ESCAPING THE SHADOW OF MALPRACTICE LAW

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I

INTRODUCTION

Medical malpractice doctrine is one of the core issues in the current debate over healthcare reform in the United States. For decades now, it has been universally accepted that the threat or reality of formal litigation stemming from—or at least claiming—malpractice has been the single most important factor shaping the medico–legal arena. While conventional wisdom has it that patient safety is and should be our paramount concern, the proliferation of malpractice claims has dramatically increased the costs of medical care and has adversely affected its quality due to the emergence of "defensive medicine" and an ensuing "brain drain" from certain medical specialties. Based on empirical findings, this article argues that this view is at once overly broad and overly narrow. First, the preoccupation with malpractice suits has served to overshadow the importance of other, more common disputes that have a profound impact on the medical environment. Second, much of the discourse has tended to overlook the pernicious byproduct of malpractice law that I term "defensive communication"—a mode of interaction designed to protect practitioners from malpractice suits, but which, in fact, breeds conflict and serves as a barrier to resolution efforts. Both the importance of non-malpractice disputes and the spread of defensive communication have often gone unnoticed in the legal and medical communities. Our prevailing understanding of the daily reality of doctor–patient relations has therefore been incomplete in two central

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spheres, hindering efforts to reform medical-malpractice law and to improve healthcare services.

These empirical findings are drawn from a qualitative research project examining the culture of disputing at one hospital. More specifically, the study analyzed the prevalent types of disputes, existing avenues for addressing them, and the potential of Alternative Dispute Resolution (ADR)- and mediation-based skills for effectively resolving and preventing conflict in two of the hospital units. This close inspection of the quotidian reality in medical settings reveals that the most common types of disputes in day-to-day hospital life are small-scale conflicts over such matters as long waits, having to vacate a bed, being transferred to another department or institution, or even a doctor's tone of voice. These "little injustices"[1] are typically ignored or dealt with on an ad hoc basis; in some cases, they lead to a formal complaint, but they are only rarely litigated. I therefore refer to them as "non-litigable disputes."[2]

As the findings of this research project reveal, despite the "small scale" nature of these conflicts, their cumulative impact is by no means trivial. Non-litigable disputes are widespread[3] and exact a high toll, not only from disgruntled patients and their angry families, but also from worn out medical staff. Doctors and nurses describe their workplace as a battlefield, an environment fraught with disputes, which detracts not only from clinicians' well-being but also, ultimately, from the quality of healthcare they deliver. Despite these compelling descriptions, we find that non-litigable disputes tend to be addressed unsatisfactorily, if at all.

Most non-litigable disputes arise from miscommunication or are exacerbated by it, and, as such, could, in theory, be addressed effectively through ADR or through the advancement of ADR-based communication skills among medical staff. Indeed, there have been numerous efforts over the years to introduce ADR mechanisms into hospitals (and the healthcare arena more generally) as well as serious attempts to enhance medical staffs' (in particular, doctors') communication skills. However, many of these initiatives have stemmed from a malpractice-driven agenda, offering these processes for the resolution of malpractice claims, as a means for preempting litigation in the aftermath of a medical mishap or preventing medical errors from occurring.

But the limitations of efforts to introduce ADR into healthcare and to enhance the communication skills of healthcare professionals are also a key to revealing the limitations in our understanding of malpractice and its enormous,

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1. *Odyssey: Little Injustices: Laura Nader Looks at the Law* (PBS television broadcast 1981). I thank Carrie Menkel-Meadow for referring me to this source. In the healthcare arena, Carol Liebman has used the term "micro-insults" to describe these disputes. Telephone Conversation with Carol Liebman, Clinical Professor of Law, Columbia University (Feb. 15, 2010).

2. Clearly, in extreme cases, they could actually present a legal cause of action and could merit a claim in cost-benefit terms.

3. *See infra* Part II.B. These qualitative data are reinforced by other data on patient complaints. *See infra* notes 6–7.

though often invisible, impact. As the analysis of the empirical findings reveals, healthcare practitioners actively adopt a mode of communication that is hierarchical, closed, and confrontational because they feel that it shields them from malpractice liability. The literature has typically attributed this mode of communication to the paternalistic nature of the culture of the medical profession, but my findings indicate that there seems to be an additional force sustaining this communication style—the desire to obscure medical decisions and protect healthcare professionals from liability. I therefore term this mode of communication "defensive communication." Since it is antithetical to the principles of ADR, which is based on open and collaborative communication, defensive communication serves as a barrier to the informal resolution of individual disputes, to the adoption of ADR processes in the healthcare setting, and to the inculcation of more flexible communication skills in clinicians. Ironically, as previous research has revealed, by maintaining traditional communication modes, medical staffs actually increase the likelihood of professional errors,[4] of being sued on account of a medical mishap,[5] and, as this research demonstrates, defensive communication further breeds non-litigable disputes. In this fashion, the shadow of legal doctrine provides distorted incentives which yield suboptimal results: high conflict rates, difficulties in communication, limited avenues for addressing disputes, and increased risk of litigation. Most important, this state of affairs has affected not only the manner in which members of medical staffs communicate, but also the quality of services they provide.

The article addresses several constituencies operating at the meeting point of ADR, communication theory, healthcare policy, and medical-malpractice doctrine. From an ADR perspective, the article shifts the focus from the resolution of malpractice claims to the need for, and barriers to, addressing non-litigable disputes, for which the "alternative" route is the only one. At the same time, the article shows that ADR mechanisms may not take root when introduced into an environment that is resistant to collaborative and open discourse without additional incentives and measures being adopted. The article also revisits the well-known notion of the "shadow of the law," exploring how the spread and influence of legal arrangements can reach well beyond their substantive subject matter, with malpractice law shaping the manner in which other types of disputes are addressed in the hospital setting. In terms of

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4. *See* Dale C. Hetzler et al., *Curing Conflict: A Prescription for ADR in Healthcare*, DISP. RESOL. MAG., Fall 2004, at 5, 6 ("[T]eam communication failure is a top contributor to severe injuries, and one study shows that 70 to 80 percent of errors are associated with interpersonal interaction breakdowns."); Benjamin B. Taylor et al., *Do Medical Inpatients Who Report Poor Service Quality Experience More Adverse Events and Medical Errors?*, 46 MED. CARE 224, 226 (2008) (finding a correlation between patient reported deficiencies with respect to quality of services and medical errors or adverse events).

5. Grant Wood Geckeler, *The Clinton–Obama Approach to Medical Malpractice Reform: Reviving the Most Meaningful Features of Alternative Dispute Resolution*, 8 PEPP. DISP. RESOL. L.J. 171, 178 (2007) ("Other key studies have demonstrated that sharing medical errors can actually decrease physicians' likelihood of being sued.").

communication theory, the article identifies a novel source for healthcare professionals' dominant form of communication, as well as a new understanding of the potential and the obstacles to alter such a mode of communication. Finally, in the areas of healthcare policy and legal doctrine, the research sheds new light on some of the reasons for a history of failed reform efforts as well as the prospects for generating change through law, professional training, or organizational transformation.

The article examines its main theses as follows: Part II offers a brief overview of disputes and dispute-resolution efforts in the medical setting as they are typically perceived and described in the literature. This summary demonstrates the current near-exclusive focus on malpractice-related disputes and the common explanation given for the barriers to addressing disputes satisfactorily in the healthcare setting. Parts III and IV offer fresh data that undermine the current understanding of disputes between patients and their caregivers, and of the barriers that hinder effective dispute resolution. The data were gathered in a study of the oncology department and the emergency room of an Israeli hospital. In each unit, professional mediators offered a two-day mediation-skills workshop to a group of up to twenty-five participants, which included a diverse group of employees from the relevant unit. The workshops served both as arenas for gathering data on dispute types and the manner in which disputes are handled, and as bases for studying the relevance and applicability of the skills introduced during the workshop to the hospital setting. The data collected included researcher notes from the workshops; questionnaires distributed at the end of the second day of the workshop; anonymous follow-up questionnaires; and individual interviews with several participants from each workshop and hospital employees, the combination of which provided rich insights on the sources of disputes at the hospital and barriers towards their effective resolution. Based on these findings, in part III, I describe an alternative reality to the "common story," one in which non-litigable disputes occupy center stage. This description presents the principal themes that emerged from the empirical findings collected in the qualitative study of the disputing culture at that hospital. The analysis in part IV ties the research findings to legal malpractice, one of the themes that was identified in the findings and that served as a prism for a reexamination and analysis of the data. The connection lies in the adoption of defensive communication by the hospital staff, a mode of communication that both breeds non-litigable disputes and presents a barrier to the application of ADR tools and skills for their resolution. Part V develops some of the theoretical implications of the research findings. The article concludes with thoughts on the conditions under which the shadow of malpractice law might be lifted by addressing a broader dispute base through ADR and by attending to the underlying incentives provided by the legal system.

While the research presented in the paper was conducted at an Israeli hospital, it is my contention that the findings are applicable and relevant for the American healthcare arena as well. Despite major differences between the

structure and nature of the American and Israeli healthcare systems, data relating to the other hospitals in Israel[6] and to the American setting[7] support the conclusion that there should be significant similarities between the findings on complaints and disputes in Israel and those that would be found in the United States, certainly in public institutions.[8] Interestingly, the two healthcare systems share similar overarching trends, in particular the dominance of malpractice and the emergence of defensive medicine.[9] I therefore analyze the "common story" about the trends in healthcare by focusing on the American setting, where developments have preceded, and often influenced those that have taken place in Israel in later years.

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6. Interviews with hospital ombudsmen from sixteen major hospitals in Israel (out of a total of twenty-six hospitals) conducted in the period from October 2008 through July 2009 confirm the prevalence of non-litigable disputes. The interviews were conducted as part of another research project and are on file with author.

7. *See* Gerald B. Hickson et al., *Patient Complaints and Malpractice Risk*, 287 J. AM. MED. ASS'N 2951, 2951 (2002) ("[R]isk [of suit] appears related to patients' dissatisfaction with their physicians' ability to establish rapport, provide access, administer care and treatment consistent with expectations, and communicate effectively."); Armand H. Matheny Antommaria, *How Can I Give Her IV Antibiotics at Home When I Have Three Other Children to Care For? Using Dispute System Design to Address Patient Provider Conflicts in Health Care*, 29 HAMLINE J. OF PUB. L. & POL'Y 273, 274–76 (2007) (exploring examples of different types of patient–provider disputes, some of which would fall under this article's definition of non-litigable disputes); Theresa Montini et al., *Content Analysis of Patient Complaints*, 20 INT'L J. FOR QUALITY HEALTH CARE 412, 412–13 (2008) (establishing a standardized aggregation method for patient complaints based on the findings of Hickson et al.); James W. Pichert et al., *Using Patient Complaints To Promote Patient Safety*, *in* AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, AHRQ PUB. 08-0034-2, 2 ADVANCES IN PATIENT SAFETY: NEW DIRECTIONS AND ALTERNATIVE APPROACHES 1–2 (2008), *available at* http://www.ahrq.gov/downloads/pub/advances2/vol2/Advances-Pichert_51.pdf.

8. At first blush, the comparison between these two disputing cultures may seem surprising in light of the cultural differences in terms of communication patterns (low-context versus high-context communication) and the degree of hierarchy that exists in each of the cultures (hierarchical versus egalitarian cultures). *See* JEANNE BRETT, NEGOTIATING GLOBALLY 34–41 (2001). Nevertheless, as shown in *supra* notes 6–7 and in *infra* notes 75–77, the reality is one in which similarities exist, not only in terms of the impact of malpractice litigation, but also in the prevalence of non-litigable disputes. One possible explanation is the broad influence that the American medical profession has had on its Israeli counterpart with many Israeli doctors studying and specializing in the United States. Another explanation could be the more general impact that the American legal tradition and American culture have had on Israeli society. For the impact on the legal culture, see generally MENACHEM MAUTNER, YERIDAT HAFORMALISM VE ALIAT HAARACHEEM BAMISHPAT HAISRAELI [THE DECLINE OF FORMALISM AND THE RISE OF VALUES IN ISRAELI LAW] (1993).

9. For the state of affairs in the United States, see *infra* notes 10–18, 35–41 and accompanying text. For the situation in Israel, see generally Ronit Harel, *Meheer Hahitgonenut* [*The Cost of Defense*], 14 ZMAN HAREFUA 8 (2004) (Isr.); *infra* note 17 and accompanying text.

II

THE COMMON STORY: DISPUTES AND DISPUTE RESOLUTION IN THE MEDICAL ARENA

A. Disputes Between Patients and Healthcare Professionals

When we examine the developments in the relations between patients and healthcare professionals in recent decades, the proliferation of malpractice litigation is at the forefront.[10] Medical errors have been found to be the eighth leading cause of death in the United States[11] and one of every seven doctors is sued every year.[12] Related litigation has led to a significant rise in insurance costs and, consequently, the practice of defensive medicine or, in the case of certain areas, a drain in medical staff.[13] These developments, in turn, have generated vigorous reform efforts, mainly in the 1970s and 1980s,[14] but also more recently.[15] Nevertheless, the problems stemming from medical-malpractice

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10. As of the mid-1970s, the United States has been addressing a crisis in malpractice (described by some as a series of crises). *See* Geckeler, *supra* note 5, at 173–75. In Israel also, malpractice litigation seems to be on the rise, with a total of 4,560 malpractice claims filed between the years 1993 and 2002. *See* Tamar Calahorra, *Tviot Rashlanut Refuit: Beyn Tzracheyha Shel Maarechet Habriut Leveyn Hashavat Matzavo Shel Hanizok le Kadmutu, Baespeklarya Shel Doch Vaadat Spanic* [*Medical Malpractice Claims: The Needs of The Health System v. Rectification of Harm—From The Perspective of The Spanic Committee*], 6 MISHPAT VE ASAKEEM [L. & BUS.] 389, 398 (2005) (Isr.); DEEN VE HESHBON HAVAADA HEBEYN MISRADEET LIVHEENAT HADRACHEEM LEHAKTANAT HAHOTZAA HATZIBURIT BEGEEN TVIOT RASHLANUT REFUIT [SPANIC COMMITTEE REPORT] III–IV (2005), *available at* http://www.justice.gov.il/NR/rdonlyres/C2C6D084-3D19-409C-90EF-75B081BB93A3/4130/rashlanut.pdf (describing the methodology used to locate such claims, but also asserting that they cannot state with absolute certainty that all such claims were located, nor could they factor other changes such as population growth or compare the increase in malpractice claims to the general increase in other types of tort cases).

11. *Executive Summary*, TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 1 (Linda T. Kohn et al. eds., 2000), *available at* http://www.nap.edu/openbook.php?record_id=9728&page=1.

12. Heidi P. Forster et al., *Reducing Legal Risk by Practicing Patient-Centered Medicine*, 162 ARCHIVES INTERNAL MED. 1217, 1217 (2002).

13. Gary A. Balcerzak & Kathryn K. Leonhardt, *Alternative Dispute Resolution in Healthcare: A Prescription for Increasing Disclosure and Improving Patient Safety,* PATIENT SAFETY & QUALITY HEALTHCARE (July–Aug. 2008) (discussing physicians' reluctance to discuss medical issues after a medical mistake or unforeseen medical outcome), *available at* http://www.psqh.com/julaug08/resolution.html; Carol B. Liebman & Chris Stern Hyman, *A Mediation Skills Model To Manage Disclosure of Errors and Adverse Events to Patients*, 23 HEALTH AFF. 22, 22 (2004) (describing the impact of malpractice litigation on physician's access to malpractice insurance); Michelle Mello et al., *Effects of a Malpractice Crisis on Specialist Supply and Patient Access to Care,* 242 ANNALS SURGERY 621, 626–27 (2005) (describing a brain drain in certain high-risk specialties).

14. Thomas B. Metzloff & Frank A. Sloan, *Foreword*, 60 LAW & CONTEMP. PROBS. 1, 1 (Winter 1997).

15. Florence Yee, Note, *Mandatory Mediation: The Extra Dose Needed To Cure the Medical Malpractice Crisis,* 7 CARDOZO J. CONFLICT RESOL. 393, 431–43 (2006).

litigation have, by and large, continued, and public attention,[16] healthcare public policy,[17] and the medical profession[18] have continuously centered on malpractice.

A primary source for the rise of medical-malpractice litigation has been the shifting power relations between doctors and patients. In recent decades, several forces have joined to strengthen patients and weaken the medical profession, thereby altering traditional relationships between patients and their caregivers. In terms of patient empowerment, these changes are mostly attributable to the legal recognition of individual patient rights[19] and the rise of consumer rights, developments that have been strengthened by the healthcare industry's own commercial interests.[20] At the same time, the medical profession has declined,[21] experiencing a brain drain in particular fields of medicine[22] and extreme financial crises at public and community hospitals.[23] Widespread availability of medical information has made patients more informed,[24] but has also made it ever more difficult for doctors to maintain the level of expertise they had in the past.[25] These developments have undermined doctors' authority

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16. In a search of the *New York Times* archives between the January 2000 and August 2009, the term "medical malpractice" came up 522 times.

17. Despite persistent reform efforts over the years, no general reform was adopted on the federal level, but some changes were introduced. *See, e.g.*, Jonathan Todres, *Toward Healing and Restoration for All: Reframing Medical Malpractice Reform*, 39 CONN. L. REV. 667, 693–704 (2006) (surveying various reform efforts); Geckeler, *supra* note 5, at 183. In Israel, four separate official committees have studied the phenomenon in the last two decades, but there has been no real change to the legal regime in this area. Calahorra, *supra* note 10, at 392, 392 n.6.

18. *See infra* note 43.

19. In terms of patient rights, in the 1970s, a series of court decisions made way for a new approach enshrining patients' right to make informed medical decisions and to view and correct their medical records, and delineated the care team's corresponding duties. *See* George J. Annas, *A National Bill of Patients' Rights*, 338 NEW ENG. J. MED. 695, 695–96 (1998); Marc A. Rodwin, *Patient Accountability and the Quality of Care: Lessons from Medical Consumerism and the Patients' Rights, Women's Health and Disability Rights Movements*, 20 AM. J.L. & MED. 147, 150–52 (1994). Several decades after the rise of the patient rights movement in the United States, we see a similar transformation in Israel. *See* The National Health Act, 5754-1994, SH No. 230 (Isr.); Patients' Rights Act, 5756-1996, SH No. 327 (Isr.).

20. Hospitals are increasingly being driven by competition and commercial considerations, seeking to simultaneously draw more patients and reduce expenditures. These changes have put certain departments under severe pressure, but have also given *some* patients suffering from *certain* illnesses more power. *See* Louise G. Trubek, *New Governance and Soft Law in Health Care Reform*, 3 IND. HEALTH L. REV. 137, 157–59 (2006). In Israel, similar changes have taken place. *See* CARMEL SHALEV, BRIUT, MISHPAT VE ZCHUYOT HAADAM [HEALTH LAW AND HUMAN RIGHTS] 21 (2003) (Isr.).

21. Marion Crain, *The Transformation of the Professional Workforce*, 79 CHI.-KENT L. REV. 543, 564–71 (2004); Herbert Kritzer, *The Professions Are Dead, Long Live the Professions: Legal Practice in a Post-Professional World*, 33 LAW & SOC'Y REV. 713, 714–15 (1999); George Ritzer & David Walczak, *Rationalization and the Deprofessionalization of Physicians*, 67 SOC. FORCES 1, 7–15 (1988).

22. Yee, *supra* note 15, at 399–400.

23. *See* John D. Blum, *Beyond the Bylaws: Hospital–Physician Relationships, Economics and Conflicting Agendas*, 53 BUFF. L. REV. 459, 463 (2005).

24. P. Greg Gulick, *E-health and the Future of Medicine: The Economic, Legal, Regulatory, Cultural and Organizational Obstacles Facing Telemedicine and Cybermedicine Programs*, 12 ALB. L.J. SCI. & TECH. 351, 373 (2001–2002).

25. David. R. Riemer, *Follow the Money: The Impact of Consumer Choice and Economic Incentives on Conflict Resolution in Health Care*, 29 HAMLINE J. PUB. L. & POL'Y 423, 425 (2008).

and have deeply altered the doctor–patient relationship. These changes have allowed patients to more frequently contest the course of treatment recommended by the healthcare team, generating arguments prior to and during medical treatment, and malpractice accusations and claims in retrospect.

Patient empowerment stemming from the sources described above has not only been a major factor in the emergence and expansion of malpractice litigation, but has also generated substantial friction over small-scale matters stemming from staff demeanor, long waits, and the like. These types of problems, to which I refer as non-litigable, typically result from miscommunication (or the lack of communication altogether) and are usually not the subject matter of litigation. This is because, in many cases, the ensuing conflict does not constitute a legal cause of action as the patient or family members, despite feeling hurt, cannot point to a breach of their legal rights. Naturally, non-litigable disputes have been reinforced by public hospitals' financial crisis, which has placed the medical team at the forefront, having to explain the delays and cutbacks to anxious and angry patients and their families.

Despite their prominence in the daily delivery of medical services,[26] non-litigable disputes have rarely attracted attention.[27] In most instances, attention has been directed elsewhere, with attempts to handle conflict between patients and the care team concentrating on malpractice. This is perhaps most evident in the two areas through which non-litigable disputes could best be addressed: the establishment of non-rights-based dispute-resolution channels into the hospital setting, and the enhancement of doctors' and nurses' communication skills and training.

In practice, efforts to introduce ombudsmen and other ADR programs into hospitals have in many cases targeted actual or potential malpractice claims.[28] There are, of course, significant exceptions, such as Carol Liebman and Nancy

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26. *See supra* note 3.

27. Naturally, it is difficult to point to what is not out there, but this dearth of research has been noted previously. *See* Barbara Beardwood et al., *Complaints Against Nurses: A Reflection of "The New Managerialism" and Consumerism in Health Care?*, 48 SOC. SCI. & MED. 363, 364 (1999).

28. *See infra* note 59. Some tort-reform initiatives have included the institutionalization of ADR channels, mainly mediation, for addressing individual malpractice claims. Despite its potential to successfully resolve malpractice claims, mediation (as ADR in general) failed to produce an attractive avenue for addressing such claims primarily because post-litigation mediation of malpractice claims is dominated by lawyers and insurance claims representatives, and the process fails to address underlying interests. *See* Thomas B. Metzloff et al., *Empirical Perspectives on Mediation and Malpractice*, 60 LAW & CONTEMP. PROBS. 107, 151 (Winter 1997) (analyzing a North Carolina mediation program); Tamara Relis, *Consequences of Power*, 12 HARV. NEGOT. L. REV. 445, 451 (2007) (arguing that lawyers' goals are different from their clients' and are diminishing the effectiveness of mediation); Leonard L. Riskin & Nancy A. Welsh, *Is That All There Is?: "The Problem" in Court-Oriented Mediation*, 15 GEO. MASON L. REV. 863, 867–77 (2008); Liebman & Hyman, *supra* note 13, at 30. In Israel, there is no specific targeting of malpractice claims for ADR, but such cases are, in practice, referred to mediation as part of a general attempt to clear the courts' dockets under section 79C of the Courts Law, 5744-1984, S.H. 198 (Isr.).

Dubler's pioneering work on the mediation of bioethics disputes at hospitals.[29] Also, some hospitals do offer ombudsmen services which target a broader dispute base that includes small-scale problems,[30] but the focus has remained on malpractice. Similarly, the move to enhance doctor communication skills, which has brought about real change in the curriculum of some medical schools[31] and in the training at some hospitals, has largely remained focused on the benefits of such skills in preventing medical mistakes[32] and in discussing such mishaps when they take place.[33] Even in this limited realm, ADR and consistent efforts to enhance doctor communication skills have failed to transform doctor–patient relations. The following section elaborates on these efforts and the barriers to their success.

B. Dispute Resolution between Patients and Healthcare Professionals

There is wide agreement that the current malpractice regime is unsuccessful. One dominant source of discontent is the failure of malpractice litigation to achieve the very goals it was designed to promote, including the compensation

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

30. Edward Dauer & Leonard J. Marcus, *Adapting Mediation To Link Resolution of Medical Malpractice Disputes with Health Care Quality Improvement*, 60 LAW & CONTEMP. PROBS. 185, 205 (Winter 1997) (describing the VMP program that handles a portion of the "myriad of [complaints voiced by] dissatisfied patients with legitimate concerns about conduct, outcomes, or communication"); Virginia L. Morrison, *Heyoka: The Shifting Shape of Dispute Resolution in Healthcare*, 21 GA. ST. U. L. REV. 931, 936–38 (2005).

31. *See*, *Medical Education Reform*, HARVARD MEDICAL SCHOOL, http://hms.harvard.edu/org.asp?mededrefrm (last visited Aug. 23, 2009); Rich Barlow, *Medical Education Reform—Coordinating the Educational Experience*, FOCUS ONLINE—NEWS FROM HARVARD MEDICAL, DENTAL, AND PUBLIC HEALTH SCHOOL (June 9, 2006), http://archives.focus.hms.harvard.edu/2006/060906/meded_reform_vig7.shtml. *See also* Hui Ching-Weng et al., *Doctors' Emotional Intelligence and the Patient–Doctor Relationship*, 42 MED. EDUC. 701, 701 (2008); ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION, COMMON PROGRAM REQUIREMENTS: GENERAL COMPETENCIES (Feb. 13, 2007), *available at* http://www.acgme.org/outcome/comp/GeneralCompetenciesStandards21307.pdf; Boston Children's Hospital, *The Program to Enhance Relational and Communication Skills*, http://www.childrenshospital.org/clinicalservices/Site755/mainpageS755P0.html (last visited Sept. 12, 2010).

32. The driving force behind these trainings and courses in most cases seems to be malpractice claims and the desire to prevent medical errors. *See* Richard C. Boothman et al., *A Better Approach to Medical Malpractice Claims? The University of Michigan Experience*, 2 J. HEALTH & LIFE SCI. L. 125, 137–46 (2009) (discussing the University of Michigan's approach to malpractice claims); Wendy Levinson et al., *Physician–Patient Communication: The Relationship with Malpractice Claims Among Primary Care Physicians and Surgeons*, 277 J. AM. MED. ASS'N 553, 554 (1997) (reporting the results of a study of physician–patient communication whose "results are important to insurance companies and physician organizations that seek to educate physicians"); Bernard B. Virshup et al., *Strategic Risk Management: Reducing Malpractice Claims Through More Effective Patient–Doctor Communication*, 14 AM. J. MED. QUALITY, 153, 153 (1999) (discussing a continuing medical education seminar aimed at diminishing risk of malpractice suits); Liebman & Hyman, *supra* note 13, at 23–24, 23–24 nn.9–12 (discussing mediation as a means of avoiding litigation and improving care). But some of these changes were prompted by a desire to address consumer concerns. *See* Marc A. Rodwin, *Exit and Voice in American Health Care*, 32 U. MICH. J.L. REFORM 1041, 1061–65 (1999) (discussing mechanisms for consumer empowerment in managed care organizations).

33. Jonathan R. Cohen, *Apology and Organizations: Exploring an Example from Medical Practice*, 27 FORDHAM URB. L.J. 1447, 1451, 1455–58, 1468–73 (2000); Liebman & Hyman, *supra* note 13, at 23.

of individual complainants and the enhancement of patient safety.[34] Instead, malpractice litigation, the high awards, and rising insurance rates for doctors have given rise to what has been termed defensive medicine, a development which has harmed patients and diminished the quality of healthcare.[35] Specifically, defensive medicine refers to a variety of practices by the healthcare team (mainly doctors) that are not guided by the best interests of the patient, but by a fear of future liability for the decisions they make. Therefore, defensive medicine is often manifested in a reluctance to take responsibility and reach decisive decisions as well as ordering a series of superfluous tests out of extreme cautiousness.[36] This conduct carries obvious costs, first and foremost due to the added expenses associated with the redundant tests ordered by healthcare staff,[37] but also stemming from other, more subtle consequences.[38] Many of these added costs are extremely difficult to locate and quantify,[39] but there seems to be abundant evidence for the existence of this phenomenon and some indication that the costs associated with it are substantial.[40] It should therefore

34. Malpractice litigation has been criticized for failing to achieve the very goals it was designed to promote: corrective justice for the individual plaintiff and deterrence for society as a whole. Dauer & Marcus, *supra* note 30, at 185; Liebman & Hyman, *supra* note 13, at 22. There are several reasons for the failure to reach adequate deterrence levels. For one, barriers to claims have skewed the pool of cases that reach the courts, sending distorted signals to the healthcare system. *See* Dauer & Marcus, *supra* note 30, at 189–90; Geckeler, *supra* note 5, at 176, 176 n.37. Even in those cases where malpractice suits have been filed, doctors have attributed the claims to their practice area or misfortune. *See* Hickson et al., *supra* note 7, at 2951. Another source of dissatisfaction for patients and their families is the legal course of action. Nadav Davidovitch & Avital Margalit, *Public Health, Racial Tensions, and Body Politic: Mass Ringworm Irradiation in Israel, 1949–1960*, 36 J.L. MED. & ETHICS 522, 526–28 (2008); Dauer & Marcus, *supra* note 30, at 185–86, 201–05.

35. Even though the medical staff does not bear the financial consequences of a successful suit because of insurance coverage, the prospect of being found negligent has a real impact on doctors' well-being, and doctors who face malpractice litigation are profoundly distressed over the harm to their reputation. *See* Samuel R. Gross & Kent D. Syverud, *Getting to No: A Study of Settlement Negotiations and the Selection of Cases for Trial,* 90 MICH. L. REV. 319, 360–67 (1991); Charity Scott, *Foreword to the Symposium: Therapeutic Approaches to ADR in Health Care Settings*, 21 GA. ST. U. L. REV. 797, 797–98 (2005). Medical malpractice and defensive medicine have also been a major source of concern for the Israeli healthcare (and legal) systems. *See* DEEN VE HESHBON HAVAADA LEBDIKAT HAACHRAYUT LEPGEEYA BETIPUL REFUEE, REPORT OF THE COMMITTEE TO EXAMINE RESPONSIBILITY FOR INJURY IN MEDICAL TREATMENT [THE KLING COMMITTEE] 13 (1999), *available at* http://www.health.gov.il/units/response/index.htm.

36. Todres, *supra* note 17, at 683–85.

37. *See* Gerald B. Hickson et al., *Development of an Early Identification and Response Model of Malpractice Prevention*, 60 LAW & CONTEMP. PROBS. 7, 8 (Winter 1997).

38. When doctors engage in defensive medicine, decisions take longer to make and thus, patients spend more time at the hospital and are attended to by additional staff members and experts who devote their precious time to unnecessary examinations. Another cost is borne by the patients and has to do with the risks associated with some of the unnecessary tests and procedures they are being put through and the danger and complications to those patients who need these treatments but now have to wait longer to receive them. *See supra* note 36.

39. Metzloff & Sloan, *supra* note 14, at 3.

40. Michael Daly, *Attacking Defensive Medicine Through the Utilization of Practice Parameters: Panacea or Placebo for the Health Care Reform Movement*, 16 J. LEGAL MED. 101, 101–02 (1995); Daniel Kessler & Mark McClellan, *Do Doctors Practice Defensive Medicine?*, 111 Q.J. ECON. 353, 386

come as no surprise that the rise of malpractice and the ensuing proliferation of defensive medicine have become the most significant factors shaping the healthcare arena in recent decades and this has generated rigorous reform efforts.[41]

Disappointment with malpractice litigation led to the adoption of alternative avenues for the resolution of malpractice claims in two major forms: (1) institutionalizing ADR processes for the resolution of patient complaints and (2) placing an emphasis on communication-skills training for medical staff.

Indeed, a close examination of the nature of medical training in the last few decades reveals real changes; in particular, the increased emphasis on doctor–patient communication and the development of the communication skills of healthcare staff. One of the principal motivations for these changes has been the rise of malpractice litigation,[42] which has generated a series of reports analyzing the state of the profession and offering avenues for improvement of the healthcare system through training.[43] Some of the ensuing reforms have led to the introduction of curricular changes aimed at transforming the communication culture in the healthcare setting.[44] These reforms were based on the recognition that (1) some medical mistakes result from communication problems,[45] and (2) the decision to sue following a medical mistake is heavily influenced by communication patterns with the medical team when disclosing the event to the patient or family.[46]

Since research has revealed that the decision whether to sue depends less on the nature of the triggering event (its characteristics and severity) but largely on the question of communication between the medical staff and the patients and their families, enhancing the communication skills of medical professionals was

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(1996); Roger A. Reynolds et al., *The Cost of Medical Professional Liability*, 257 J. AM. MED. ASS'N 2776, 2776 (1987).

41. *But see generally* TOM BAKER, THE MEDICAL MALPRACTICE MYTH (2005) (questioning common claims about a flood of litigation by demonstrating that many injured parties do not file malpractice claims at all).

42. *See supra* note 32.

43. One of the most influential documents, TO ERR IS HUMAN, *supra* note 11, a report published in 1999 by the Institute of Medicine, offers a comprehensive strategy for reducing medical errors, one that recognizes that human errors are inevitable, but that systems, organizations, and practices can be improved so as to prevent some mistakes from occurring. In the past, reforms were adopted that focused on such measures as limiting the workload on residents, which have been viewed as insufficient. Just recently, another round of changes aimed at reducing medical errors was proposed by a national panel of medical experts. *See* Tara Parker Pope, *Panel Calls for Changes in Doctor Training*, N.Y. TIMES, Dec. 2, 2008, *available at* http://well.blogs.nytimes.com/2008/12/02/panel-calls-for-changes-in-doctor-training/.

44. *See* Bobbi McAdoo, *Physicians: Listen Up and Take Your Communication Skills Training Seriously*, 29 HAMLINE J. PUB. L. & POL'Y 287, 289–93 (2008) (describing the impressive effort to introduce communication skills training into the curriculum of medical schools in the years since the publication of *To Err is Human*).

45. *See supra* note 4.

46. Donald J. Cegala & Stefne Lenzmeier Broz, *Physician Communication Skills Training: A Review of Theoretical Backgrounds, Objectives and Skills*, 36 MED. EDUC. 1004, 1004 (2002); Hetzler et al., *supra* note 4, at 6.

understood to be important in reducing the scope of litigation.[47] In this regard, patients seem to care both about the content and choice of words (an apology can be crucial) and on the mode of communication (the manner in which they are being addressed—briskly or politely, while sitting down or while walking). These findings, in turn, have generated efforts to transform the legal framework and professional culture to allow for such communication to take place pre-litigation.[48]

Other reform efforts relating to communication between patients and staff have centered on promoting the use of alternatives to court for addressing patient complaints pre-litigation.[49] As such, these attempts involved creating institutionalized channels for communication between the medical care team and patients and the improvement of doctors' and nurses' own communication skills. Again, the driving force for these developments was the research findings that a large portion of malpractice litigation could be prevented through better communication among the care team, patients, and families.[50] Since a substantial body of research now shows that plaintiffs' motivation to sue is often not monetary,[51] but driven by frustration over lack of communication over medical errors and mishaps, the hope was that introducing ADR opportunities pre-litigation would both reduce the number of claims (and errors) and enhance patient satisfaction. Plaintiffs typically prefer processes that not only give them a voice, but also allow them to devise tailored, non-pecuniary remedies, such as an apology[52] or evidence of structural changes adopted that would prevent such a mistake from recurring in the future.[53] When ADR is employed post-litigation, the likelihood of reaching such outcomes is significantly diminished.[54]

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47. Indeed, some research has shown that the motivation to sue is sometimes fueled by miscommunication (or lack of communication altogether) after the medical mistake has occurred. *See* Hetzler et al., *supra* note 4, at 7; Geckeler, *supra* note 5, at 177–78; Virshup et al., *supra* note 32, at 153.

48. Jonathan R. Cohen, *Advising Clients to Apologize*, 72 S. CAL. L. REV. 1009, 1061–1065 (1999) [hereinafter *Advising Clients*]; Jonathan R. Cohen, *Legislating Apology: The Pros and Cons*, 70 U. CIN. L. REV. 819, 820 (2002); Carole Houk, *The Internal Neutral: Why Doesn't Your Hospital Have One?*, MEDIATE.COM, June 2002, *available at* http://www.mediate.com/articles/houk.com; Liebman & Hyman, *supra* note 13.

49. Liebman & Hyman, *supra* note 13, at 24; Geckeler, *supra* note 5, at 171–72.

50. *See supra* note 32.

51. Tamara Relis, *"It's Not About the Money!": A Theory on Misconceptions of Plaintiffs' Litigation Aims*, 68 U. PITT. L. REV. 701, 702 (2007); Liebman & Hyman, *supra* note 13, at 30.

52. Research shows that by apologizing, doctors could actually prevent many of the malpractice claims filed, but it is often the legal environment that prevents them from doing so by linking the act of apology to legal liability. *See* Jay L. Hoecker, *Guess Who Is Not Coming to Dinner: Where Are the Physicians at the Healthcare Mediation Table?*, 29 HAMLINE J. PUB. L. & POL'Y 249, 257–58, 258 nn.18–21 (2008); *Advising Clients*, *supra* note 48, at 1011–12.

53. Thomas H. Gallagher et al., *Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors,* 289 J. AM. MED. ASS'N 1001, 1005–06 (2003).

54. As parties invest more time and effort in the litigation process, it becomes more difficult to offer a new paradigm for addressing the dispute because their egos become associated with the positions presented in the legal argumentation and because the expenditures on litigation make alternatives to litigation less attractive (the "sunk costs" bias). For the "sunk costs bias," see Samuel Issacharoff & George Loewenstein, *Second Thoughts About Summary Judgment*, 100 YALE L.J. 73,

The adoption of internal complaint-handling mechanisms in hospitals is related to the more general trend of what has come to be known as "internal dispute resolution," or IDR.[55] IDR processes are typically touted for allowing communication among disputing parties to take place early on in an informal and confidential setting, conditions that have contributed to their success in preventing the escalation of conflict into a full-blown dispute.[56] These characteristics—together with the malleability of these processes, which allows parties to tailor design processes that meet a wide range of disputes and party needs—have made IDR appealing and successful. Hospitals are no exception and, like other institutions, have also been an arena in which IDR mechanisms, such as ombudsmen, mediation, arbitration, or a panel of neutrals have been introduced[57] in the hope that they could provide an effective avenue for addressing patient complaints (as well as disputes among hospital employees). In some cases, mediation has been offered to facilitate difficult conversations between staff and patients or their families and even among medical staff on such matters as bioethical dilemmas.[58] In general, however, the introduction of IDR into healthcare systems has, in many instances, been driven by malpractice, highlighting the potential of ADR processes to better address malpractice complaints than courts, as well as to prevent medical mistakes from occurring or malpractice litigation from taking place when ADR is offered at the hospital pre-litigation.[59]

113–14 (1990) (stating that the sunk cost bias can hinder settlement once parties have invested in litigation).

55. The term IDR was introduced by Lauren Edelman. *See* Lauren B. Edelman et al., *Internal Dispute Resolution: The Transformation of Civil Rights in the Workplace*, 27 LAW & SOC'Y REV. 497, 502 (1993). But the processes have received significant attention in the dispute-resolution literature under this and other titles. *See generally* CATHY A. COSTANTINO & CHRISTINA SICKLES MERCHANT, DESIGNING CONFLICT MANAGEMENT SYSTEMS: A GUIDE TO CREATING PRODUCTIVE AND HEALTHY ORGANIZATIONS (1995) (discussing conflict-management systems within organizations); DAVID B. LIPSKY ET AL., EMERGING SYSTEMS FOR MANAGING WORKPLACE CONFLICT: LESSONS FROM AMERICAN CORPORATIONS FOR MANAGERS AND DISPUTE RESOLUTION PROFESSIONALS (2003) (discussing conflict management systems in the workplace and analyzing the systems devised by almost sixty corporations); WILLIAM URY ET AL., GETTING DISPUTES RESOLVED: DESIGNING SYSTEMS TO CUT THE COSTS OF CONFLICT (1988) (discussing ways to improve dispute resolution systems by focusing on interests-based procedures).

56. Orna Rabinovich-Einy, *Beyond IDR: Resolving Hospital Disputes and Healing Ailing Organizations Through ITR*, 81 ST. JOHN'S L. REV. 173, 184–86 (2007).

57. Susan J. Szmania et al., *Alternative Dispute Resolution in Medical Malpractice: A Survey of Emerging Trends and Practices*, 26 CONFLICT RESOL. Q. 71, 79–80 (2008). In Israel, the Patient Rights Act established a legal obligation to appoint an ombudsman in every hospital. *See* Patients' Rights Act, *supra* note 19, at ch. 7 § 25.

58. *See* I. Glenn Cohen, *Negotiating in the Shadow of Death*, DISP. RESOL. MAG., Fall 2004, at 12, 13 (advocating a "'multi-modal' ADR approach to resolving disputes at the end of life"); Robert Gatter, *Unnecessary Adversaries at the End of Life: Mediating End-of-Life Treatment Disputes To Prevent Erosion of Physician–Patient Relationships*, 79 B.U. L. REV. 1091 (1999) (discussing mediation in end-of-life treatment disputes); DUBLER & LIEBMAN, *supra* note 29.

59. Sheea Sybblis, *Mediation in the Health Care System: Creative Problem Solving*, 6 PEPP. DISP. RESOL. L.J. 493, 494–95 (2006); Liebman & Hyman, *supra* note 13, at 23–24; Balcerzak & Leonhardt, *supra* note 13; Szmania et al., *supra* note 57, at 72, 77; Scott, *supra* note 28, at 799.

Despite impressive achievements by some IDR programs in healthcare in terms of cost savings, claim rates,[60] and even in bringing about a deeper change in parties' understanding of the dispute[61] and in the organizational culture,[62] these initiatives have yet to become widespread and, no less importantly, expand beyond the malpractice domain. Similarly, despite the multitude of courses and training offered, recent research clearly demonstrates that real communication problems between healthcare professionals and patients are still prevalent.[63]

Speculation and inquiry as to the reasons for the "failure of ADR to deliver"[64] vary with some attributing this state of affairs to the way doctors think,[65] the complexity of the work,[66] and the tension between the values underlying ADR processes and those underlying organizational culture and professional training in medicine.[67] The explanations seem to center on the traditional values and culture of the medical profession, which have inculcated a culture of one-sided, hierarchical communication.[68] According to this

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60. Balcerzak & Leonhardt, *supra* note 13.

61. Szmania et al., *supra* note 57, at 74–75 (noting that mediation better manages emotional issues than litigation in medical-malpractice disputes).

62. *Id.* at 77.

63. Coby Anderson & Linda D'Antonio, *Empirical Insights: Understanding the Unique Culture of Health Care Conflict*, DISP. RESOL. MAG., Fall 2004, at 15, 17 (citing a healthcare professional who described how the conflict-resolution skills taught in medical school get "untaught" in the residency period). Naturally, although this could be a result of the quality of particular trainings and courses offered, *see* Cegala & Broz, *supra* note 46, at 1004–05, the view offered in this article is that there is a deeper explanation for this failure.

64. Edward A. Dauer, *Post-Script on Health Care Dispute Resolution: Conflict Management and the Role of Culture*, 21 GA. ST. U. L. REV. 1029, 1035 (2005). *See also* Susan Szmania et al., *Emerging Trends in Alternative Dispute Resolution Programs in Healthcare Settings* 2, Paper Presented at National Communications Association 93d Annual Convention (Nov. 15, 2007), *available at* http://www.allacademic.com/meta/p_mla_apa_research_citation/1/8/8/9/3/pages188931/p188931-1.php (last visited on Mar. 6, 2011) (stating that "[a]lthough alternative dispute resolution systems have become common in many industries, the health care profession has been slow to change the way disputes are handled. The traditional approaches to conflict in the health care field continue to be direct negotiation, litigation and/or legislation and regulation.").

65. Hoecker, *supra* note 52, at 252–53; Szmania et al., *supra* note 57, at 73.

66. *See* Marc R. Lebed & John J. McCauley, *Mediation Within the Health Care Industry: Hurdles and Opportunities*, 21 GA. ST. U. L. REV. 911, 914–15 (2005); Hoecker, *supra* note 52, at 252–53; Szmania et al., *supra* note 57, at 73.

67. *See* Anderson & D'Antonio, *supra* note 63, at 15 (noting the need for data-driven research of healthcare conflict to attract healthcare professionals); Lebed & McCauley, *supra* note 66, at 913–14 (discussing the need for mediators to be familiar with medicine and medical cultures to bridge the "widely divergent cultures"); Morrison, *supra* note 30, at 938–39 (describing a healthcare culture that views collaboration as a sign of weakness); Szmania et al., *supra* note 57, at 73 (noting that physicians are often focused on macro-issues such as customer service, meeting their professional obligations, or simply handling large case-loads).

68. While traditionally, the high-context culture and the need for quick and precise intervention have been understood as necessitating clear and hierarchical communication, research conducted in recent decades within the medical setting has underscored the fact that more open, collaborative, and mutual communication actually yields better medical outcomes, in addition to higher patient satisfaction. *See* DEBRA L. ROTER & JUDITH A. HALL, DOCTORS TALKING WITH PATIENTS/PATIENTS TALKING WITH DOCTORS 133–48 (1992). *See also generally* M. Robin DiMatteo,

explanation, despite the dramatic changes that have taken place in doctor–patient relations and the strong emphasis on customer relations in an increasingly privatized and competitive setting, the communication mode of doctors has persisted and continues to pose a significant barrier towards the inculcation of an alternative mode of communication. While professional culture is certainly a factor in sustaining traditional communication patterns and resisting change, the empirical analysis in this article indicates that an additional factor might have shaped such communication—the fear of malpractice liability.

As we can see, what may seem at first blush to be a success story of patient empowerment, can be more accurately described as a mixed development. With patient rights, enhanced voice for patients, and increased access to medical information came more friction with the medical staff, some of which has been channeled to the courts but the majority of which has not been dealt with satisfactorily. Attempts to transform this reality by adopting communication channels that are more open and collaborative have, in many instances, failed because of the underlying legal incentives for medical staff to conceal information. The following two sections reveal these intricate dynamics through a study of the disputing culture at one hospital, which uncovers an alternative story to the common view of malpractice. The findings and analysis demonstrate both the way in which our understanding of malpractice has been overly broad, concealing the prevalence and impact of non-litigable disputes, and overly narrow, by missing the impact malpractice has had on medical professionals' mode of communication and the resulting difficulty in transforming the disputing culture through ADR and communication training.

III

AN ALTERNATIVE STORY: THE PROLIFERATION OF NON-LITIGABLE DISPUTES BETWEEN PATIENTS AND THE MEDICAL STAFF

A. Methodology

Between April 2007 and March 2008, I conducted an empirical research project at an Israeli hospital examining the culture of disputing. The research sought to uncover the types of conflicts that exist, the ways in which these disputes are addressed (if at all), the relevance of mediation-based skills for addressing such disputes, the conditions for the successful acquisition and employment of such skills over time, and the various barriers that prevent the use of these skills.

Research was conducted at three of the hospital units, data from two of which are presented here—the oncology department and the emergency room

The Physician–Patient Relationship: Effects on the Quality of Healthcare, 37 CLINICAL OBSTETRICS & GYNECOLOGY 149 (1994) (discussing how physician–patient communication significantly affects patient care and medical outcomes).

(ER).[69] In each unit, professional mediators offered a two-day workshop to a group of up to twenty-five participants. The workshops focused on the development of listening and understanding skills through such tools as active listening and reflection, borrowed from the world of mediation. For the most part, the workshops were taught through exercises and simulations taken from the experiences of the particular department or school, based on information gathered beforehand and content raised by the participants in real time. In addition, the workshops included some theoretical exposure to the dispute-resolution field and to the goals of the research of which the workshops were a part. Each workshop included a diverse group of employees from the relevant unit—department heads, doctors, nurses, receptionists, et cetera, and, in the case of the ER, satellite employees such as radiologists and urologists. The total number of workshops amounted to five, with the ER, the largest department, taking up three of the workshops.

The workshops served both as arenas for gathering data on dispute types and the manner in which disputes are handled, and as bases for studying the relevance and applicability of the skills introduced during the workshop to the hospital setting. The data collected included researcher notes from the workshops, questionnaires distributed at the end of the second day of the workshop, and anonymous follow-up questionnaires.[70] Concurrent with the distribution of the follow-up questionnaires, individual interviews were conducted with several participants from each workshop.[71] The goal was to gain a richer understanding of the characteristics of disputes that arise in the hospital environment, the effectiveness of avenues for addressing disputes there, and the relevance and contribution of the workshops. Finally, in-depth interviews were conducted with several hospital employees[72] in order to gain insight into the culture of disputing at the hospital from an organizational perspective.

The interview notes, the open questions from the questionnaires, and the workshop notes were analyzed through a qualitative paradigm drawing on grounded theory.[73] This method was required in order to uncover the subtle

69. The departments were selected based on a conversation with the hospital's management and upon the agreement of the department heads. The research conducted at the third department, the hospital's nursing school was irrelevant to this article's focus as the conflicts revolved around teacher–student relations and therefore, the findings were not included here.

70. The follow-up questionnaires were mailed approximately four months after the workshop with prepaid, stamped envelopes to the secretariat of each department where they were distributed to the various participants so that they could be answered anonymously. Expectedly, the percentage of the participants who responded to the first questionnaire, distributed at the end of the second day of the workshop, was substantially higher than that of the second questionnaire.

71. Three participants from each workshop were chosen as interviewees. Interviewees were selected based on their level of engagement during the workshop and according to their formal role and occupation, in an attempt to allow for the expression of diverse viewpoints.

72. These employees were identified in conversations with the hospital Deputy Director General and were approached by email. Interviews were conducted with those who responded to the email.

73. In this research project, the materials were read repeatedly, categories were identified, and coding was conducted by three separate readers to enhance reliability of the findings and analysis. For the principles and methodology of grounded theory on which this research project draws, see generally

characteristics of the disputing culture at the hospital. Indeed, the elusive role played by medical-malpractice law was not part of the original research question and emerged as a theme only from the examination of the materials. This interpretive analysis, which is based on a careful examination of the hospital staff's choice of words, examples, and conduct during conflict simulations, discussions, interviews, and questionnaire texts, could not be achieved through quantitative analysis and statistical data.

Similar to other qualitative research projects, there are methodological weaknesses.[74] For one, the research subjects are not a random sample and therefore, generalizations are necessarily limited, although thematic generalizations are acceptable and can be instructive. In addition, it can be risky to extrapolate from the particular research location to others. Specifically, learning from the Israeli hospital setting as applied to the American context can be problematic. Nevertheless, as explained above, despite major differences in the structure of the American and Israeli healthcare systems and in the American and Israeli cultures more generally,[75] they share similar overarching trends, in particular the dominance of malpractice, emergence of defensive medicine,[76] and prevalence of non-litigable disputes,[77] which provide fertile ground for comparative analysis. But before we focus on the impact of malpractice on doctor–patient relations, the section below provides a more general description of the research findings and the major themes that emerged from these findings.

B. Key Findings and Analysis

1. Proliferation of Non-litigable disputes

"It's difficult to engage in anger management for eight straight hours."

The picture that emerges from the two research sites is one of an abundance of disputes. In the ER, over seventy percent of the workshop participants reported that disputes are very common at their workplace, while in the oncology department, over fifty percent responded in the same vein. However, unlike the focus on medical-malpractice disputes that exists in the legal and medical realms, these disputes are different; they are over minor, small-scale complaints.

ANSELM STRAUSS & JULIET CORBIN, BASICS OF QUALITATIVE RESEARCH: GROUNDED THEORY PROCEDURES AND TECHNIQUES (1990); ANSELM STRAUSS & JULIET CORBIN, GROUNDED THEORY IN PRACTICE (1997).

74. SHARAN B. MERRIAM, CASE STUDY RESEARCH IN EDUCATION: A QUALITATIVE APPROACH 32–34, 173–77 (1988) (discussing the weaknesses of qualitative case-study analysis in education, including ability to generalize).

75. *See supra* note 8 and accompanying text.

76. *See supra* notes 13, 19, 20, 35 and accompanying text.

77. *See supra* notes 6–7 and accompanying text.

Expectedly, the disputes vis-à-vis the patients and their families in the different departments have distinctive characteristics in accordance with the nature of the work environment in which they arise. The abundance of external disputes in the ER is not surprising given that patients arrive there because of an urgent medical condition (or at least so they believe); they are in a state of anxiety and distress and there is typically no preexisting or ongoing relationship between the patient and the staff. In addition, the existence of significant informational asymmetries between them and the care team—both in terms of the medical and procedural issues—exacerbate feelings of insecurity and the potential for conflict arises. At the same time, the staff work under extremely difficult conditions—heavy workloads, severe shortage of employees, and extreme time pressure, and therefore, have difficulty providing answers that satisfy patients and their families and prevent potential conflicts from arising or escalating. This state of affairs begets misunderstandings and frustrations that often evolve into disputes, some of which involve violence.

Specifically, the ER is dominated by disputes over such issues as discharge from the department contrary to the patient or her family's wishes, long wait periods (for seeing a doctor, undergoing tests, test results, et cetera), and other physical conditions in the department (shortage of beds, placement of beds in the corridor). Complaints and conflicts regarding quality of care and choice of treatment were mentioned, but received very little focus from workshop participants both in the discussions during the workshop and in the answers provided to the questionnaires. By contrast, participants in the workshop for the oncology department highlighted the significance of bioethical dilemmas to their practice. Dilemmas such as the conditions under which a morbid prognosis should be disclosed to the patient or her family, decisions regarding treatment, and the like, although, here as well the department employees reported that disputes arise regarding such matters as bed assignment or treating someone ahead of their turn, that is, non-litigable disputes—small-scale conflicts that are unlikely to reach the court system.

One example of a non-litigable dispute and its impact is the following story, told by a participant in one of the ER workshops:

> I arrived at the ER in the middle of the day. There was an Ethiopian woman who was shouting. She had brought her father to the ER. They had been there for many hours and he had not been treated. A nurse and doctor talked to them and told the woman that she was right but the shouts continued. Another nurse showed up and the woman yelled at him—"Go away, shut up." I took the woman aside to find out what had happened. She calmed down. I returned later that day; another shift with a new team, but the woman was still there, shouting. I was surprised that she was still in the ER. The doctor said she was there because they wanted to hospitalize the father in a nursing home and the daughter refused. I talked to her again and discovered that she did not understand that they wanted to hospitalize him.

In this case, as in others, we see how a dispute erupts and is magnified due to the miscommunication surrounding the patient's condition and the medical staff's intentions. This case also provides a good demonstration of the costs associated with such disputes in terms of time and energy of all involved.

These tensions also infiltrate internal relations among staff. Some of the nurses reported that they felt as though they were acting as a buffer between the doctors on the one hand and the angry patients and families on the other. A similar feeling was voiced by staff at the oncology department where a portion of the disputes also arise out of interactions between doctors and nurses. As we can see, non-litigable disputes can become triangular conflicts and involve both internal and external aspects.

2. The Impact of Disputes

> "It's sad to see people who go to work feeling like they're going to a battlefield because the system places them in an impossible position."

The discussions during the workshops, as indicated in the content of the interviews, reveal the price exacted by an environment that is mired in conflict. Some of the participants in the ER workshops, as evidenced by the quote above, described their workplace as a battlefield between themselves on the one hand and the patients and their families on the other. Many members of the ER team spoke of feeling increasingly depleted. For example, one participant wrote in the questionnaire that "the team constantly encounters conflicts and it would be preferable to address them rather than to leave a residue that could last years or the entire career." The impact such residue can have was aptly described by one of the interviewees:

> If you do not know how to adequately resolve conflicts and small-scale disputes, the attention, thinking, and focus will not be on the patient, but on our emotions, feelings, and anger. You can see it through the corner of your eye. You cannot concentrate on what you should. If we do not solve this, we cannot diagnose and see what's most urgent. It's noise. The mind is somewhere else. It is extremely difficult to detach from a conflict, in particular one that involves verbal violence. It is an awful humiliation. You feel bad; you continue to live the situation. You are not available for anything else.

Most disputes described by the research participants were non-litigable. In light of the high price that the dispute-wrenched environment exacts from those who work at the hospital, the following questions arise: Are there mechanisms and processes in place at the hospital to address disputes? If so, how can we explain the persistence of disputes? In particular, how do we explain the prevalence of small-scale, non-litigable disputes?

3. Lack of Effective Avenues for Addressing Conflict: Existing Avenues at the Hospital

> "The workshop made me more aware of the fact that there are numerous conflicts that should be addressed and unfortunately are not addressed on a routine basis."

The information gathered during the research paints a bleak picture of the near absence of structured avenues for addressing disputes. A high rate of the workshop participants expressed dissatisfaction with the existing avenues for addressing disputes at the hospital: seventy-one percent (eighteen individuals) of participants from the oncology department who responded to the

questionnaire, and forty percent (forty-seven individuals) of the respondents from the ER, stated that existing avenues for dispute resolution are completely unsatisfactory.

It seems that small-scale, non-litigable disputes are often viewed as a given, inherent part of rendering medical services at a hospital and a product of the lack of resources there. As one participant pointed out, “Most of the problems arise in the evenings and nights, when there aren't many staff members or management present.” Another participant acknowledged that “if you place yourself in the shoes of the family member, you understand she is uncomfortable. [But] it’s not up to you. That’s how the system is.” While this is undoubtedly an important factor in the emergence of such conflicts, the role played by other factors, mainly modes of communication with patients and their families, is minimized. Organizational resources are devoted to addressing the vocal and patently costly conflicts that the system worries about—malpractice claims (mainly through risk management), while hospital employees on the ground are left to deal on their own with the “other” types of conflict, the costs of which are more elusive and less tangible.

Non-litigable disputes are typically handled formally only when violence is involved. At that point, hospital security is called upon to intervene. But even in this narrow realm, effectiveness is questionable. In most cases where security is called, the staff refrains from pressing charges with the police and therefore, the feeling is that security is ineffective in dealing with the spread of violence at the hospital after the fact and certainly does not present a means for addressing conflict in its earlier stages or preventing it altogether.

Most non-litigable disputes, however, are not addressed formally, and are handled by the staff through informal, ex post techniques ranging from avoidance to an appeal to a higher authority. Some of the participants reported that, at times, they attempt to discern what the cause of the problem is by distancing the disputants from the area where the conflict erupted so as to prevent further escalation. Others mentioned that in such situations, the medical team should apologize, but others still expressed difficulty with offering an apology or displaying empathy. In some instances, participants recounted that when experiencing tension with patients and their families, they asked a colleague to take their place or passed the case along to a higher medical authority. Some stated that in these situations, it is easier to remain silent in an attempt to calm things down. In one case, an interviewee recounted that he turned his back on a patient, which resulted in a violent attack on him by the patient. Finally, there are those who deal with angry patients by treating them more rapidly, or as stated by one of the participants, “I try to get those who shout out of the system as quickly as possible.”

Where they cannot solve the problem on their own or choose not to "lump it,"[78] the staff or the patients may involve a higher authority. One such avenue is the hospital's head nurse, who seems to be an effective channel for addressing certain types of conflicts during evening and night shifts, perhaps because, in some cases, the mere involvement of a more senior person—be it the department head or a representative of management—can bring the problem to an end. However, it is also true that the senior officials are only involved under extreme circumstances.

Those conflicts that are not addressed satisfactorily within the department, may reach the hospital ombudsman, appointed under the Patients' Rights Act of 1996.[79] The ombudsman has a broad mandate to address patient complaints that extend beyond the legal realm. Alongside the ombudsman, the legal counsel handles disputes that have matured into legal claims and the risk-management unit handles the examination of medical mistakes and patient-safety issues. The ombudsman at the hospital is a retired Deputy Director General and fills this position voluntarily with no remuneration and no budget. He receives approximately 500 complaints annually, only ten percent of which relate to medical treatment, and only a portion of those require that the hospital prepare for a lawsuit. Lawsuits are a rare occurrence, with the hospital typically handling one or two lawsuits annually. The vast majority of complaints to the ombudsman relate to non-litigable disputes stemming from the staff's bedside manner or clerical problems and errors.

Interestingly, while the ombudsman post conveys a promise for an informal route to address complaints, the ombudsman seems to conduct an adjudicatory dispute-resolution process. Upon receiving a complaint in writing, the ombudsman conducts an internal investigation. Often, he requests that the relevant department head address the complaint. If the response seems adequate—an in-depth examination has been conducted and conclusions drawn—then he answers the complainant in writing. Where necessary, he may "scold" the complainant, writing that "people do not come in at 7 am to hurt other people." Otherwise, where the department head's response is unsatisfactory, he may initiate a three-way mediation meeting. Despite conducting such meetings in certain cases, the prevailing mode seems to be that of an adjudicatory approach. This is evidenced by the dominance of written communication, the primacy of investigation as a form for addressing complaints, and the prism through which complaints are examined—whether they are "justified," connoting an examination according to some objective

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78. For a discussion of the "lump it" strategy in addressing small-scale disputes, see Richard E. Miller & Austin Sarat, *Grievances, Claims and Disputes: Assessing the Adversary Culture*, 15 LAW & SOC'Y REV. 525, 538 (1980–1981) ("One buyer of a defective good may find it unacceptable and remediable; another may regard the bad purchase as 'inevitable' and 'lump it' or write it off to experience. According to our definition, the first individual has a grievance; the second does not.").

79. Patients' Rights Act, *supra* note 19.

criteria as opposed to a subjective perception of complainants' sense of grievance.

The ombudsman avenue, which held promise for a different kind of discourse, is therefore predominantly formal and adjudicatory, perhaps reflecting both that the requirement for appointing an ombudsman is located in the Patients' Rights Act as well as the fact that the ombudsman in this particular institution is a high-ranking medical official who is concerned with the hospital's exposure to claims and would like to defend the stature of the profession. While these findings relate to a single hospital in Israel, they seem to be reflective of the reality in other medical institutions in Israel and elsewhere.[80]

The picture that emerges from the above description is therefore one in which there are very few institutionalized avenues for addressing the medical staff's conflicts with patients and their families and virtually no such channels for addressing internal conflicts. To the extent that the latter avenues exist, they are rights-based and mobilized relatively late in the evolution of disputes, which means some of the disputants will choose to lump it, and in the other cases, chances of effective resolution are diminished. In sum, it seems that the scarcity of existing avenues for addressing disputes as well as the stages in which those avenues are activated and their rights-based approach, are a major source of discontent, as evidenced by the percentage of ER and oncology department participants who stated they were highly dissatisfied with existing avenues for addressing disputes.

One of the questions that arises is to what extent ADR-communication skills, currently not used at the hospital, could be helpful in addressing those conflicts that are most prevalent—non-litigable disputes. What are the sources of non-litigable disputes and in what way can ADR-communication skills assist in addressing these conflicts? And finally, to the extent that these skills are indeed helpful, what is the likelihood of their adoption in the hospital setting? In what ways can the experience with ADR training at this hospital contribute to the understanding of barriers towards ADR-skills training and the emergence of ADR mechanisms in the healthcare setting elsewhere?

4. The Potential of ADR for Addressing Conflict and the Barriers Towards the Adoption of ADR in Healthcare

a. Source of Non-litigable disputes

> "We all speak, we all know [the language], but we do not understand anything."

The workshops, interviews, and questionnaires distinctly reveal that many of the disputes at the hospital—both internal and external—result from communication problems and could be prevented, or at least better addressed,

80. *See supra* note 8–9 and accompanying text.

through the acquisition of mediation-based communication skills. There were instances in which a problem arose due to the absence of dialogue (or speech) when, for example, discrepancies between expectations and reality on such matters as wait periods and type of treatment arose: "[I]t all results from people not knowing, the information is missing, no one gives them an explanation ahead of time." Some of the staff described cases in which they expressed their anger towards patients through silence, for example, by ignoring a patient and turning their back on her. This mode of behavior only seemed to make things worse since one such case ended with violence against the nurse and another left the employee feeling she had mistreated the patient.

In other cases, the medical team does speak, but the problem lies in the mode of communication—"we speak in an unclear fashion, partial sentences." Often times, said one of the participants at the oncology department workshop, "We the doctors, place less emphasis on reflection. We attach more significance to being understood. We do not give the patient the feeling that we understand him."

Communication difficulties are a real problem in internal staff-member relations as well. As stated by a participant in the ER workshop: "When someone says no to me, I start arm wrestling. It's all communication. It's important how you say something, how you ask. When a ping-pong [game] starts [between the two sides], then people dig in. No one concedes." Often, communication problems among staff expand to the external realm, generating disputes between staff and a patient or her family. In other instances, such problems are rooted in an external dispute and present an extension of such conflict.

Communication difficulties are obviously even more extreme where there are cultural differences. This is evident both in interactions within the care team and in those that take place between the staff and patients or their families, such as the case of the family of Ethiopian origin described above, in which a substantial period of time was devoted to purposeless arguments with the family, during which time, the work of some of the medical staff was suspended, and the vocal argument most probably contributed to the escalation of other conflicts at the ER relating to different matters.

Some of the staff attributed the communication problems to their having to function under fierce budgetary constraints, extreme workload, fatigue, and time pressure. As many of the research participants indicated, these circumstances create an environment that breeds disputes. One of the interviewees stated that "the main problem is being tired, working an average of three-hundred hours a month and this fatigue supplies fuel for disputes." Similar statements were made by others at the ER workshop. One participant stated that many of the problems arise at night, when shifts are sparsely staffed. Others admitted that time constraints and pressure were not the real barrier to adopting ADR-based communication skills ("aside from CPR [cardiopulmonary resuscitation] there is nothing that cannot stand a thirty-

second delay"), but resented nevertheless having to bear the costs of a failing system:

> [T]here's no money for doctors, CT [Computerized Tomography], taxis, standbys, but 'if you speak nicely, then everything will be OK.' I support these tools but the situations are tough. I mainly feel that no matter how much we study these tools it won't help. Someone else needs to take some responsibility.

Despite these sentiments, there was significant recognition that a change in the communication mode could not only assist in addressing conflict ex post but could also prevent a significant portion of the disputes from arising to begin with.

b. Applicability of ADR Skills

> "I never thought that through such a simple tool, meaning a communication tool, one could get so much cooperation. . . . I discovered I can talk, I can reflect myself and others and it does not demonstrate weakness but actually strengthens others and teaches them how to address [such situations] in the future."

The research findings were that the ADR skills introduced through the workshop—active listening and reflection skills aimed at improving listening and understanding capabilities—were found relevant and contributed to the staff's ability to address conflict. A high percentage of the participants that responded to the questionnaire in each of the departments thought the tools presented in the workshop were very relevant and applicable for their workplace (eighty-three percent and seventy-one percent in the oncology department and the ER, accordingly) and that the workshop contributed substantially (seventy-one percent and sixty percent in the oncology department and the ER, accordingly).

The open text areas in the questionnaires and the participants' remarks during the workshops and in the interviews provide a richer understanding of the ways in which ADR skills were found relevant and the milieus in which the workshop contributed. Most significantly, the workshop raised awareness of the link that exists between the mode of communication employed and the eruption of disputes. One of the principal insights of many participants was that the "regular" mode of communication generates many misunderstandings that are caused by the assumption that the parties to such exchanges accurately understood one another, while in reality their understanding was constrained by biases and prejudgments that derive from heuristics, cultural conventions, and differing personalities.

Many of the participants spoke of the contribution of the skills for clarifying misunderstandings and resolving disputes. Some of the participants pointed at the role these tools play in preventing biases thereby improving the understanding of the other. One participant pointed at "the need for humility" as a contribution of the workshop. "Perhaps I do not understand everyone better than they understand themselves," he stated. Another participant stated, "[My] thinking has changed. I realized that people grasp things differently and this is what causes disputes. Later, I tried to implement this and explain to

others that I was misunderstood." Reflection was mentioned by many as the principal tool they acquired through the workshop. In that vein, one of the participants stated that "many things that sound trivial, I realized that I did not understand in the process of reflecting them."

In an attempt to understand the patients and their families, a significant number of participants stated that they learned to connect to the feelings of the people who face them and to place themselves in their shoes. One interviewee stated that since the workshop, she asks herself, "How would I feel as a young person lying there with a problem?" Others emphasized the need to verify that they were understood correctly by the patients and in this respect, the significance of "addressing people at eye level, without using bombastic words, verifying that you understand what I told you." Where such a discourse takes place, "[T]here is full disclosure . . . [I] am respectful [to others] and expect respect [from them]." As one participant stated, the level of tension can be reduced through "inclusion [of the patient and family] in the considerations that drive the treatment given by the doctors and nurses," and inclusion can be reached through active listening and reflection.

A principal contribution of the employment of the skills, according to the participants, is in the realm of dispute prevention. As one interviewee put it, "In ninety-five percent of the cases, if matters are clarified and/or reflected, the eruption quiets down." Instead of arguing, ignoring the problem, or rewarding the most vocal patients, the staff stated they would take proactive future-oriented measures aimed at uncovering the needs, wishes, and concerns of those facing them: "If until now, I would continue walking from one spot to another without checking on what was happening behind the curtain, now I will stop and put out the fire before it erupts." One interviewee said she understands the state of distress of people arriving in the ER. As she said, she now puts herself in their shoes and "from the moment I understand their situation, no dispute arises. I am not superior to them. Today I am the caretaker. Tomorrow, the situation may be the reverse."

Despite the high percentage of participants who found ADR skills relevant and applicable, only a small number of those who answered the follow-up questionnaires stated that they had actually applied such skills in the months that had passed since the workshop. What is the explanation for this gap? Some of those who answered the follow-up questionnaire indicated that further training and internalization were needed. While this may be true, this seemingly could not explain the shift from a strong belief in the potential of such skills to address and prevent conflict to their abandonment. A deeper explanation seems warranted.[81]

81. Liebman and Hyman have made the point that it is extremely difficult for the party who has caused the harm to use these skills and have therefore recommended a model that relies on a neutral party. *See* Liebman & Hyman, *supra* note 13, at 24–25. Such an approach has also been adopted at Baystate Health, a system of three hospitals in western Massachusetts, where a disclosure advisory committee has been set up to manage the disclosure of medical errors. *See* Randolph R. Peto et al., *One*

5. Interim Summary

The picture that emerges from these findings is of a hospital that is fraught with conflict—disputes over such issues as long waits, the availability of hospital beds, the order in which patients are received and treated, and staff's bedside manner. These disputes can best be described as non-litigable disputes. Despite their abundance, there seems to be no effective means for addressing these conflicts. Institutionalized organizational avenues seem to satisfactorily address a limited range of the conflict experienced on the ground, while ad hoc intervention by managers is sporadic and its success unpredictable. Hospital staff, while recognizing the heavy toll exacted by these conflicts, employ a mode of communication that is not only ineffective in addressing such disputes, but often leads to escalation and breeds further conflict. The ER and oncology staff recognized the contribution ADR-based communication skills could have in addressing small-scale conflicts and in preventing such disputes from arising to begin with, but nevertheless have had real difficulty in adopting ADR-based communication skills and in implementing them.

The medical staff associates these difficulties with lack of resources and sufficient training, and the incompatibility of ADR-communication skills to the medical setting. However, a close examination of the language employed by the medical staff who participated in the workshops and interviews, their conduct during simulations, and their comments in response to such exercises reveals a different narrative. As evidenced in the next section, these findings can be at least partially attributed to the influence of the shadow of malpractice law.

While the writing on ADR in healthcare and on communication skills for healthcare professionals has traditionally viewed antagonism to such avenues and skills as a product of competing professional and organizational cultures, these explanations seem incomplete. The interpretive analysis adopted in this paper is that the culture of disputing and the operation of dispute resolution avenues at the hospital studied can be partially attributed to the fear of malpractice liability; this fear has shaped the culture of disputing even when the subject matter of disputes is not related to medical treatment proper. Malpractice has therefore permeated the entire healthcare setting, impacting the various interactions that take place at the hospital. This happens because of the adoption of defensive communication which breeds conflict and can pose real obstacles to its resolution.

System's Journey in Creating a Disclosure and Apology Program, 35 JOINT COMMISSION J. ON QUALITY & PATIENT SAFETY 487, 487–88 (2009). The context here, however, is typically not that of medical mistakes, but of non-litigable conflicts relating to long waits, transfers, et cetera. The question arises why the staff should have difficulty in adopting listening and understanding tools with respect to these issues.

IV

THE LONG ARM OF MALPRACTICE LAW: THE IMPACT OF TORT DOCTRINE ON MEDICAL STAFF'S COMMUNICATION MODE WITH PATIENTS

A. Defensive Communication on the Interpersonal Level

1. Defensive Communication as the Dominant Form of Communication

The research findings above reveal that many of the disputes at the hospital result from communication problems related to the medical staff's dominant mode of communication. As further explained below, the staff's communication with patients and their families (as well as with some of the other staff) is hierarchical, distant, and confrontational or is based on avoidance and withdrawal. There seems to be no real engagement, listening, and understanding. This communication style creates fertile ground for the emergence of disputes and often contributes to the escalation of existing conflict with patients and their families. In addition, this form of communication also shapes interactions among the medical team members who frequently engage in confrontational communication, in particular across departments and roles.

2. Defensive Communication as a Shield

The connection between the medical staff's communication mode and the shadow of malpractice claims is apparent on several levels. One of the strongest sources of support for this connection lies in the reactions of some of the medical staff towards the alternative mode of discourse presented to them during the workshop, one that is based on ADR skills and is premised on listening and verifying understanding. This type of discourse is in many respects the antithesis of defensive communication: non-hierarchical, open, and inclusive. As the workshop participants stated, it allowed them to relate to the person with whom they were communicating, recognize and acknowledge what they were feeling, and place themselves in their position. Some of the participants viewed ADR-based communication as being in inherent tension with their role: "I believe in assertiveness. I am thinking about how to combine the two [assertiveness and ADR skills]. I think one necessarily detracts from the other."

One discussion during the ER workshop was particularly instructive in this respect. Participants conducted a simulation involving a dispute between a doctor at the ER and a patient's daughter over the doctor's decision to transfer the patient to a geriatric institution. The daughter was having difficulty in accepting this decision, which contradicted her perception of her father's condition. In addition, the particular institution mentioned suffered from a problematic reputation, a factor that also impacted the daughter's reaction. One of the ER doctors who played the role of the doctor in the simulation attempted to implement an alternative mode of communication in his interactions with the

daughter. While he listened to her, he picked up on information relating to the father that he had missed earlier. He therefore indicated that he would be willing to look at the father's medical file again and reconsider his decision. The daughter was satisfied and grateful. Later, we discussed the simulation and the doctor's conduct. Several physicians viewed the decision to reexamine the medical file as a sign of weakness and lack of professionalism.

During the same simulation conducted by another group, another doctor who played the doctor's role was unable to reflect what the patient's daughter was saying and feeling because he felt that he had to "protect the system." We see how changing the mode of communication to a more open and inclusive interaction is viewed as a dangerous move that weakens the doctors and exposes the system. The hierarchical, one-sided traditional mode therefore serves to shield the doctors and the system as a whole, while the object from which they need protection remains veiled.

One indication for malpractice being the factor from which doctors seek protection through communication, lies in doctors' reaction to the issue of compensation. Where the issue of compensation is raised and doctors feel that no medical harm has been done, this is a trigger to shutting off conversation. This was evident in a simulation during one of the ER workshops, in which a participant played the part of a patient who received the wrong treatment. No medical harm resulted but she felt hurt. The senior doctor to whom she complained conceded that the treatment was inappropriate but focused on the fact that no harm was done. Once the issue of compensation came up, the doctor "lost all sympathy towards her" and fended her off. He explained that "on the one hand, the patient was right [in complaining about the treatment she received]. But on the other hand, I had to protect my team." As described below, the hospital ombudsman reacted in a similar fashion to what was perceived by him as an unjustified demand for compensation. A patient who demands monetary compensation places the medical staff on guard, a state of mind that reinforces defensive communication.

Another link between defensive communication and malpractice has to do with the fact that defensive communication is the ultimate mask for medical decisions that are grounded in defensive medicine. One incident discussed in the workshops and another described in an interview highlight this connection. One of the simulations at the workshop was based on an incident that occurred several months beforehand and, in fact, was the driving force for the ER department head's agreement to take part in the research. In that case, an injured motorcyclist arrived at the ER and was referred to a series of tests and specialists—a surgeon, an orthopedist, a spine specialist, back to the orthopedist for a scan, and a long wait for the radiologist. Then, after they discovered that he was also suffering from headaches, he was referred to a neurologist. The neurologist was no longer there and the patient had to wait until the evening, at which time they decided to involve an eye specialist. This lasted a full day, while the feeling of the department head and others was that the patient could have

been treated within a few hours in the morning. The problem, as one of the workshop participants stated, is that "no one assumes responsibility."

Excessive testing is a clear manifestation of defensive medicine, while defensive communication is what serves to mask such a phenomenon, making these tests seem indispensable. The more doctors expose the choices they make and the discretion they employ, the more vulnerable they become.[82] Therefore, patients are directed to series of examinations and tests that are portrayed as medically required with little explanation given for the course of action taken. The link between defensive practices and communication was explicitly drawn by one of the interviewees, a doctor: "We see how in medicine defensive medicine enters the picture. It is sometimes easier to provide vague answers than to admit we do not know the answer." Both defensive practices and the accompanying mode of communication breed non-litigable disputes, as patients are angered by the long waits for tests and the scarcity of information about the timeframe and course of action.

B. Defensive Communication on the Professional Level

1. Communication as a Source of Professional Authority and Protection

One of the most dominant issues that came up in the workshop was the connection between professionalism and mode of communication employed by the medical staff. To many of the participants (primarily doctors, but not all doctors), sustaining the "traditional" hierarchical mode of discourse vis-à-vis patients and families was perceived as essential for maintaining professional authority and functioning in a professional manner. With statements like "[the relationship with patients] is not an equal relationship, but a hierarchical one" and "the phrase [by patients] 'I read it on the Internet' really upsets me" voiced by doctors in response to the simulations and introduction of ADR skills, it quickly became clear that real barriers exist towards the adoption of these skills. One of the doctors stated that

> the discourse between doctors and patients is different. I have a goal, to provide the patient with the right treatment. I do not want to review positions, et cetera. I want to understand what I need to understand in order to orient her towards the appropriate treatment. I shut myself off and do not listen to anything else. This is asymmetrical communication, but it is not judgmental.

Several nurses also had difficulty with ADR-based communication skills, one of them stating that "it is important to sustain our leadership and to say to the patient 'you can count on me to do what is necessary in the professional realm.'"

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82. Naturally, medical intervention is often based on complex and uncertain conditions and, therefore, cannot always be transmitted clearly and in a timely fashion to patients and their families. Nevertheless, as the findings of this article seem to indicate, this potential ambiguity is sometimes actively embraced as a means for obscuring the conditions surrounding actions by medical staff.

Interestingly, in other cases, there were doctors who did not see ADR-communication skills as being in tension with medical professionalism, but as occupying a distinctly separate and inferior realm. In this view, there is a clear distinction between professional knowledge and expertise on the one hand, and the communication aspects relating to such knowledge, on the other. Furthermore, a clear hierarchy exists under which medical expertise comes first. Communication, under this approach, is not viewed as a core feature of what being a doctor is about. One doctor stated that

> this tool [reflection] is more appropriate for inter-staff relations than for interactions with family members [and patients]. These are brief and are subject to an ethical code that we are obligated to. This tool should not change the proportions: first we treat . . . the person who yells is not the one who will receive treatment, the person whose medical condition is urgent is the one who will receive treatment first.

Unlike doctors, a significant number of nurses viewed communication skills as an essential component of their own sense of professionalism and typically mentioned communication skills as equally important to medical expertise and knowledge.

The separation between medical expertise and communication in an underbudgeted and understaffed environment results in the staff's sacrificing the communication elements while performing clinical tasks. As described above, several staff members emphasized the exacting work conditions, while others admitted that time was not the issue. Mostly, anger and frustration were expressed towards the healthcare system since the medical team was being asked to bear yet another duty by adopting more effective communication skills. While working under extreme conditions, doctors and other staff members trying to do their job well and to avoid mistakes adopt an abrupt and authoritative mode of communication, but it is often precisely such an environment that breeds mistakes.

2. Instrumental Use of ADR-Based Communication

In one of the workshops, a senior ER doctor recounted the episode described above, regarding the patient who sought compensation because she received erroneous treatment. The treatment did not result in any physical harm and the doctor felt that the request was unjustified. While discussing his attempts to reflect what the complainant was saying, the doctor wondered whether the issue of compensation would have been raised had he used ADR-based skills. As we saw earlier, the doctor's query does have grounding in research on the impact of ADR-based communication skills on the likelihood of patients and their families to sue for malpractice.

In another case, a senior nurse at the ER described an incident that took place at the ER. Senior doctors examined a patient in her early thirties suffering from back pain, gave her pain killers, and decided to discharge her from the hospital. The young woman's father refused to leave while his daughter was in pain. A real commotion started, with curses and threats by the father. The nurse approached the patient and her father. The father shouted at the nurse. She

asked to speak to the daughter, the patient, and invited the father to be present. The nurse noticed that the patient seemed extremely uneasy and yelled that she was in pain. The nurse explained to her that she had received the maximal dosage of pain killers and discussed options for relieving her pain. The nurse approached the doctor and had a difficult conversation with him. Finally, they agreed that a back specialist would be consulted. The doctor was upset and said that he was confident that the back specialist would decide to hospitalize the patient and indeed that is what happened, to the doctor's dismay. The nurse responded by telling him that they were "not at war with the patients." Finally, the senior specialist arrived and ordered a CT. After the examination, they decided to operate. The nurse said that this could have ended differently.

The patient and her father engendered antagonism and it was very difficult to believe that her pain was genuine after her having received such a large dosage of pain killers. These circumstances, the nurse explained, made it seem like the patient was complaining for no reason. Later, the nurse ran into the doctor and told him that "anyone can make a mistake." Interestingly, we see how the nurse employed ADR skills (listening skills and reflection) in her communication with both the patient and the doctor. In fact, she was fully aware of the potential of these communication skills to uncover biases and cognitive shortcuts (the assumption that no one on so many painkillers could be suffering from pain) and prevent medical mistakes.

Both examples uncover the paradox of defensive communication: the very hierarchical and confident discourse that veils discretion and protects decision-making from scrutiny also serves to fortify assumptions and breed mistakes (on top of raising friction level). However, as we can see from these cases, even when a shift from defensive communication to the alternative ADR-based communication occurs, it fails to escape the shadow of malpractice law. The engagement of an inclusive and open ADR-skills-based communication style is also driven by the fear of malpractice liability, in an attempt to prevent medical mistakes and deflate potential complaints.

C. Defensive Communication on the Organizational Level

As described above, the hospital that served as a research site has an ombudsman—as required under the Patients' Rights Act—who is charged with addressing a broad range of patient complaints that extends well beyond malpractice complaints to encompass non-legal and non-litigable disputes. Indeed, most of the complaints that reach the office are not grounded in malpractice. However, close scrutiny of the operation, policies, and goals of the ombudsman reveal the shadow of malpractice.

The impact of malpractice claims seems most evident in the policies the ombudsman has developed for addressing complaints. For one, the ombudsman carefully phrases his responses to complainants, using phrases like "the hospital regrets what happened," while trying to refrain from saying they apologize.

Another policy has to do with the outright dismissal of complaints. In certain cases, the ombudsman dismisses complaints without conducting an investigation. The two examples he provided for such a policy are instructive. One case involved a complaint by a family member following the death of his mother. The patient, an elderly woman was very ill and admitted for a hip fracture. She received adequate treatment but died from complications relating to her general condition. The ombudsman mentioned that the son had written in his complaint letter that he did not expect that the doctors at the hospital would use their medical license to kill someone. The ombudsman replied that he was rejecting the complaint outright.

The other case mentioned by the ombudsman in this regard was one in which an elderly man was released after having been successfully treated, but due to a clerical mistake, his release papers indicated that he was HIV positive. They explained what had happened to the patient's daughter, but, according to the ombudsman, her reaction was exaggerated since there was no real harm. The daughter received an explanation. Later, the ombudsman received a letter with a demand for compensation, which he dismissed.

Both examples involve complaints in which the medical treatment rendered was appropriate, there was no medical mistake, and patient safety was not jeopardized. Nonetheless, in both instances, malpractice lurked in the background. In the first case, the son blamed the medical team for the death of his mother. He used harsh language, but did not threaten the hospital with a lawsuit. In the other situation, a mistake did occur, but not on the medical front. Nevertheless, this mistake opened the door for what was viewed by the ombudsman as an opportunistic request for compensation. In both instances, the ombudsman fended off what he viewed as unjustified complaints.

If, however, we understand the role of an ombudsman to be one that is charged with providing an avenue for addressing a broad range of disputes, legal and non-legal, this does not seem to be a required policy. On the contrary, this policy seems to embody a legalistic outlook on complaints, under which the ombudsman investigates complaints that, on their face, seem to have merit. This is shaped by a determination of whether "adequate treatment" has been rendered while the complainant's demeanor or request for redress is judged by an ombudsman who is a doctor and high-ranking hospital official and seems to identify with the staff and the hospital.

An alternative approach would be to adopt a subjective view of complaints, seeking to address the grievance experienced by the complainant whether "objectively" justified or not. This is clearly not the approach taken by the ombudsman who typically investigates complaints before responding to the complainant in writing. Even though he addresses non-legal complaints, such as patients complaining about the disappearance of their personal effects when taken to the operating room, his approach remains legalistic, offering complainants an objective determination of whether their complaint was justified or not. The implication of this approach is that a large number of

complaints, precisely those complaints that organizational mechanisms like the ombudsman are meant to address, remain with no redress, to the chagrin of the medical staff as well as patients and their families. As Sally Engle Merry has shown us, where informal avenues are ineffective in addressing conflict, those with power are victorious.[83] And so the battle between the care team and patients continues and those who are vocal are often victorious.

D. Interim Summary: Lessons from the Field on the Healthcare Disputing Culture

While public attention in the last several decades has been devoted to the dispute-laden healthcare arena, attention has been focused on one type of dispute—medical-malpractice claims, ignoring a whole host of prevalent non-litigable disputes. Despite being small-scale and mundane, these disputes exact a heavy price from all involved. The hope that such conflicts could be effectively addressed through ADR—whether by relying on the assistance of a third party ombudsman or by training medical staff in communication skills—has been deflated, as seen in the case study presented here, as well as in other places.

The phenomena described—the frequent clashes between doctors and patients and the mode of communication employed by healthcare professionals—have typically been viewed as resulting from the professional culture of doctors and organizational culture of hospitals. These factors certainly account for some of what is happening, but this article has advanced the claim that there is another significant source that lies at the heart of the findings presented: the impact of medical-malpractice law. As commonly noted, the fear of malpractice liability has engendered problematic medical practices typically referred to as defensive medicine. What has been overlooked is that the reach of malpractice has extended beyond defensive medicine, infiltrating the realm of patient–physician communication and producing defensive-communication patterns. Defensive communication is a mode of communication that is similar to the traditional interaction style employed by doctors towards patients—hierarchical, distant, and confrontational—but its source is different and can be linked, among other roots, to the desire to avoid legal liability. This is what has made defensive communication elusive—it is the persistence of traditional communication that represents the impact of malpractice, not a change in such mode that would have been easier to detect.

Defensive communication is in direct tension with ADR-based communication skills and therefore will make any attempt to inculcate such skills difficult. This is the paradox of defensive communication: the medical staff will not adopt ADR-based communication skills for fear of liability in malpractice, but by maintaining their traditional communication mode, they

83. *See* Sally Engle Merry, *Going to Court: Strategies of Dispute Management in an American Urban Neighborhood*, 13 LAW & SOC'Y REV. 891, 919–23 (1979).

actually enhance conflict level and raise the likelihood of their making a mistake[84] and being sued.[85] Defensive communication infiltrates all levels of communication at the hospital because communication modes are typically unitary—it is difficult for staff to use different communication styles in addressing what could be perceived as different dispute types.[86] Therefore, we see that malpractice disputes and "other" conflicts are addressed similarly, in a legalistic and cautious manner, coopting the dispute resolution avenue that could have introduced an alternative discourse, for legal and non-litigable disputes.

V

THEORETICAL IMPLICATIONS

The findings described in this article have several implications for the theory of ADR. One important consequence of the research findings has to do with our understanding of the ways in which the shadow of the law operates. Robert Mnookin and Lewis Kornhauser coined the term "shadow of the law" to describe the impact substantive and procedural legal arrangements have on negotiations in the same area of law that take place pre-litigation.[87] Over the years, this has proven to be one of the single most influential concepts describing the relations between formal law and informal dispute-resolution efforts. A long list of articles have examined the concept in a wide range of fields, extending well beyond the subject matter of custody disputes, but generally remaining within the confines of the original term.[88] The findings of this research project seem to suggest that the traditional understanding of the shadow of the law needs to be expanded. In our case, the legal arrangements in

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84. *See* Hetzler et al., *supra* note 4, at 6.

85. *See* Geckeler, *supra* note 5, at 178.

86. While some may view hierarchical communication as a necessary attribute of the delivery of medical services, research in recent decades has cast serious doubt on this approach. *See supra* note 68.

87. Robert Mnookin & Lewis Kornhauser, *Bargaining in the Shadow of the Law: The Case of Divorce*, 88 YALE L.J. 950, 968, 997 (1979).

88. *See, e.g.*, Catherine R. Albiston, *Bargaining in the Shadow of Social Institutions: Competing Discourses and Social Change in Workplace Mobilization of Civil Rights*, 39 LAW & SOC'Y REV. 11, 16 (2005) (discussing the "shadow of the law" and the shadow of other social institutions on informal civil-rights negotiations in the workplace); James J. Alfini & Catherine G. McCabe, *Mediating in the Shadow of the Courts: A Survey of the Emerging Case Law*, 54 ARK. L. REV. 171, 172–73 (2001) (discussing the "shadow of the law" with respect to confidentiality in mediation, "mediation in good faith" requirements, and enforceability of mediation agreements); Ethan Katsh et al., *E-Commerce, E-Disputes, and E-Dispute Resolution: In the Shadow of "eBay Law"*, 15 OHIO ST. J. ON DISP. RESOL. 705, 707–08 (2000) (discussing mediation and the shadow of "eBay law" over disputes on the auction website eBay); William J. Stuntz, *Plea Bargaining and Criminal Law's Disappearing Shadow*, 117 HARV. L. REV. 2548, 2548 (2004) (discussing the shadow of the law in the context of plea bargaining in criminal cases). *But see* Lloyd C. Anderson, *Interpretation of Consent Decrees and* Microsoft v. United States I*: Making Law in the Shadow of Negotiation*, 1 U. PITT. J. TECH. L. & POL'Y 1, 1 (2000) (discussing the role negotiated settlements play in the creation of substantive law); Omar M. Dajani, *Shadow or Shade? The Roles of International Law in Palestinian–Israeli Peace Talks*, 32 YALE J. INT'L L. 61, 64–65 (2007) (arguing that the law has less of a shadow on international mediation).

one area of law (medical malpractice) have shaped the way in which disputes in other areas are being addressed. This may stem from the fact that the disputes affected by the shadow of malpractice law are non-litigable disputes, disputes for which the law seems to offer no shadow.

On closer inspection though, we may come to realize that communication over non-litigable matters in hospitals does not take place in a vacuum; rather, it is the non-intervention by law that creates a shadow of sorts, which actively shapes the outcome of such disputes. Where there is no legal avenue, patients have fewer alternatives and are more inclined to accept the portrayal of such problems as a consequence of limited resources. On the medical staff's end, the encounter with parties who are also potential malpractice plaintiffs, allows the infiltration of the shadow of malpractice law through defensive communication, even though the subject matter under dispute is different.

Another important implication has to do with a different facet of the relations between ADR and formal law, and relates to the negative impact law can have on ADR processes when they are institutionalized in formal legal settings, or, in other words, the "cooptation" of ADR by law.[89] The literature on ADR has described the negative impact institutionalization has had on the quality of ADR processes, often reducing such alternatives as mediation into a discrete and quick settlement conference. In this mode, alternatives like mediation fail to realize the expectation for a process that would allow party involvement (let alone control), as well as imaginative and tailored outcomes.[90] In fact, critics' claims that ADR processes present a dangerous tool for deflating justified complaints[91] have found some support within the ADR community in those cases in which institutionalization has left parties without either the protection of the courts or the advantages of ADR.[92]

The findings in this article reinforce the concerns about the destructive impact law can have on ADR in several respects. For one, this research makes evident that the danger of cooptation of ADR by law is not restricted to those cases where ADR is institutionalized in courts. In our case, despite being

89. This is, of course, a reference to Carrie Menkel-Meadow's well-known article, *Pursuing Settlement in an Adversary Culture: A Tale of Innovation Co-opted, or 'The Law of ADR'*, 19 FLA. ST. U. L. REV. 1, 1–2 (1991), which discussed the impact that the formal legal system has had on alternative processes as a result of institutionalization of ADR in courts.

90. Nancy A. Welsh, *The Thinning Vision of Self-Determination in Court-Connected Mediation: The Inevitable Price of Institutionalization*, 6 HARV. NEGOT. L. REV. 1, 4–5 (2001).

91. *See, e.g.*, Richard Delgado et al., *Fairness and Formality: Minimizing the Risk of Prejudice in Alternative Dispute Resolution*, 1985 WIS. L. REV. 1359, 1375–91 (1985) (analyzing the prevalence of racial and ethnic prejudice in ADR and, consequently, such processes' harmful impact on minorities); Laura Nader, *Controlling Processes in the Practice of Law: Hierarchy and Pacification in the Movement to Re-Form Dispute Ideology*, 9 OHIO ST. J. ON DISP. RESOL. 1, 13–14 (1993).

92. *See* Trina Grillo, *The Mediation Alternative: Process Dangers for Women*, 100 YALE L.J. 1545, 1549–50 (1991) (arguing that divorce mediation poses dangers for women); Jacqueline M. Nolan-Haley, *Court Mediation and the Search for Justice Through Law,* 74 WASH. U. L.Q. 47, 99–100 (1996) (noting a growing population of unrepresented parties in mediation who are unaware of their legal rights); Welsh, *supra* note 90, at 5–6 (noting that some disputants in mediation are coerced into settlement).

located in a hospital and addressing complaints and disputes pre-litigation, the law is still very much present. In this context, the operation of the ombudsman, but also the informal approach of management and staff, reflect a legalized approach to conflict. One lesson seems to be that to protect against the danger of cooptation, ADR systems, even when operating outside the courts, need to adopt clear criteria as to the type of process they would like to conduct, and to employ rigorous quality-control measures.[93]

But our understanding of the law's coopting effect is challenged in other ways as well. While the literature in this area has focused on the negative impact law has had on the ADR *processes*, this research suggests that we also must pay attention to the adverse effect law can have on the *types of disputes* our ADR processes target and address. As we have seen, in general, the driving force for the institutionalization of ADR has been the desire to prevent malpractice litigation. Despite the proliferation of informal channels for addressing complaints and conflict at hospital, most notably ombudsmen offices, non-litigable disputes in many institutions remain prevalent with such disputes being attributed to the "culture of medicine" and financial difficulties. Specifically in our case, the investigatory mode employed by the ombudsman who seeks to determine whether a complaint is "justified," inevitably leaves a substantial number of non-litigable complaints without redress.[94]

This last point also raises some questions with respect to our approach to barriers to dispute resolution and cultural differences. While heavy attention has been paid to the role strategic[95] and cognitive[96] barriers play in the resolution of disputes, the impact of cultural differences on dispute-resolution efforts has played a less dominant role. In recent years, however, increased attention has been devoted to the role played by cultural differences between the parties, or the mediator and the parties, or both,[97] as well as the cultural biases embedded in the design and form of the ADR process itself.[98] In the present case study, we

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93. For an analysis of the limitations of current quality-control measures in mediation and a framework of an alternative approach, see Orna Rabinovich-Einy, *Technology's Impact: The Quest for a New Paradigm for Accountability in Mediation*, 11 HARV. NEGOT. L. REV. 253, 278–80 (2006).

94. *See generally* William L.F. Felstiner et al., *The Emergence and Transformation of Disputes: Naming, Blaming, Claiming . . .*, 15 LAW & SOC'Y REV. 630 (1980–1981) (exposing that many disputes are not being addressed because there are real barriers that prevent the aggrieved from airing their complaints).

95. *See, e.g.*, DAVID A. LAX & JAMES K. SEBENIUS, THE MANAGER AS NEGOTIATOR: BARGAINING FOR COOPERATION AND COMPETITIVE GAIN 33–35 (1986) (discussing how acceptable agreements between parties in mediation are often lost because of tactical decisions such as "[e]xaggerating the value of concessions and minimizing the benefits of other's concessions").

96. *See, e.g.*, Max H. BAZERMAN & MARGARET A. NEALE, NEGOTIATING RATIONALLY 4 (1992) ("[W]e will show you how various factors—such as how you structure problems, process information, frame the situation, and evaluate alternatives—can influence your judgment as a negotiator and limit your effectiveness.").

97. *See, e.g.*, MICHAL ALBERSTEIN, TORAT HAGISHUR [JURISPRUDENCE OF MEDIATION] 308–41 (2007); Jeffrey Z. Rubin & Frank E. Sander, *Culture, Negotiation and the Eye of the Beholder*, 7 NEGOT. J. 249, 249 (1991).

98. *See* ALBERSTEIN, *supra* note 97.

could see the different layers in which culture and cultural differences operate—individual, professional, organizational, and even international. Non-litigable disputes often stem from the cultural differences between the professional and organizational cultures of healthcare professionals at hospitals and the expectations of patients.[99]

While there have been some attempts to study the links between organizational culture and ADR, typically the literature does not link the organizational barriers for adopting ADR to legal incentives.[100] This research seems to suggest that the efforts to transform professional and organizational culture cannot be separated from an examination of legal incentives.[101] The story of the Veterans Affairs Medical Center in Kentucky brought by Jonathan Cohen is an excellent illustration of this point. That hospital was able to bring about a dramatic change in its approach to medical mistakes and their disclosure to patients and family members, among other reasons, because of the reduced liability exposure for the hospital, the lack of personal liability for physicians, and the fact that the hospital is self insured. These all contributed to the success of the new approach.[102] It remains an open question whether this change has infiltrated other realms of communication between the medical team and patients, impacting non-litigable disputes. Nevertheless, if defensive communication is abandoned, the level of non-litigable disputes can be expected to decrease and the efforts to address these conflicts to be more effective.

VI

CONCLUSION, OR HOW TO ESCAPE THE SHADOW OF MALPRACTICE CLAIMS

When we examine the culture of disputing in the healthcare arena, we see the unintended, elusive, and sometimes debilitating impact formal law can have. Unlike the traditional notion of the shadow of the law, the impact of malpractice claims extends beyond clear-cut medical-negligence cases and permeates the medical profession as a whole through the adoption of defensive communication. This impacts the manner in which conflict is addressed both by individual members of the staff as well as the institutionalized avenues for dispute resolution.

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99. *See* Szmania et al., *supra* note 57, at 73 (stating that disputes between health care professionals and patients have been called "akin to cross-cultural").

100. Most of the focus has been on the barriers posed by the medical professional culture. *See supra* notes 65–67 and accompanying text.

101. *See* Gross & Syverud, *supra* note 35, at 360–66 (revealing the role played by legal incentives, attorney fee arrangements, and insurance schemes in inducing and deterring malpractice litigation as well as negotiations prior to litigation).

102. *See* Cohen, *supra* note 33, at 1451, 1455–58, 1469–73. Cohen has made this point in the past. *See* Jonathan R. Cohen, *The Culture of Legal Denial*, 84 NEB. L. REV. 247, 257–58 (2005); Jonathan R. Cohen, *Toward Candor After Medical Error: The First Apology Law*, 5 HARV. HEALTH POL'Y REV. 21, 22–24 (2004).

Naturally, the connection between law and medicine has not been all negative; the law has made significant contributions to patient rights and to the practice of medicine. However, the close interaction between law and medicine in recent years also has come at a cost. What has been offered as a solution to the ills of the healthcare arena—ADR—has been neutralized by both law and what has become the business of medicine.[103] While a real need for ADR exists, as evidenced by the abundance of non-litigable disputes, conducting such processes in the shadow of existing tort doctrine has failed to bring about broad change.

The research findings in this article are instructive not only in uncovering the ills of the healthcare system, but could also offer direction for healthcare policy and reform efforts. Policymakers have viewed ADR and enhanced communication skills for medical staff as key in reducing mistakes and augmenting the quality of healthcare services, but have failed to realize ADR's potential for addressing and preventing non-litigable disputes. To seriously address non-litigable disputes, these conflicts would need to be identified as meriting attention and intervention.[104] Efforts to introduce ADR avenues and enhance communication skills in healthcare would have to be expanded and rigorous quality-control measures would need to be applied to ensure that ADR mechanisms are effective in preventing and addressing these problems. At the same time, the law governing medical malpractice must be reformed so as to allow for a more open and collaborative mode of communication to take place between healthcare professionals and patients. Such communication would not be limited to the disclosure of mistakes, but should guide doctor–patient relations more generally. In this context, ombudsmen could prove key players in satisfactorily addressing patient complaints[105] and in drawing on such complaints to induce organizational learning and change. Ombudsmen can employ proactive attempts to uncover systemic problems.[106] However, as we have seen in the case study presented here, the characteristics of the person occupying such a role (their professional training, background, and experience) as well as the institutional design of such an office (independence, formal and informal stature) can be key elements in shaping the ombudsman's goals, mandate, and mode of operation, and, ultimately, in succeeding to escape the shadow of malpractice law.

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103. *See* Blum, *supra* note 23, at 463–64.

104. Liebman and Hyman found it difficult to "convince healthcare professionals to spend the time needed to develop the [ADR] skills, especially since most will be involved in only a few such conversations [over medical mistakes] during their careers." *See* Liebman & Hyman, *supra* note 13, at 25. It may very well be that if healthcare professionals see ADR skills as assisting them in their daily encounters with patients and not only on the rare occasion of disclosure of medical mistakes, they will be more cooperative in learning and mastering these skills.

105. *See id.* (stating that it is more challenging for the medical staff to address disputes with patients satisfactorily since they have a stake in the outcome. Therefore, a neutral party would most likely be able to handle such conflicts more effectively, certainly once they have escalated into a full blown dispute).

106. *See* Cohen, *supra* note 33, at 1464–68.