

Market Opportunities for Mediation in the Healthcare Industry

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INTRODUCTION

The healthcare industry is, by nature, prone to conflict. Moreover, as medicine becomes more complex, develops more new technologies, and faces more daunting challenges of resource distribution with an increasingly aging population, the number and types of disputes in this industry are rising at an alarming rate. One might think that this industry would follow the national trend and adopt mediation as a significant vehicle for resolving those disputes. But it does not. Instead, more than most, this industry litigates its disputes – either in arbitration or in court. And attempts to introduce mediation into medicine have been met with resistance and skepticism. The question is, “Why?”

It is not that health providers are peculiarly fond of litigation. No one in the profession speaks highly of litigation as the mode by which to resolve conflicts over perceived malpractice or other healthcare disputes. That mode is fully recognized to be adversarial by its nature, and imperiling to two things in life physicians in particular tend to value most highly: their ability to maintain control over the manner in which they practice, and their ability to maintain good relationships with colleagues and patients. It is for this reason a *special* mystery that the best escape from litigation, i.e. mediation, has to date been poorly received in the field of medicine.

Although many articles on the topic of mediation of healthcare disputes have begun to appear in the medical, legal and ADR literature, only one, to our knowledge, addresses itself to the fundamental issue of identifying the barriers to healthcare professionals' willingness to use mediation for such disputes. That welcome contribution is the relatively recent article by Rob Robson and Ginny Morrison, "ADR in Healthcare: The Last Big ADR Frontier?" (4)

THE BARRIERS IDENTIFIED BY ROBSON AND MORRISON

In their article, Robson and Morrison attribute the resistance to four factors:

1. The existence of widely divergent "cultures" and value-systems between plaintiffs and defendants in the typical healthcare dispute;
2. The existence, in healthcare institutions, of complex adaptive systems;
3. Issues of inequalities and imbalances of power;
4. The lack of education about the availability and benefits of mediation;

In short, not enough people know about mediation (factor 4), and those that do are discouraged by their sense that healthcare is indeed a special case, burdened with a combination of challenges (factors 1 through 3) that make its disputes relatively resistant to the power of mediation.

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

1. **The Widely Divergent “Cultures” Factor**

We certainly agree that cultural differentiation between physicians and their patients exists, and is a major factor in both the onset and the resolution of conflicts.¹ For this reason, healthcare conflict mediation, at least for disputes between physicians and their patients, is akin to cross-cultural mediation. It may well be that potential users of mediation are daunted by the recognition that it would take special sophistication to resolve such disputes, and may simply conclude that the field of mediation is just not up to the task.

The reality is that mediators with the proper tools can meet this challenge. The irony is that healthcare stands in greater need of such mediators to resolve its disputes than do most industries. In a typical business-to-business dispute, for example, the

¹ In fact, in an ongoing, randomized prospective study using modified Hofstede cross-cultural parameters ([reference](#)) (power distance, uncertainty avoidance, individualization, “masculinity”) along with temporal considerations and contextual levels, we have demonstrated that physicians are markedly disparate to their host population, their patients.

parties are already “talking the same language.” Thus, the very circumstances that may be discouraging the healthcare industry from using mediation – the inherent difficulty of resolving disputes among culturally diverse parties – is the circumstance that should create the largest demand for mediation.

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

2. The “Complex Adaptive Systems” Factor.

We also agree that medicine represents a complex adaptive system. Recent trends in medicine – including the adoption of patient safety programs to reduce errors, team building, and the application of cockpit management programs – have, if anything, intensified the complexity. (5,6) Potential consumers of mediation services may look to the complexity of their field, and resist mediation out of skepticism that an outsider attempting to mediate could become conversant enough with the subject at hand to be effective resolving the disputes that arise from it.

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

3. The Inequalities and Imbalances of Power Issues.

Power imbalances are common in medical disputes, but that factor appears to us to have the least convincing connection to the unwillingness of the medical industry to use mediation. Such imbalances are often present in business or employment disputes, where mediation has been widely embraced. This is not surprising. Properly handled, mediation is a process that tends to ameliorate the power imbalances, not exacerbate them.

4. The Lack Of Education Factor.

Finally, it is undoubtedly true, as represented in their article, that many, perhaps even most, healthcare professionals are uninformed, or worse, *misinformed* about mediation, and that education is therefore critical for acceptance for non-adversarial

dispute management. But education is “doable,” and the barrier of ignorance is therefore surmountable, particularly in healthcare, where a lifetime of continuing education is itself part of the “culture.” We further agree with Robson and Morrison that the building of alliances and increased contact within the healthcare industry is critical and with that educational programs will become more prevalent.

ADDITIONAL BARRIERS TO MEDIATION WITHIN HEALTHCARE

In addition to those challenges pointed out by Robson and Morrison, there exist other unique challenges to the acceptance of ADR in healthcare. The healthcare industry, although famous for its penchant for new technology and clinical care advances, *is highly resistant to change* when it comes to the manner in which medicine is practiced and the *acceptance of “outsiders”* into the community of caregivers.

A great deal of money is being expended on healthcare distribution, and today’s hospitals exist under extreme pressures of budgetary restrictions. *Money for “outsourcing” to Alternative Dispute Resolution professionals is very limited*, and hospitals continue rely on internal conflict management – an approach that, although cost contained, has met with only limited success, especially in the face of the increasing complexity of intra-hospital conflicts.

In litigated conflicts, the medical profession has always been resistant to going outside the “comfort” of the established litigation process. Although, the process of litigation is a painful one, and their opinions about attorneys often hostile, they are

familiar with the system and continue to demonstrate a strong, albeit sometimes unrealistic, *sense of security with traditional litigation and the court system*. There is also a widespread misunderstanding by healthcare professionals about litigation. They tend as a group to underestimate the emotional, financial and reputational damage wrought by litigation. Their own proclivities can bottleneck resolutions desired by others: professional liability policies such as a medical malpractice policy are the only insurance products in which the insured has the power to decline with impunity a settlement opportunity offered by plaintiff that is acceptable to the insurer.

There is also a *resistance to relinquishing power to others*, and a prevailing attitude that it is up to them to handle their own conflicts. The position they take is, “If I can’t fix it, it can’t be fixed!” Although this is generally the case with most healthcare providers, it is most evident with physicians. It is a time when physicians are feeling their autonomy threatened from many sources: Hospital administrators, Insurance companies, Medical boards, Legislative actions, Malpractice carriers, and even their own patients who, albeit rightfully so, are demanding more collaborative relationships with historically authoritarian physicians.

There is *growing relational stress between administration and private medical staff*, in which highly positional posturing is becoming more prevalent, especially in states that allow the hiring of physicians as employees. Although certainly not insurmountable, it is unquestionably a challenge that is a product of the new “corporate” hospital environment.

However, none of these barriers, outside of medical malpractice disputes, are insurmountable. With increasing familiarity of the process and the introduction of educational programs, especially at the medical and nursing school levels, the eventual acceptance of ADR for the resolution of many healthcare conflicts seems assured.

THE BIG ADDITIONAL BARRIER IMPACTING THE SPECIAL CASE OF MEDICAL MALPRACTICE ACTIONS

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

Consider for a moment the present legislative penalties to settlement from the doctor's perspective:

1. If even one penny is paid to a patient disputant as a result of a negotiated settlement, once a claim or written notice has been filed of allegations of professional negligence, the physician is reported to the National Practitioner's Data Bank (NPDB), regardless of whether it is agreed that the

physician was not blameworthy. This information, although not openly available to the public at the present time, is available to hospitals, state medical boards, medical associations, and insurers, and can directly or indirectly negatively impact the physician's ability to maintain good standing with his or her malpractice carrier, provider contracts, peers and patients, and may even jeopardize hospital staff privileges and medical board status. (7) Many malpractice carriers will insist on reporting all settlements, even on pre-complaint allegations, to the NPDB.

2. If a negotiated amount exceeds the state's reporting limit (California's is \$29,999) then the physician is reported to the State Medical Board, again regardless of blame, or the degree of adverse outcome associated with the claim. (8) This information is considered by the medical board for physician censuring, disciplinary actions including but not limited to licensing restrictions, remedial mandates, and practice restrictions. Such reports made by the state medical board, at least in California, are available to the public for review. (9,10) This reporting process can have an even greater negative impact than NPDB reporting.
3. As a result, for a broad range of cases, "standing firm" is arguably a tactically sound approach for physicians to take. Overall only about 10% of disputes patients want to bring to litigation are accepted for filing by plaintiff attorneys. Approximately 75% of disputes that reach the point of being filed

actions just “go away,” often because the expected recovery is not worth the cost to litigate the case to conclusion (especially in “capped” states). Of cases that go to trial (at least in California) physicians often prevail. Overall, the physician who simply folds his arms and refuses to be engaged in settlement discussion even after a case has been filed has, in general, about a 95% chance of being spared an adverse judgment.(11) Malpractice insurers and defense attorneys recognize and respond to these statistics and are generally resistant to mediation proceedings, particularly early mediation proceedings, that may “breath life into dead cases,” and bring the certainty that the doctor will be reported for any settlement dollars paid. The upshot: Only about 15% of cases settle in pre-trial negotiations or mediations, and a full 10% get resolved through the travails of trial (more than double the ordinary rate for business cases).

The perverse incentive posed by the legislative reporting requirements makes an already bad situation worse. There is already a “cultural” resistance of healthcare providers to admit errors, accept responsibility for adverse outcomes, and openly discuss such matters with their patients.(12,13,14)

But in the current institutional setting, overcoming this attitudinal resistance to settlement will often not be enough. For even if a physician were otherwise prepared to resolve the dispute through facilitated communication, or simply authorize the insurer to proceed to purchase the patient’s offered release, that physician would suffer the pain of a

generally punitive reporting system. When faced with a choice between resolving a conflict with a non-adversarial process and pursuing litigation and likely prevailing, litigation becomes a matter of professional survival (15). The impact of being reported is significant to a doctor's ability to practice in a market of highly competitive provider contracts, tightening institutional staff privileges standards, and rapidly escalating malpractice premiums. According to Barry Schifrin, MD, a nationally recognized specialist in Maternal-Fetal Medicine and a highly respected expert in the area of medical malpractice: These circumstances give insight into the "war metaphor" of Winston Churchill, that is now widely applied within the medical profession, in which the notion becomes, "We are at war, with the very survival of the practitioner and the specialty at stake. Under these circumstances customary rules of engagement can be temporarily suspended." Until we establish reporting reforms and establish some degree of confidentiality for mediated settlements - *along with* providing education about the nature and benefits of mediation – the market for mediation in malpractice actions is destined to remain quite limited.

OTHER AVAILABLE MARKETS FOR MEDIATION WITHIN HEALTHCARE

Although medical malpractice mediation is, at the present time, a limited source for mediation, there are other venues within healthcare that are more readily amenable to the process of mediation. We are presently weathering a healthcare crisis of historic proportions. Last year healthcare distribution costs exceeded 1.6 trillion dollars, up from 750 billion in 2000, and from 1.3 trillion in 2001. (16) Costs related to medical

malpractice, although increasing dramatically from 55 billion in 2000 to 110 billion in 2003, represent only a small portion of healthcare costs. (1,2,3 re-order them) Of course, we must remember that this \$110 billion impacts a very small percentage of individuals physicians, and while this additional crisis deserves considerable attention, it is certainly not the only area of “financial illness” in the healthcare industry. Because malpractice has become such a newsworthy and visible part of the healthcare crisis, we tend to think of it, and its challenges, to be representative of the entire crisis in healthcare. The reality is that it is not: not all healthcare disputes are malpractice disputes, and the breadth of those non-malpractice disputes is *immense*.

An overview of a few developing patterns in this 1.6 trillion dollar industry tells us more than the numbers can:

- According to a major California healthcare insurer, Blue Shield of California, about 90% of that distribution goes to about 10% of insured patients, with the majority of distribution for care within the last 30 to 90 days of life; and much of that money is spent on futile care (care without chance of survival). Hence, the increasing importance of bioethical conflict management, and the specter of rationed care conflicts, which I fear are looming in our near future.

- There are 50 million Americans who do not have health insurance (17) and an increasing percentage of these people are employed, but cannot

afford the cost of healthcare, which continues to rise in the double digits.(18)

- Medical advances have historically been associated with claims of malpractice, based both on an “outcome learning curve,” and the recognition of previously unknown complications associated with new technologies and medications. As such, the present conflicts and resultant costs associated with litigation and the protection of R&D companies’ from potential litigation from unforeseen complications are not insignificant, and at least to some degree are passed on to the consumer.

- Financial stresses and organizational restructuring of medical institutions and medical staffs, have created new areas of conflict within hospitals and staff. A few of these conflicts are associated with:
 1. There is a growing adversarial relationship between attending physician staff and hospital administrators.
 2. “Turf Wars” between different specialties and “hospitalists” versus private attendings are on the rise.
 3. JACHO and public pressure has created an urgent need to address patient safety, which has created system integration conflicts and staff conflicts over responsibility for organizational (complex hospital based) errors. In addition, many more hospitals are introducing “Early

Intervention Services” to address patient satisfaction concerns and unanticipated outcomes.

These patterns alone suggest several areas of growing social need for ADR, other than resolving malpractice lawsuits, including:

- **Medical Education Programs**
 - o Programs for healthcare providers and medical students in communication skills & conflict prevention and management
- **Intra-Institutional Conflict Management**
 - o Mediation, including consensus building mediation, for conflicts within medical institutions pertaining to patient safety, risk management, integrated system management, staff privilege and quality management
- **New Drug and Technology Disputes**
 - o Mediation for conflicts arising from availability of and unanticipated outcomes from new drugs and new technologies
- **Medical Staff Privileges & Licensing Disputes**
 - o The establishment of a hierarchal system of review that is founded on remediation and patient safety. One proposed system includes the substitution of the Judicial Review Committees (JRC) with mediation/arbitration for staff privilege disputes.
 - Of note, California already has a binding arbitration alternative to JRC, however to date it is rarely utilized,

- **Professional Associations**
 - o Conflict resolution and consensus building between, such as MA (medical associations) and HA (hospital associations), and among the constituents of those associations in conflicts pertaining to such matters as staff privileges, hospital by-law modifications.

- **Bio-Ethical & Rationed Care Conflicts**
 - o Conflicts over restricted or rationed care
 - o Conflict over “futile care” or care for patients who have no chance for survival, especially those who have been comatose for greater than three months. (19)

- **Quality of Care Conflicts**
 - o Conflict involving:
 - patient satisfaction issues
 - unanticipated outcomes.

SUMMARY

We applaud the efforts of Robson and Morrison, and feel that they have accurately portrayed many challenges to mediation in medical malpractice. We feel however, that there are other barriers leading to resistance to mediation in healthcare, especially in medical malpractice disputes, including: resistance to change, poor acceptance of outsiders, budgetary limitations, false sense of security with the litigation and court system, resistance to relinquishing power to others, and growing relational stress between administration and private medical staff.

We believe that the majority of resistance to mediation, in malpractice disputes, is associated with the existing punitive reporting system, physicians' misimpression of the litigation process, the existing statistics for physicians prevailing in the litigated arena, and the recalcitrance of physicians, their insurers, and defense attorneys to stray from the comfort of a system on which they have become dependent. Essentially, even if a physician wished to negotiate a settlement, regardless of whether the care was negligent, he/she cannot afford the consequences it may have on his ability to survive in the field and continue to practice. We believe that at the present time mediation for medical malpractice cases will continue to be primarily a tool for 11th hour distributive bargaining.

We do, however, believe that there are many areas within healthcare other than medical malpractice cases that are ripe for mediation and, although burdened with some unique challenges, are not faced with the same barriers as in medical malpractice. With the present healthcare distribution crises of 1.6 trillion dollars per year and increasing, the inability to insure our population for healthcare costs, the specter of rationed care and limited availability of new costly technology, we face many new areas of conflict that must be resolved in a timely, cost-effective, and non-adversarial manner.

We must remember that Healthcare professionals, although quick to apply new technologies, are admittedly slow to change in their "practice" behavior. However, *once accepted*, a new methodology is generally embraced widely and becomes a nationwide standard in a short time. Intra-hospital markets will begin to seek out mediation more frequently when it is demonstrated that the mediation process is cost effective, non-

punitive, time conserving, and effective for the resolution, not just the settlement, of healthcare conflicts.

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

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