpractice Law*, 74 LAW & CONTEMP. PROBS. 241 (Summer 2011).

29. *See id.* at 242.

30. *See id.* at 249.

process and avoid legal liability.[31] Such mode of communication is antithetical to the open and collaborative nature of ADR processes and mediation-based communication skills, and therefore serves as a barrier to their effective adoption.[32] The article concludes with some thoughts on the conditions under which such shadow might be lifted, permitting non-litigable disputes to be effectively addressed, thereby reducing conflict levels, increasing patient and providers' satisfaction, and, ultimately, improving the quality of healthcare.[33]

As we can see, while the contributors examine healthcare-related conflicts from different perspectives and in varying contexts, there are several overarching themes that connect the proposed contributions. On one level, this issue presents an overview of the different disputes that arise in the healthcare setting, highlighting similarities and differences, which can shed light on the underlying structural, professional, and cultural features of such setting. Whether studying conflicts over bioethical dilemmas, malpractice claims, small-scale "non-litigable disputes," problems arising from the shift to digital medical records, or ideological debates over healthcare reform, these conflicts often share common sources. Many of these difficulties stem from the "life or death" nature of medical interventions that are rendered under economic constraints and extreme time pressure to anxious patients and family members. These dynamics are often exacerbated by linguistic, cultural, and information differences that make it extremely difficult for patients and family members to communicate with medical staff. These differences and barriers are often echoed on the organizational level and even in national initiatives, as evidenced in many of the contributions.

On another level, healthcare serves as an area that provides multiple insights into ADR's potential and limitations for a wide range of disputes. As we have seen, the impact of the shadow of the law on the ways in which mediation or arbitration processes operate can be debilitating, shaping such factors as who participates in these processes, what types of disputes are being addressed through them, as well as the efficiency of ADR processes and the potential of such processes to deliver a qualitatively different avenue for addressing conflict that results in noneconomic benefits.

On yet a third level, healthcare disputes serve as a lens for studying conflict and dispute resolution in an environment that is complex and subject to rapid change—in technologies, values, or power relations. It is precisely in settings of this kind that formal dispute resolution avenues may fail, while ADR processes can promote strategic change, trust and collaboration, and norm elaboration and dispute prevention. As we can see in each of the contributions, in the healthcare arena, as in many other complex settings, commonly accepted dichotomies are often called into question, most notably the long-established

31. *See id.* at 243.
32. *See id.*
33. *See id.* at 277–78.

distinction between clinical knowledge and technical skills on the one hand, and communication skills and emotional intelligence on the other.[34] As we recognize the connection between these elements, communication skills and the availability of effective dispute resolution avenues—formal and informal—become an integral part of what high quality healthcare is about.

Finally, I would like to thank the authors for their valuable contributions to this issue, and the student and faculty of *Law and Contemporary Problems* for their excellent work, dedication, and patience. It has been a real privilege for me to work with you.

34. Sagit Mor & Orna Rabinovich-Einy, Relational Malpractice and the Transformation of Healthcare Law (2011) (unpublished manuscript) (on file with author).