

GETTING HEALTHIER: A PROPOSAL FOR IMPROVING MEDICAL MALPRACTICE MEDIATION

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INTRODUCTION

A middle aged police officer was receiving continuous treatment from her podiatrist for a severely injured, painful wound in her foot.¹ Because it was not healing, she finally went to see another doctor, who rushed her into the hospital for a bunionectomy.² Due to the delay in receiving correct treatment, she could no longer run and was no longer employable as a police officer.³ She was furious at the first doctor for not reaching out, not apologizing, not admitting what she believed was his error and not expressing care about what eventually happened to her.⁴ She sued and in a mediated session, in which neither she nor the doctor was allowed to attend nor give voice to their concerns, the doctor settled with her for \$437,500.⁵ Her attorney tells her that by settling, the doctor has, in effect, admitted liability and offered the only version of an apology he could, which, the attorney believes, means more to the officer than the money.⁶

A philosopher once articulated a theory of medical ethics premised upon a reciprocity between doctor and patient: the doctor's primary moral obligations to be competent, beneficent and diligent and the patient's reciprocal obligation to return honor,

¹ Telephone interview with medical malpractice attorney Alan Figman (March 31, 2010).

² *Id.* A bunionectomy is a surgical procedure to excise, or remove, a bunion.

³ *Id.*

⁴ *Id.*

⁵ *Id.*

⁶ *Id.*

gratitude and reward.⁷ As the episode recounted above, as well as a great multitude of others in the medical malpractice literature reveal, allegations of medical malpractice can result in a complete breakdown in the envisioned ethically based, reciprocal relationship.⁸ The possibility of reciprocity is shut down because communication generally ceases after the occurrence of such an event.⁹ As this paper will elaborate upon in great detail, patients and doctors, in the aftermath of the occurrence of medical error, have a multitude of needs and desires. For patients, a finding of negligence and an award of damages may not begin to reflect the extent of what they actually require in order to get on with their lives. For physicians, an accusation of medical malpractice may result in a need for the catharsis of communication, apology or confession, in order to heal.¹⁰

Opportunities for parties to medical malpractice disputes to enter into a meaningful, significant discourse through the process of mediation, offering the potential for dealing with extra-legal concerns that may not rise up on the face of their complaints are often squandered because the form of mediation provided was not capacious enough nor designed to permit such a discourse. This paper proposes that the model of mediation employed for handling

⁷ W.R. Albury & G.M. Weisz, *The Medical Ethics of Erasmus and the Physician-Patient Relationship*, 27 J. MED. ETHICS: MEDICAL HUMANITIES 35, 39 (2001), available at <http://mh.bmj.com/content/27/1/35.full.pdf> (registration required) (discussing Desiderius Erasmus's philosophical theory which he articulated in 1518).

⁸ See, e.g., STEPHEN L. FIELDING, *THE PRACTICE OF UNCERTAINTY: VOICES OF PHYSICIANS AND PATIENTS IN MEDICAL MALPRACTICE CLAIMS* (1999) (incorporating in-depth interviews with patients and doctors who were parties to medical malpractice claims where complaints were often based upon a post-incident failure of communication); Eric Galton, *Mediation of Medical Negligence Claims*, 28 CAP. U.L. REV. 321, 321-322 (2000) (noting that dysfunctional communication often results after an adverse outcome).

⁹ See *infra* note 96 and accompanying text.

¹⁰ See WILLIAM T. CHOCTAW, *AVOIDING MEDICAL MALPRACTICE: A PHYSICIAN'S GUIDE TO THE LAW* 80 (2008)

the vast majority of medical malpractice disputes—the evaluative model¹¹—is inadequate for handling the many concerns and deeper needs of the parties. Instead, this paper proposes a model, grounded in the facilitative approach¹², which would better serve the unique, extra-legal needs of patients and healthcare providers who find themselves embroiled in medical malpractice disputes. It is well established that mediation provides an effective, efficient process for settling medical malpractice claims;¹³ this paper

¹¹ CAROL B. LIEBMAN & CHRIS STERN HYMAN, *MEDICAL ERROR DISCLOSURE, MEDIATION AND MALPRACTICE LITIGATION: A DEMONSTRATION PROJECT IN PENNSYLVANIA*, at 7 http://www.pewtrusts.org/uploadedFiles/wwwpewtrustsorg/Reports/Medical_liabilityh/LiebmanReport.pdf (last visited March 30, 2010) (noting that the evaluative model predominates for handling such disputes); Leonard R. Riskin & Nancy A. Welsh, *Is That All There Is? “The Problem” In Court-Oriented Mediation* 15 *GEO. MASON L. REV.* 863, 864 (2008) (noting that in the court connected context, medical malpractice mediations usually define the issues narrowly along a litigation-risk framework dominated by valuation); The evaluative method is explained in detail in Part I of this paper.

¹² The facilitative method is explained in detail in Part I of this paper.

¹³ *E.g.*, Edward A. Dauer & Leonard J. Marcus, *Adapting Mediation to Link Resolution of Medical Malpractice Disputes with Health Care Quality*, 60-WTR *LAW & CONTEMP. PROBS.* 185, 186 (1997) (“we hypothesize that mediation . . . can make claims resolution more efficient and simultaneously promote quality improvement in health care more effectively than does the litigation/settlement process.”); Max Douglas Brown, *Rush Hospital’s Medical Malpractice Mediation Program: An ADR Success Story*, 86 *Ill. B.J.* 432, 440 (1998) (“Mediation is not a better way to try cases than jury trials. It may, however, be a better way to settle cases than is otherwise available.”); Thomas Metzloff et al., *Empirical Perspectives on Mediation and Malpractice*, 60-WTR *LAW AND CONTEMP. PROBS.* 107, 108 (1997) (“Mediation should be considered seriously. It is a less formal ADR method than arbitration, and it offers the potential for an early intervention to resolve a dispute without resort to trial or indeed without resort to litigation at all.”); Florence Yee, *Mandatory Mediation: The*

proceeds under that general assumption. However, there are different models of mediation and it is this paper's thesis that factors unique to medical malpractice disputes argue for an interest-based approach grounded in the facilitative model.

Part I of this paper will provide an overview of the evaluative and facilitative models and the debate that ignited in the mid 1990s over what mediation was and how it could best serve those who partook in it. Part II will discuss the concerns, issues and interests unique to medical malpractice disputes, including a patient's need for agreement on future harm prevention measures, for concrete and honest communication, and for apology, all of which may co-exist or even prevail over requests for damages. This part will also discuss a physician's potential interest in communication and catharsis. Finally, this part will conclude with a discussion of the model currently prevailing in use for medical malpractice disputes. Part III will unite the matters discussed in Parts I and II in concluding that the unique facets of medical malpractice disputes are best served by a model grounded in the facilitative, interest-based approach to mediation. Part IV will offer a concrete proposal on how such mediations optimally could be set up.

I: THE FACILITATIVE AND EVALUATIVE MODELS

A. *Evolution*: Mediation at its core is a process where a neutral third-party—the mediator—works with parties to a conflict, aiding them in communicating more productively to improve their

Extra Does Needed to Cure the Medical Malpractice Crisis, 7 CARDOZO J. CONFLICT RESOL. 393, 418 (2006) (finding that the advantages to mediating medical malpractice disputes include that it avoids excessive litigation costs and delayed resolutions); Edward A. Dauer, et al., *Prometheus and the Litigators: A Mediation Odyssey*, 21 J. LEGAL MED. 159, 159 (2000) (“voluntary mediation is an alternative that can contribute significantly both to the efficiency of the malpractice claim process and to its ability to promote ‘deterrence,’ or what health care managers call ‘patient safety.’”).

mutual understanding of a situation.¹⁴ Although its use for conflict resolution has ancient origins,¹⁵ the contemporary mediation movement was fueled by the idealism of the 1960s and early 70s,¹⁶ generating what has come to be seen as some of mediation's key advantages,¹⁷ which include: allowing the parties, rather than the courts, to exert control over issues; developing outcomes tailored to the disputants' needs, which would thus be more durable than what a court would order; and encouraging active party involvement in a voluntary process.¹⁸

Another force that came to form mediation along the lines of the vision described above came about in 1980,¹⁹ with the publication of the seminal and groundbreaking work, *Getting to Yes*,²⁰ which proposed a new theory of negotiation, termed *principled negotiation*.²¹ Central is the belief that a negotiation is better served when parties focus on interests and needs rather than positions.²² This revolutionary approach soon after began

¹⁴ JOSEPH P. STULBERG & LELA P. LOVE, *THE MIDDLE VOICE: MEDIATING CONFLICT SUCCESSFULLY* 15 (2009).

¹⁵ CARRIE MENKEL-MEADOW, LELA PORTER LOVE & ANDREA KUPFER SCHNEIDER, *MEDIATION: PRACTICE, POLICY, AND ETHICS* 96 (2006).

¹⁶ Nancy A. Welsh, *The Thinning Vision of Self-Determination in Court-Connected Mediation: The Inevitable Price of Institutionalization?* 6 HARV. NEGOT. L. REV. 1, 15-16 (2001).

¹⁷ *Id.* at 18 (noting that at the time, community centers adopted a mediation model employing these key tenants).

¹⁸ MENKEL-MEADOW, et al., *supra* note 15, at 14-15; Welsh, *supra* note 16, at 18.

¹⁹ Robert A. Baruch Bush, *Staying in Orbit, or Breaking Free: The Relationship of Mediation to the Courts Over Four Decades*, 84 N.D. L. REV. 705, 721- 722 (2008).

²⁰ ROGER FISHER & WILLIAM URY, *GETTING TO YES: NEGOTIATING AGREEMENT WITHOUT GIVING IN* (1980).

²¹ *Id.* at 10.

²² *Id.* at 10-11, 41 (Arguing that positional bargaining often obscures what people really want. "Interests" are the needs and underlying motivations that often infuse positions but resonate for individuals on a deeper level. An example from the book: Israel's *position* on keeping part of the Sinai during the 1978 Camp David

appearing in mediation scholarship and “gradually became central to an understanding of what mediation does.”²³ This development informed what has come to be known as the “facilitative” model of mediation.²⁴

In 1994 the mediation landscape was vastly redefined by Leonard Riskin,²⁵ who noted that mediators in practice utilize techniques and strategies that hew along two distinct but sometimes interrelated continuums which he placed along a grid:²⁶ the facilitative/evaluative and the narrow/broad.²⁷ On the facilitative/evaluative continuum, Riskin identified that the evaluative mediator evaluates the merits of the disputed issues providing guidance to the appropriate grounds for settlement.²⁸ In contrast, the facilitative mediator believes it is not appropriate for a mediator to offer opinions.²⁹ Along the narrow/broad continuum,

peace negotiations with Egypt, and their underlying *interest* in security. A solution was obtained by allowing Egypt to keep the land so long as they kept their tanks off it.).

²³ Bush, *supra* note 19, at 722-723.

²⁴ *Id.* at 723.

²⁵ Leonard L. Riskin, *Mediator Orientations, Strategies and Techniques*, 12 ALTERNATIVES TO HIGH COST LITIG. 111 (1994); Leonard L. Riskin, *Understanding Mediators' Orientations, Strategies, and Techniques: A Grid for the Perplexed*, 1 HARV. NEGOT. L. REV. 7 (1996). Riskin did not propose a new model but merely identified what was going on in the field. The word “merely” is used to qualify that he had not created anything new; however, in identifying these trends, Riskin had a remarkable effect on the mediation dialogue that continues to this day.

²⁶ This is familiarly known as “Riskin’s Grid”.

²⁷ Leonard L. Riskin, *Mediator Orientations, Strategies and Techniques*, 12 ALTERNATIVES TO HIGH COST LITIG. 111, 111-112 (1994).

²⁸ Leonard L. Riskin, *Understanding Mediators' Orientations, Strategies, and Techniques: A Grid for the Perplexed*, 1 HARV. NEGOT. L. REV. 7, 24 (1996). More on the evaluative model to follow.

²⁹ Riskin, *supra* note 27, at 111. Riskin offers two reasons: that the opinions will impair the appearance of mediator impartiality and that the mediator might not be qualified to provide an accurate

the problem is defined either narrowly, so only a limited number of issues may be discussed; or broadly, where the parties are provided a wide berth to reach any issues or underlying interests that may arise.³⁰

B. *Debate*: In formulating his thesis, Riskin did at least two things that aroused controversy among the adherents of the facilitative approach. First, he accepted the premise that a mediator *could* function as an evaluator who offered opinions on the merits of a dispute.³¹ And, compounding the controversy, he postulated that evaluative mediation had some advantages.³² Riskin believed this approach could make it easier to reach agreement.³³ He also believed that the evaluative mediator could give parties and/or their lawyers a better understanding of their “Best Alternative to a Negotiated Agreement”,³⁴ could assist lawyers who had difficulty getting through to their clients, and could provide the parties with a feeling of vindication.³⁵

Many in the mediation community reacted negatively to Riskin’s Grid.³⁶ The most vocal and influential³⁷ reaction came

evaluation. Lela Love responded with an additional eight reasons. Lela P. Love, *The Top Ten Reasons Why Mediators Should Not Evaluate*, 24 FLA. ST. U. L. REV. 937 (1997). More on the facilitative model to follow.

³⁰ Riskin, *supra* note 28, at 42-43.

³¹ Kimberlee Kovach and Lela Love responded by stating “Evaluative mediation is an oxymoron.” Kimberlee K. Kovach & Lela P. Love, *Evaluative Mediation is an Oxymoron*, 14 ALTERNATIVES TO HIGH COST LITIG. 31 (1996).

³² Riskin, *supra* note 28, at 44-45.

³³ *Id.*

³⁴ *Id.* Here Riskin refers to a term coined by Fisher and Uri in *Getting to Yes*. The phrase is self-explanatory. *See* FISHER & URY, *supra* note 20, at 100.

³⁵ Riskin, *supra* note 28, at 45.

³⁶ Eventually, even Riskin himself would come to distance himself, in some respects, from his own grid, later stating “The fundamental problem is this: mediation is facilitative negotiation. Its essence is facilitation. If facilitation is the essence of mediation and evaluation is the opposite of facilitation, evaluation would seem to

from Lela Love and Kimberlee Kovach; the titles of their articles speak volumes: “Evaluative Mediation is an Oxymoron”,³⁸ “The Top Ten Reasons Why Mediators Should Not Evaluate”,³⁹ and “Mapping Mediation: The Risks of Riskin’s Grid”.⁴⁰ In arguing against the use of Riskin’s Grid for guidance as to what mediators can and should do, they argued for a clear conception of mediation where the mediator did not “evaluate” but rather worked to “reorient the parties toward each other,” helping them toward a new, shared perception of their relationship.⁴¹ They decried mediation devolving into other processes,⁴² including “Michigan Mediation”⁴³ which did not “fit comfortably under the same

rob mediation of its essence. This might be the gist of Kim Kovach and Lela Love’s conclusion—with which I have belatedly come to sympathize—that “[e]valuative mediation is an oxymoron.” Leonard L. Riskin, *Decisionmaking in Mediation: The New Old Grid and the New New Grid System* 79 NOTRE DAME L. REV. 1, 17-18 (2003).

³⁷ And, even to this day, oft-quoted and referenced.

³⁸ Kovach & Love, *supra* note 31.

³⁹ Love, *supra* note 29.

⁴⁰ Kimberlee K. Kovach & Lela P. Love, *Mapping Mediation: The Risks of Riskin’s Grid*, 3 HARV. NEGOT. L. REV. 71 (1998)

⁴¹ *Id.* at 74 and at 92, quoting Professor Lon Fuller.

⁴² However, they did not take a stand on the merits of evaluation itself but rather argued that evaluative mediation should be placed in an entirely different category and that it not be considered a subcategory of mediation. *Id.* at 77-78.

⁴³ In Michigan state trial courts, this was a process used for case settlement, where a panel of three lawyers would hear shortened case presentations and then present an evaluation, which might include an evaluation of the merits of the case or an assessment of what a likely jury verdict or damages award would be. MENKEL-MEADOW, et al., *supra* note 15, at 400. In 2000, the Michigan Supreme Court revised its rules to change the name of what was formerly known as “Michigan Mediation” to “case evaluation”. Another rule was also enacted to distinguish what was now termed “case evaluation” from mediation, which the Michigan trial courts also employed in a form consistent with traditional uses of mediation. Susan Naus Exon, *The Effects That Mediator Styles*

terminological umbrella.”⁴⁴ Love, as noted *supra*, gave ten reasons why mediators should not evaluate.⁴⁵ Among them were beliefs that when a mediator offered an opinion favoring one side, the appearance of neutrality would be challenged; that evaluative models like arbitration were already available so the genuine alternative of mediation should not be lost by transforming it into another such model; and, arguably Love’s most decisive point, a fear that evaluation would kill the “jet engine of idea generation”, stifling party creativity by forcing them to fall-in-line with the solution the mediator offered rather than allowing them free rein to generate their own solutions.⁴⁶

Another take on mediation provided around the time Riskin formulated his grid (but not offered in response to it) was presented by Bush and Folger in their seminal work, *The Promise of Mediation*.⁴⁷ Having found through research and anecdotal evidence that most mediators took a settlement-focused approach, they instead proffered their ideal of mediation, “The Transformative Story”,⁴⁸ now commonly known as transformative mediation. Much of what they advocated could be seen as a more philosophical and expansive take on what the facilitative approach could already potentially accommodate⁴⁹: its “less tangible”

Impose on Neutrality and Impartiality Requirements of Mediation, 47 U.S.F. L. REV. 577, 597-598 (2008).

⁴⁴ Kovach & Love, *supra* note 40, at 92.

⁴⁵ Love, *supra* note 29.

⁴⁶ *Id.* at 937-945.

⁴⁷ ROBERT A. BARUCH BUSH & JOSEPH P. FOLGER, *THE PROMISE OF MEDIATION: RESPONDING TO CONFLICT THROUGH EMPOWERMENT AND RECOGNITION* (1994)

⁴⁸ *Id.* at 17.

⁴⁹ However, the transformative model is distinguishable from the facilitative in that the transformative mediator would not define issues, offer suggestions or proposals but would instead concentrate on empowering the parties to do that work themselves. *Id.* at 12. In contrast, Kovach and Love’s facilitative vision accommodates a mediator who structures an agenda of issues up for discussion; who probes and assesses positions; who challenges proposals through “reality testing” (i.e. making the parties aware of any potential issues that might arise regarding solutions or

aspects.⁵⁰ They believed that through the experience of open, facilitated discourse individuals could experience a sense of their own value and strength, and could have evoked in them an empathy for the concerns of the other party; this, they believed, mattered as much, if not more, than any settlement reached.⁵¹ To them, this was the promise of what mediation could offer and they believed that the current state of settlement-focused mediation ignored its potential for engendering moral growth and “transforming human character toward both greater strength and compassion.”⁵²

C. The Facilitative Approach: In addition to points already raised, the following may flesh-out the discussion. Facilitative mediation is designed to give expression to the individuals’ “insights, imagination and ideas.”⁵³ It is premised upon allowing the parties to identify the issues; to decide freely whether to reach agreement through a process of “self determination”;⁵⁴ and permitting parties to enter into a discourse without pressure or even advice from experts.⁵⁵ When viewing mediation on a continuum, at the extreme facilitative end the intent is simply to permit the parties to communicate with and understand each other.⁵⁶

The facilitative mediator’s tasks would include: the laying down of ground rules; the creation of an agenda of issues communicated to the parties; the use of various techniques designed to generate progress (e.g. focusing on interests,

suggestions proposed), and who suggests solutions. Kovach and Love, *supra* note 40, at 80.

⁵⁰ BUSH & FOLGER, *supra* note 47, at 3.

⁵¹ *Id.* at 3 and 4.

⁵² *Id.* at 4-5, 17. This paper does not consider a fourth version of mediation, narrative mediation. Dr. Brian Jarrett, *The Future of Mediation: A Sociological Perspective*, 2009 J. DISP. RESOL. 49, 55 (2009) (describing the form).

⁵³ Joseph B. Stulberg, *Facilitative Versus Evaluative Mediator Orientations: Piercing the “Grid” Lock*, 24 FLA. ST. U. L. REV. 985, 1001 (1997).

⁵⁴ Riskin & Welsh, *supra* note 11, at 864.

⁵⁵ Stulberg, *supra* note 53, at 1001.

⁵⁶ Riskin, *supra* note 28, at 24.

highlighting areas of common agreement⁵⁷); caucusing separately, if necessary, with each of the parties for psychological and strategic reasons designed toward eliciting critical information; and, if a written agreement is called for, creating one using the words of the parties themselves.⁵⁸

D. *The Evaluative Approach*: An evaluative mediator makes assessments or proposals for agreement, assuming that is what is wanted.⁵⁹ The approach assumes the mediator is obligated to facilitate fair and legally just results, which often requires the imposition of law.⁶⁰ An evaluative mediator may believe that in order for parties to understand their rights the mediator should provide legal information.⁶¹ Proponents see this as necessary so the parties trust the process and feel ensured that the mediator is unbiased and has not withheld necessary information that might make an agreement ultimately disadvantageous to them.⁶² The evaluative mediator uses evaluation to correct the parties often distorted picture of the legal merits of their case.⁶³ This can work to aid lawyers fearing a “kill the messenger” mentality, preferring bad news be delivered to their clients by a third party neutral.⁶⁴ As parties often evaluate their own issues in legal terms, mediators are ultimately encouraged *to* evaluate.⁶⁵ In order to provide an authoritative evaluation, the mediator should possess substantive

⁵⁷ Robert A. Baruch Bush, *One Size Does Not Fit All: A Pluralistic Approach to Mediator Performance Testing and Quality Assurance*, 19 Ohio St. J. on Disp. Resol. 965, 985 (2004).

⁵⁸ STULBERG & LOVE, *supra* note 14, 49-113.

⁵⁹ Riskin, *supra* note 27, at 111.

⁶⁰ See Welsh, *supra* note 16, at 30-31, discussing commentary from evaluative mediators working in a court setting.

⁶¹ James H. Stark, *The Ethics of Mediation Evaluation: Some Troublesome Questions and Tentative Proposals, from an Evaluative Lawyer Mediator*, 38 S. TEX. L. REV. 769, 795 (1997).

⁶² *Id.* at 795-796.

⁶³ Dwight Golann, *The Changing Role of Evaluation in Commercial ADR*, 1 DISP. RESOL. MAG. 16, 19 (2007).

⁶⁴ *Id.*

⁶⁵ *Id.*

knowledge regarding the issues to be evaluated.⁶⁶ Many evaluative mediators lack the facilitative skills previously described.⁶⁷

The evaluative mediator's tasks would include: document review;⁶⁸ providing assessments of factual and legal matters; actively participating in the formulation of a resolution; predicting trial outcomes; caucusing to convince participants to accept a suggested solution; applying pressure to settle; and, typically, limiting emotional expressions, seeing them as disruptive.⁶⁹

Scholars note that many mediators employ flexibility between the two approaches.⁷⁰

II. MEDICAL MALPRACTICE AND MEDIATION

A. *Background*: What distinguishes a simple negligence claim from a medical malpractice claim is the relationship between the healthcare provider and the patient; when the duty inherent in

⁶⁶ Jarrett, *supra* note 52, at 55.

⁶⁷ Riskin, *supra* note 27, at 114.

⁶⁸ The facilitative mediator, however, is not necessarily precluded from document review. Reviewing document review pros (preparation, time saving, focus) and cons (a belief that the mediator should obtain her perception of the dispute live without reaching a premature determination that could impair the perception of neutrality) in a facilitative setting, Josh Stulberg decided the practice may vary, depending on the context of the dispute. Stulberg, *supra* note 53, at 999.

⁶⁹ Paula M. Young, *A Connecticut Mediator in a Kangaroo Court?: Successfully Communicating the "Authorized Practice of Mediation" Paradigm to "Unauthorized Practice of Law" Disciplinary Bodies*, 49 S. TEX. L. REV. 1047, 1180 (2008).

⁷⁰ See, Riskin, *supra* note 28, at 36-38; E. Patrick McDermott & Ruth Obar, "What's Going On" In *Mediation: An Empirical Analysis of the Influence of a Mediator's Style on Party Satisfaction and Monetary Benefit*, 9 HARV. NEGOT. L. REV. 75, 79 (2004); Susan Oberman, *Style vs. Model: Why Quibble?* 9 PEPP. DISP. RESOL. L.J. 1, 26 (2008); Dwight Golann, *Variations in Mediation: How—and Why—Legal Mediators Change Styles in the Course of a Case*, 2000 J. DISP. RESOL. 41, 42 (2000).

the relationship is breached, the breach gives rise to a cause of action sounding in medical malpractice.⁷¹ The elements of proof are 1) a deviation from the accepted standard of care; and 2) a showing that that the deviation was the proximate cause of plaintiff's injury.⁷² The majority of such suits are dropped or settled before trial.⁷³ Most state licensing boards in the U.S. require that a physician carry malpractice liability insurance;⁷⁴ as coverage is usually complete, the physician is not exposed to cost sharing when they incur losses.⁷⁵ Whether there is an overabundance of litigation in relation to the actual amount of medical malpractice that occurs is disputed.⁷⁶ Regardless, the extent of injury inflicted due to medical malpractice is staggering.⁷⁷

⁷¹ *Stanley v. Lebetkin*, 123 A.D.2d 854, 854 (2nd Dept. 1986).

⁷² *Bloom v. City of New York*, 202 A.D.2d 465, 465 (2nd Dept. 1994).

⁷³ CHOCTAW, *supra* note 10, at 73.

⁷⁴ EDWARD D. MCCARTHY, *THE MALPRACTICE CURE: HOW TO AVOID THE LEGAL MISTAKES THAT DOCTORS MAKE* 12 (2009).

⁷⁵ FRANK A. SLOAN & LINDSEY M. CHEPKE, *MEDICAL MALPRACTICE* 93 (2008).

⁷⁶ *Compare* TOM BAKER, *THE MEDICAL MALPRACTICE MYTH* 2 (2005) (“As confirmed by recent studies, we know that the real problem regarding medical malpractice is too much medical malpractice, not too much litigation. Most people do not sue, which means the victims—not the doctor, hospitals, or liability insurance companies—bear the lion’s share of the costs of medical malpractice.”) and CHOCTAW, *supra* note 10, at 15 (“Most lawsuits come from medical malpractice.”) with David M. Studdert, et al. *Claims, Error and Compensation Payments in Medical Malpractice Litigation*, 354 *NEW ENG. J. MED.* 2024 (2006) (“In 40% of the lawsuits reviewed there was no evidence of medical error or verifiable injury.”).

⁷⁷ Aviva Orenstein, *Apology Excepted: Incorporating a Feminist Analysis Into Evidence Policy where You Would Least Expect It*, 28 *SW. U. L. REV.* 221, 257 (1999). A report by the Institute of Medicine of the National Academy of Science summarized research showing that nearly 100,000 people die yearly in the United States due to medical malpractice. BARKER, *supra* note 76, at 5.

Mediation is generally used where the insurer, the healthcare provider and the patient are willing to settle but are not in agreement on terms.⁷⁸ Settlements are reported to the National Practitioner Data Bank⁷⁹ (hereinafter “NPDB”); therefore, healthcare providers may consider that fact before they enter into mediation with a patient.⁸⁰ Sometimes, the physician’s goal of avoiding the issuance of a negative report to the NPDB, which might require going to trial for a finding that the doctor was not negligent, may not align with the insurer’s interest in keeping losses at a minimum, which might require mediation to avoid litigation expenses.⁸¹ However, that is not always so; while the insurer does pay the attorney fees, some insurers avoid coming between the doctor and the attorney.⁸² An insurance claims representative generally will attend a mediated session⁸³ and, where mediation is court-ordered, their attendance is often required.⁸⁴

B. Issues Arising for Patients in Medical Malpractice Disputes:

1. Compensation in Damages: Compensation is clearly one factor in the decision to sue following an adverse medical outcome.⁸⁵ Patients sue for a breach in medical care that can result in significant or permanent injury or death and they seek

⁷⁸ MCCARTHY, *supra* note 74, at 175.

⁷⁹ A repository for, inter alia, any negative actions or findings taken against healthcare practitioners including settlement payments. National Practitioner Data Bank Healthcare Integrity and Protection Data Bank; Fact Sheet for the General Public (March 2010), available at http://www.npdb-hipdb.hrsa.gov/pubs/fs/Fact_Sheet-General_Public.pdf.

⁸⁰ MCCARTHY, *supra* note 74, at 175.

⁸¹ Dauer, et al., *supra* note 13, at 159.

⁸² *Id.*

⁸³ Telephone interview with Alan Figman, *supra* note 1.

⁸⁴ See Thomas Metzloff, et al., *Empirical Perspectives on Mediation and Malpractice*, 60 LAW & CONTEMP. PROBS. 107, 116 (1997).

⁸⁵ Richard C. Boothman, et al. *A Better Approach to Medical Malpractice Claims? The University of Michigan Experience*, 2 HEALTH & LIFE SCI. L. 125, 133 (2009).

compensation for those injuries.⁸⁶ In fact, in the civil liability system, money *is* the only remedy available to the victim of medical error.⁸⁷ However, in one study, only 24% of medical malpractice plaintiffs sued for money, which meant, of course, that 76% were suing for reasons other than monetary compensation.⁸⁸ This may be because patients often believe the only avenue they have to address their concerns is through adjudication.⁸⁹ Studies bear out that the predominant motivation underlying a medical malpractice suit is not to obtain money.⁹⁰ Yet plaintiffs often sue for money as a way to achieve something else⁹¹ as money and litigation often serve as surrogates for other needs.⁹²

2. Harm Prevention: At the top of the list of nearly every study conducted on why

patients sue is a desire on the part of patients that that what happened to them should not occur again.⁹³ Some patients have accepted settlement outcomes that are hinged on agreements by their physicians that they undertake corrective action and they make such agreements in lieu of dollar settlements, or with little payment of money.⁹⁴ In a study in Massachusetts, it was found that agreements based on “quality improvement” and future patient safety often satisfied claimants.⁹⁵

3. Communication Failure: Studies on the etiology of a medical malpractice suit indicate that communication inadequacies

⁸⁶ Thomas M. O’Toole, et al., *The Anatomy of a Medical Malpractice Verdict*, 70 MONT. L. REV. 57, 58 (2009).

⁸⁷ Dauer & Marcus, *supra* note 13, at 205 (noting, in contrast, that mediation offers a flexibility of remedy).

⁸⁸ *Id.* at 203-204 (discussing a study of parents of children who had been neurologically impaired at birth).

⁸⁹ Dauer, et al., *supra* note 13, at 166.

⁹⁰ Dauer & Marcus, *supra* note 13, at 203-204.

⁹¹ *Id.* at 203-204.

⁹² Dauer, et al., *supra* note 13, at 162.

⁹³ *Id.* at 161.

⁹⁴ *Id.* at 159.

⁹⁵ Dauer & Marcus, *supra* note 13, 185 (conceding, however, that the results did not “satisfy the requisites of statistical analysis.”).

or breakdowns between the healthcare provider and the patient are more responsible for the vast majority of suits than any other factor.⁹⁶ Basically, the literature reveals that patient issues regarding communication can be divided along two lines: the concrete need to hear an explanation for an adverse outcome and the human need for validation.⁹⁷

The need for a concrete explanation works as a motivating factor when patients seek basic answers—which doctors fail to provide—as to why an adverse outcome occurred: for example, why did a family member die, or why did great harm result from a procedure in which a great risk was not perceived?⁹⁸ It is difficult, if not impossible, for patients to obtain closure without the receipt of basic, concrete information regarding events which upturned their lives.⁹⁹

One study noted that a large percentage of patients filed suit “when they decided that the

⁹⁶ Galton, *supra* note 8, at 321-322 (claiming “every reliable study” leads to this conclusion); *see also* FIELDING, *supra* note 8, at 109 (noting that a British study found 81% of injured patients were “dissatisfied with the clarity and thoroughness of the explanations given for their injuries” and that this lack of openness gave them incentive to sue); Dauer & Marcus, *supra* note 13, at 203-204 (the same study cited *supra* at note 88 indicating that only 24% of medical malpractice suits are brought over money also indicated that 44% were brought over communication issues which included getting someone to tell them what happened and issues with perception of the doctor’s honesty); LIEBMAN & HYMAN, *supra* note 11, at 3 (“Research shows that ineffective communication with patients—not negligence—puts physicians at greatest risk of malpractice lawsuits.”).

⁹⁷ *See, e.g.*, Galton, *supra* note 8, at 322-330, enumerating patient communication issues which can be viewed as dividing along these lines.

⁹⁸ *Id.* (also noting patient dissatisfaction with delayed, confusing or conflicting explanations).

⁹⁹ *See, id.*

courtroom was the only forum in which they could find out what happened” to them.¹⁰⁰

The human need for validation when receiving medical care is noted in a book by Stephen Fielding, which includes a compendium of interviews giving voice to patients and doctors involved in medical malpractice disputes.¹⁰¹ Fielding found that patient marginalization—in the form of a physician’s patronizing remarks, lack of empathy, evasiveness, not acknowledging personal and social issues as they relate to the patient’s medical condition, and failure to listen carefully to what patients say—was of frequent issue.¹⁰² This failure to listen made some of Fielding’s interviewee patients angry.¹⁰³ The resulting poor relation with the physician became a crucial factor in a decision to bring suit.¹⁰⁴ Fielding also noted that for women patients, experiencing medical error requires a narrative mechanism: they want to tell their story to their doctor and they want to feel that this story had been seriously listened to.¹⁰⁵

4. Apology:¹⁰⁶When a physician makes an error, the trust-based relationship with a patient is breached; failure to apologize for such errors compounds the problem.¹⁰⁷ Patients expect that someone worthy of their trust will behave ethically; that ethical responsibility may extend an obligation on a physician to offer an

¹⁰⁰ Jennifer K. Robbennolt, *What We Know and Don’t Know About the Role of Apologies in Resolving Healthcare Disputes*, 21 GA. ST. U. L. REV. 1009, 1016 (2005) (quoting a study by Gerald Hickson).

¹⁰¹ FIELDING, *supra* note 8, at 86.

¹⁰² *Id.*

¹⁰³ *Id.*

¹⁰⁴ *Id.* at 109.

¹⁰⁵ *Id.* at xiii (from the foreword by Howard Waitzkin).

¹⁰⁶ Aviva Orenstein notes that apologies have two fundamental requirements: the offender has to both be sorry and express sorrow. At their deepest level, apologies are “a form of self-punishment that cut[] deeply because we are obliged to retell, relive and seek forgiveness for sorrowful events” Orenstein, *supra* note 77, at 239 (quoting Nicholas Tavuchis).

¹⁰⁷ LIEBMAN & HYMAN, *supra* note 11, at 45.

apology for a mistake.¹⁰⁸ Although this paper is in no way advocating for the use of an apology as a strategy for avoiding a malpractice suit, an apology can offset a patient's inclination to sue.¹⁰⁹ Apologies can begin a dialogue that can help repair the damaged physician-patient relationship and be part of a discussion on how to avoid further errors.¹¹⁰ They can make those who might otherwise have brought suit less angry and less suspicious and can have a powerful impact on the relationship with the healthcare provider.¹¹¹

In line with the discussion on communication and validation in the previous section, the failure to issue an apology is often viewed by patients as a failure to empathize with the patient's plight, leaving the patient feeling as if the doctor, who is supposed to care, does not.¹¹² A dehumanized response in the face of a patient's fear and anxiety destroys trust and makes the doctor appear unsympathetic.¹¹³ If the doctor instead apologizes, the apology can facilitate emotional healing and can even help in maintaining the relationship.¹¹⁴

In a negotiation context, an apology can be value-creating: if the apology makes an injured feel less injured, they may feel they have obtained a worthwhile money substitute.¹¹⁵ An apology may be regarded as an exchangeable good.¹¹⁶ Furthermore, "[i]ndignity can be a large barrier to compromise" and apology may be necessary before a settlement can be reached.¹¹⁷

¹⁰⁸ *Id.*

¹⁰⁹ *Id.* at 46.

¹¹⁰ *Id.*

¹¹¹ Jonathan Todres, *Toward Healing and Restoration for All: Reframing Medical Malpractice Reform*, 39 CONN. L. REV. 667, 686 (2006).

¹¹² *Id.* at 711-712.

¹¹³ *Id.* at 689.

¹¹⁴ *Id.* at 723.

¹¹⁵ Jonathan R. Cohen, *Advising Clients to Apologize*, 72 S. CAL. L. REV. 1009, 1016 (1999).

¹¹⁶ Deborah L. Levi, *The Role of Apology in Mediation*, 72 N.Y.U. L. REV. 1165, 1176 (1997).

¹¹⁷ Cohen, *supra* note 115, at 1020.

There are reasons why physicians might refrain from issuing an apology. Lawyers and insurance carriers usually insist that a physician cease communication with a suing a patient.¹¹⁸ Physicians fear an apology may be used as evidence against them at a later trial.¹¹⁹ Physicians

also fear that disclosure and apology will result in a loss of respect from patients and colleagues.¹²⁰

C: *Issues Arising for Doctors in Medical Malpractice Suits*: It can be devastating for a doctor when things go wrong.¹²¹ In the aftermath of an adverse incident, an absolute prohibition on communication placed on a doctor by attorneys and the insurance company may go against a doctor's need to discuss the overwhelming emotional experience they have endured.¹²² Compounding the devastation for the doctor may be a tactic often employed by plaintiff's attorney to hurl very many accusations at a doctor to see which will stick; and to put added pressure on the doctor, which will add to a doctor's grief. The impact of all this on the physician is "insidious, often overwhelming and difficult to process."¹²³

Thus doctors, as well as patients, have a need for mechanisms that will allow them to express their emotions and experience catharsis.¹²⁴ Under existing systems, often there is no support mechanism available for the physician.¹²⁵ This may be

¹¹⁸ Yee, *supra* note 13, at 420.

¹¹⁹ LIEBMAN & HYMAN, *supra* note 7, at 51. However, eleven states have enacted laws which do not permit certain apologies from being entered into evidence against the issuer. *Id.* Apologies may also receive protection through rules of evidence and, to be discussed further in Part IV, through formal mediation and confidentiality agreements. Cohen, *supra* note 115, at 132.

¹²⁰ Robbennolt, *supra* note 100, at 1009-1010.

¹²¹ CHOCTAW, *supra* note 10, at 55.

¹²² *Id.* at 59.

¹²³ *Id.* at 80.

¹²⁴ See FIELDING, *supra* note 8, at xii (from the foreword by Howard Waitzkin).

¹²⁵ *Id.*; see also Dauer & Marcus, *supra* note 13, at 199.

because the psychological benefit to the offender of apologizing is often overlooked; however many offenders do feel guilty.¹²⁶

D: How Medical Malpractice Claims are Typically

Mediated: Because a malpractice claim is presumed to be a matter for adjudication, insurers and attorneys tend to think of mediation as a tool for settling monetary issues.¹²⁷ Their interest in mediation extends solely to its ability to save time and money in comparison to litigation.¹²⁸ Malpractice attorneys working on a contingency fee basis may have an additional incentive to view mediation along these

narrow lines: 33% of intangibles such as apologies and explanations add up to \$0.¹²⁹ Thus they tend to steer their clients toward money and away from processes that are not money-centric.¹³⁰

Evaluative mediation tends to be the form of mediation most often utilized to settle medical malpractice claims.¹³¹ Some of the evaluative elements employed in these sessions are: 1) the use of caucuses for settlement rather than joint sessions (thus minimizing the possibility of mutual party understanding, a prime

¹²⁶ Cohen, *supra* note 115, at 1022.

¹²⁷ Dauer, et al., *supra* note 13, at 176.

¹²⁸ *Id.* at 163.

¹²⁹ *See, id.* at 176.

¹³⁰ Dauer, et al., *supra* note 13, at 176.

¹³¹ LIEBMAN & HYMAN, *supra* note 11, at 6; *see* Riskin & Welsh, *supra* note 11, at 864 (noting that most court-oriented mediations, including medical malpractice mediations, follow an evaluative approach). Although offered only as anecdotal evidence, a medical malpractice session I attended at JAMS (a leading provider of mediation services) followed a highly evaluative model. The doctor and patient were not permitted to attend and the attorneys, after briefly presenting their cases to each other, were separated into separate caucuses to which the mediator shuttled back and forth with negotiating terms expressed entirely in dollar amounts. Alan Figman, the plaintiff's attorney, indicated to me that this was typical. The JAMS mediator confirmed that as well.

feature of facilitative mediation);¹³² 2) physicians rarely attend and even if they do attend the attorneys tend to do most of the talking (thus making the focus on party interests, a prime feature of the facilitative model, almost inaccessible);¹³³ 3) mediators almost exclusively focus on the legal issues¹³⁴ and tend to trivialize non-legal issues.¹³⁵

Most medical malpractice mediation tends to follow the Rush University Medical Center model (hereinafter, “the Rush model”)¹³⁶ which follows the evaluative model.¹³⁷ Mediators “evaluate” by focusing on the strengths and weaknesses of each party’s case, propose monetary settlements, emphasize money, rarely include party interests and spend little time in joint sessions.¹³⁸ Although the plaintiff, plaintiff’s counsel and defense counsel attend, the physician does not.¹³⁹ Rush University considers their program to be a great success and, when viewing it through a prism of avoiding litigation time and monetary expenditures, it is.¹⁴⁰

Mandatory mediation, or “case evaluation”, a program used by Michigan courts and once known as “Michigan Mediation” follows an evaluative model as well.¹⁴¹ These examples show that most medical malpractice mediation, using Riskin’s language, would fall into the evaluative-narrow quadrant of Riskin’s famous grid.

¹³² Riskin & Welsh, *supra* note 11, at 876.

¹³³ *See id.* at 894; Welsh, *supra* note 16, at 4.

¹³⁴ Welsh, *supra* note 16, at 4.

¹³⁵ Galton, *supra* note 8, at 324.

¹³⁶ LIEBMAN & HYMAN, *supra* note 11, at 6.

¹³⁷ *Id.* at 74.

¹³⁸ *Id.* at 6.

¹³⁹ Brown, *supra* note 13, at 434.

¹⁴⁰ *See, id.* The author of the article here cited is the vice president and general counsel of the Rush Medical Center, who states that while mediation has neither reduced nor increased the monetary amounts of Rush’s settlements with claimants, it has allowed the center to substantially reduce defense costs. *Id.* at 440.

¹⁴¹ *See supra* note 43 and accompanying text.

III: THE FACILITATIVE APPROACH IS BETTER-SUITED TO MEDICAL MALPRACTICE MEDIATION

The evaluative-narrow model of mediation, the model that predominates in handling medical malpractice disputes, is inadequate to many of the needs of patients, doctors and even insurance companies. The evaluative-narrow model appears to presume that the best outcome for a suing patient is to obtain as much money as possible, that the best outcome for a doctor is to avoid at all costs a negative report to the NPDB and that the best outcome for an insurance company is to fork over the least amount of money possible.¹⁴² The evaluative model assumes that the shadow of law is the only shadow the healthcare provider and the patient bargain in.¹⁴³ The evaluative model is mostly concerned with a doctor's legal "duty of care" to a patient and whether a doctor has negligently breached that duty; however, the evaluative model can miss what a patient may view as a doctor's other duties, which the law may not recognize, such as a duty to take steps to prevent further harm from occurring in the future, a duty to communicate with the patient openly and honestly, and a duty to apologize for error. What the evaluative model basically provides is a streamlined, more efficient version of what adjudication already offers: providing a decision, articulated in the form of an "evaluation" provided by the mediator informed by what the law requires and usually addressing only monetary issues.¹⁴⁴

The broad criticisms of the evaluative model discussed in Part I of this paper apply with no less force in the medical malpractice context. Parties to medical malpractice disputes are losing the opportunity to enter into a process which they can drive,

¹⁴² See *supra* discussion Part II.D.

¹⁴³ Incorporating a reference to Robert Mnookin's seminal article on divorce mediation, which articulated that when parties enter into settlement negotiations they often bargain with one another under an understanding that the applicable legal rules give them certain bargaining chips. Robert H. Mnookin, *Bargaining in the Shadow of the Law: The Case of Divorce*, 88 YALE L.J. 950 (1979).

¹⁴⁴ Of course even an evaluative mediator would only suggest a resolution, which the parties do not necessarily have to agree to; in contrast, a judge's decision is imposed upon the parties.

forming agreements that are self-determined and imbued with their “values, preferences and priorities”¹⁴⁵ because the process is wrestled away from them and placed into the hands of the lawyers and evaluators. In fact, even the lawyers who do attend and participate may not fully invest in the process if a mediator’s evaluations go against their client’s positions, resulting in a belief that the mediator is not neutral and that the process is biased against them. The evaluations provided by the mediator may simply be wrong, especially in a medical malpractice context where the opinions of experts¹⁴⁶ could result in a mediator, especially one who is chosen for his expertise, providing an evaluation going in one direction where a jury might rule in another.¹⁴⁷ The opportunities for “creative, integrative problem-solving”¹⁴⁸ are lost when the mediation is singularly focused on what a court would determine in terms of a doctor’s legal liability for an alleged medical error but ignoring other issues such as a doctor’s need for catharsis, and a patient’s need for an apology, to have the doctor commit to harm prevention, and to provide more complete and more honest communication. Additionally, although some believe mediator evaluations are necessary in order to protect the parties so they engage in the process fully informed of the legal ramifications of any agreement reached, in a medical malpractice setting, where lawyers invariably represent all the parties involved, the parties’ lawyers can assume this responsibility.

It is this paper’s contention that the facilitative model of mediation is better suited to medical malpractice disputes. This becomes clear when looking at the issues arising for patients and doctors discussed in Part II.B and C. Of the all the issues there

¹⁴⁵ Lela P. Love, *Mediation: The Romantic Days Continue*, 38 S. TEX. L. REV. 735, 741 (1997).

¹⁴⁶ “To establish the standard of care, causation, and damages, the patient ordinarily has to present expert testimony to the fact finder.” MCCARTHY, *supra* note 74, at 9.

¹⁴⁷ See, SLOAN & CHEPKE, *supra* note 75, at 185 (discussing the difficulty in obtaining medical malpractice experts who are sufficiently neutral because such experts may possess underlying biases resulting in plaintiffs who prevail too frequently or not frequently enough).

¹⁴⁸ Love, *supra* note 145, at 741.

mentioned, the evaluative model is only fully able to accommodate compensation in damages, and only then when measured in terms of a healthcare provider's legal liability to a plaintiff. However, when looking at the arguments raised in the previous paragraph against the use of the evaluative model, it becomes clear that even on this issue, the facilitative model is preferred.

The extra-legal concerns of the parties that arise in a medical malpractice dispute—harm prevention, communication failures, the need for apology and a doctor's need for a mechanism that will provide a cathartic avenue for dealing with the emotional issues arising from malpractice accusations—are all better dealt with in a facilitative setting. Much of what may need addressing for parties regarding all of these issues may be more profoundly connected to a party's deeper underlying interests, which the facilitative model is designed to accommodate. For example, a plaintiff's position might be that they feel a doctor has an ethical obligation to disclose error; their deeper interest might be in a need for recognition, validation and empathy from someone in whom they once placed great trust. With an evaluative mediator, the discussion would not reach that interest so important for a patient to express and perhaps, even, for a doctor to hear. Instead the focus would be on law, legal liability and likely court outcomes. Thus the evaluative-narrow approach might not recognize concerns and interests based in harm prevention, communication, apology and catharsis, all of which have proven to be as valuable, if not more valuable, to suing patients and sued doctors than a monetary settlement. In contrast, the facilitative mediator gives the parties a wide berth; initially to bring up issues of importance to them; and continuously, to engage in a back and forth discussion where communication is given freedom to develop and evolve, so that parties may reach extra-legal issues and interests of great importance to them.

Additionally, a plaintiff's lawyer may actually be disincentivized from bringing up any of these non-monetary, or arguably non-legally cognizable, issues or interests, fearing that a doctor's acquiescence on any one of them would work as an assumed offset against a dollar settlement. For example, a patient suing because they believe a monetary legal claim is their only avenue of redress, might forsake or reduce a monetary request

once they actually obtain an apology. In an evaluative setting, the defendant doctor and/or plaintiff patient might not even be in attendance, or they may be counseled not to speak. In a facilitative setting, their participation would be expected.¹⁴⁹

Finally, the parties to medical disputes mediated through the evaluative approach lose the opportunity to engage in a process where aspects “less tangible” than the agreement itself may, in the end, be of greater significance to them than any agreement reached.¹⁵⁰ The use of evaluative mediation would foreclose the parties from experiencing what Bush and Folger describe as “the promise of mediation”¹⁵¹ which, in a medical malpractice setting, may be even more profoundly fulfilling than in other settings: the opportunity to enter into a facilitated discourse in which patients damaged physically and emotionally and doctors plagued by guilt, a need for catharsis and complicated grief¹⁵² can enter into a rich meaningful dialogue. Use of the facilitative approach will give doctors and patients the potential to experience moral growth, greater strength and greater compassion¹⁵³ as they give expression to the deeper underlying interests that may be of far greater significance to them than the monetary and liability issues that rise up on the face of their disputes.

IV: RECOMMENDATIONS

A. *Adhesion contracts*:¹⁵⁴ although these would typically require the use of binding arbitration for settling disputes, they

¹⁴⁹ See discussion *infra*, Part IV.

¹⁵⁰ BUSH & FOLGER, *supra* note 47, at 4. Although mentioned previously, it bears repeating that the aspects of the Bush/Folger transformative model discussed in this section are applicable to the facilitative model as well.

¹⁵¹ See, *id.*, at 1-17.

¹⁵² See CHOCTAW, *supra* note 10, at 80.

¹⁵³ See BUSH & FOLGER, *supra* note 47, at 39.

¹⁵⁴ An adhesion contract in a medical setting would be a pre-dispute contract entered into by a patient agreeing to resolution of any disputes arising over treatment by a prescribed dispute resolution process. CHOCTAW, *supra* note 10, at 29-31. Contracts could be options offered to health plan enrollees. SLOAN &

could require that parties attempt to resolve their disputes first through mediation. It is suggested that such contracts include provisions that would result in a mediation utilizing a facilitative approach. These provisions are discussed *infra* at Part IV.D.

B. *Mediation agreements*: The Rush Model (and other healthcare provider models) use mediation agreements, which the parties enter into in agreeing to attempt resolution of a dispute through mediation.¹⁵⁵ Such agreements need to recognize that healthcare providers who are parties to a mediation may be leery of communicating freely in the session for fear that such communication will come back to haunt them if used as evidence in a later trial.¹⁵⁶ As stated *supra*,¹⁵⁷ a number of states protect apologies in some contexts from being used against the offeror as evidence at trial. More states should follow that lead in order to facilitate necessary and beneficial communication in mediated sessions between doctors and patients. Parties to these disputes must consult the laws of their jurisdiction as to how thoroughly the laws of evidence or the laws regarding apology will protect their communications. While mediation confidentiality requirements *may* protect what is disclosed in mediation, the extent of that protection is far from clear.¹⁵⁸ Parties may want to enter into confidentiality agreements, with rigidly drawn clauses protecting communications from use outside the session.¹⁵⁹ It is suggested that mediation agreements include specific provisions for the

CHEPKE, *supra* note 75, at 93. The use of adhesion contracts is highly controversial and Congress is considering outlawing them in certain contexts. H.R. 1020, 111th Cong. (2009). It is beyond the scope of this paper to take a policy stand on these contracts.

¹⁵⁵ Brown, *supra* note 13, at 434.

¹⁵⁶ See LIEBMAN & HYMAN, *supra* note 11, at 50-51 (noting that physicians fear apologies may later be used against them as evidence).

¹⁵⁷ See *supra* note 119.

¹⁵⁸ Carrie Menkel-Meadow, *Public Access to Private Settlements: Conflicting Legal Policies*, in MENKEL-MEADOW, et al., *supra* note 15, AT 319.

¹⁵⁹ However, these agreements are far from full-proof as a court may disregard them as being against public policy. MENKEL-MEADOW, et al., *supra* note 15, AT 321.

mediation of medical malpractice disputes that would result in a mediation utilizing a facilitative approach. These provisions are discussed *infra* at Part IV.D.

C. *Court rules*: Numerous states have enacted some form of mediation statute, giving courts the power to order parties to attempt settlement through mediation and providing guidelines for the process.¹⁶⁰ It is suggested that court rules include specific provisions for the mediation of medical malpractice disputes that would result in a mediation utilizing a facilitative approach. These provisions are discussed *infra* at Part IV.D.

D. *Provisions*:

1. The mediator: if a *sine qua non* of mediation is the parties right to self-determination,¹⁶¹ then it *should* follow that who mediates should be left to the parties. However, another *sine qua non* of mediation is that the mediator be neutral and have no preference that a dispute be resolved one way or another.¹⁶² Neutrality can be compromised in a medical malpractice dispute if the mediator is an expert in the field and carries “content bias”.¹⁶³ Perhaps a medical expert’s orientation might predispose them to seeing the matter from a doctor’s point of view. It is suggested that the mediator chosen not be an expert in the field in order to avoid issues with neutrality or the appearance of bias. This is especially important since the use of a facilitative approach is suggested and “[t]he need for subject-matter expertise typically increases in direct proportion to the parties’ need for the mediator’s

¹⁶⁰ Holly A. Streeter-Schaefer, *A Look at Court Mandated Civil Mediation*, 49 Drake L. Rev. 367, 373-374 (2001).

¹⁶¹ Mercedéh Azeredo da Silveira, *Impartiality v. Substantive Neutrality: Is the Mediator Authorized to Provide Legal Advice?*, 62-APR DISP. RESOL. J. 26, 26 (2007).

¹⁶² STULBERG & LOVE, *supra* note 14, at 29.

¹⁶³ Cris M. Currie, *Mediating Off the Grid*, 59-JUL DISP. RESOL. J. 9, 12 (2004). Alan Figman told me defendants would prefer, and he would oppose, the use of expert doctors as mediators for fear they would possess subject matter bias disposing them toward favoring doctors. Telephone interview with Alan Figman, *supra* note 1.

evaluations.”¹⁶⁴ If the mediator is not an expert, it is less likely they will provide expert evaluations. Admittedly, there are advantages to employing a mediator with medical expertise: they can more easily follow the discussion and “reality test” by raising hidden dangers perhaps not apparent to the participants.¹⁶⁵ However, the facilitative mediator can make up for this lack by brushing up on all the relevant law, science and medicine helpful for facilitating the discourse.¹⁶⁶ After all, we require no less of judges and juries when they resolve medical malpractice disputes and lawyers do it all the time.

2. Mediator orientation: It is suggested that the mediator, though contract provision,¹⁶⁷ court rules¹⁶⁸ or election of the parties, be directed toward the facilitative approach, which would include a provision forbidding or discouraging the use of mediator evaluations. This would be consistent with general state court rules and model codes already in place.¹⁶⁹ However, since it has often been found that the facilitative approach is largely eschewed in favor of the evaluative, particularly in court connected settings,¹⁷⁰ it is suggested that court rules create separate provisions for medical malpractice disputes which mandate that mediators not provide evaluation in the course of mediating such disputes. It is also suggested that adhesion contracts contain such provisions. Insurers and health-care plans would be incentivized to include

¹⁶⁴ Riskin, *supra* note 28, at 46.

¹⁶⁵ See Currie, *supra* note 163, at 12.

¹⁶⁶ See Stulberg, *supra* note 53, at 997.

¹⁶⁷ See Lela P. Love & Stewart E. Sterk, *Leaving More Than Money: Mediation Clauses in Estate Planning Documents*, 65 WASH. & LEE L. REV. 539, 546 (2008) (stating in an estate-planning context: “a thoughtful drafter of a mediation clause might want to specify a particular format for the mediation process”)

¹⁶⁸ Some state courts, Alaska and Virginia, for example, permit the parties to choose between facilitative and evaluative mediation. Donna Shestowsky, *Disputant’s Preferences for Court-Connected Dispute Resolution Procedures: Why We Should Care and Why We Know So Little*, 23 OHIO ST. J. ON DISP. RESOL. 549, 571 (2008).

¹⁶⁹ Young, *supra* note 69, at 1293 n.608 (providing an extensive list of state rules and codes on the role of the mediator).

¹⁷⁰ Riskin & Welsh, *supra* note 11.

such provisions since they would result in an increase in the range of non-monetary “exchangeable goods” up for discussion.¹⁷¹

3: Who should or should not attend:

i. The insurer’s claims representative: The Rush Model, on occasion, permits representatives from insurance companies to attend mediations.¹⁷² In the court-connected/medical malpractice context, insurance claims representatives are nearly always involved and are often required to attend mediations.¹⁷³ As was discussed in Part II.A., the amount of control an insurer will attempt to exert over settlement negotiations can vary. However, the insurance company is not being sued; the healthcare provider is.¹⁷⁴ It is suggested that an insurer’s claims representative be permitted to attend the session as it is the insurance company’s money that is at stake. However, it is also suggested that the claims representative be advised that it is in their best interest that the mediator direct the discussion so that the full panoply of concerns be given voice in the session.¹⁷⁵

ii. The defendant and plaintiff: Although it seems counterintuitive, doctors often do not attend medical malpractice mediations.¹⁷⁶ As the entire thesis of this paper may only be sustained if both the defendant and the plaintiff attend the mediation, it is recommended that their attendance be made mandatory. At least one way of guaranteeing this would be to change clauses within court rules or mediation codes so that parties to medical malpractice disputes would no longer be permitted to

¹⁷¹ See *supra* notes 115-117 and accompanying text. Note, also, that I am not making this proposal so that insurance companies can save money but merely pointing out that they have an incentive to include such provisions in contracts.

¹⁷² Brown, *supra* note 13, at 434.

¹⁷³ Riskin & Welsh, *supra* note 11, at 864.

¹⁷⁴ MCCARTHY, *supra* note 74, at 178.

¹⁷⁵ See *supra* notes 115-117 and accompanying text on how that would be in insurer’s best interest.

¹⁷⁶ Tamara Relis, *Consequences of Power*, 12 HARV. NEGOT. L. REV. 445, 457; Metzloff et al., *supra* note 84, at 125.

contract around rules that require party attendance.¹⁷⁷ Adhesion contracts and mediation agreements provided by healthcare models like the Rush Model should also mandate party attendance, as it is in the interest of the providers and insurance companies to have the parties attend so that more than just money is up for discussion and exchange.

iii. The lawyers: This paper accepts as a given that lawyers will attend. Parties to medical malpractice suits are almost invariably represented by counsel and they would not feel protected without the presence of their attorneys at these sessions.

CONCLUSION

It remains to be seen what effect Congress's recent historic enactment of healthcare reform legislation¹⁷⁸ will have on medical malpractice. Whatever effect is realized, mediation will continue to be an entrenched and relied upon process for dealing with and resolving such disputes. The evaluative-narrow model, which currently prevails for use in mediating medical malpractice disputes, is inadequate to the needs of parties to such disputes. It is the lawyers, who are *not* the parties but merely the representatives to the parties, who currently dominate in directing the process and the form it takes. Steps should be taken to wrestle control of the process away from the adversarial, narrow-minded approach the lawyers typically bring. Instead, the facilitative approach should be employed. It is capable of accommodating the legal liability and monetary damages claims that arise; however, it is capacious enough to accommodate so much more, including the more deeply felt interests in communication, validation, catharsis and apology that often accompany such disputes and that may resonate on far deeper levels for both doctors and patients.

¹⁷⁷ Relis, *supra* note 176, at 451 (discussing how to avoid defendant absences from "litigation track mediations").

¹⁷⁸ Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (2010); Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010).