

**THE OBAMA HEALTHCARE LEGISLATION: FERTILE GROUND FOR ALTERNATIVE DISPUTE
RESOLUTION**

BY

HAILEY M. NOONAN

Submitted in partial fulfillment of the requirements of the
King Scholar Program
Michigan State University College of Law
under the direction of
Professor Mary A. Bedikian
Spring, 2011

**THE OBAMA HEALTHCARE LEGISLATION: FERTILE GROUND FOR ALTERNATIVE DISPUTE
RESOLUTION**

HAILEY M. NOONAN*

INTRODUCTION.....	2
I. INCREASED ACCESS TO HEALTHCARE.....	4
II. INSURANCE COMPANIES’ INTERNAL AND EXTERNAL REVIEW	6
a. Patients’ New Consumer Protections.....	6
b. Insurance Providers’ Increased Reliance on ADR Process.....	8
c. Insurance Providers’ Increased Need for Independent Review Organizations....	10
III. ENHANCED OPPORTUNITIES FOR MEDIATION	13
a. Likelihood of Mediation Reducing Number of Claims Filed.....	13
b. Apology Laws as a Way of Ameliorating Conflict.....	15
c. Limitation of Apology Laws.....	15
d. Characteristics of an Effective Apology in Healthcare Setting.....	18
e. Apology Working in Tandem with Mediation.....	21
f. Uniform Mediation Act and Confidentiality.....	23
g. Possible Problems with Increased Mediation and Solutions.....	25
CONCLUSION.....	28

INTRODUCTION

The Patient Protection and Affordable Care Act (PPACA), passed on March 23, 2010, aims to provide increased access to healthcare previously denied to many individuals.¹ This expansion of healthcare delivery will increase the number of healthcare disputes earmarked for litigation.² Consensual alternative dispute resolution (ADR) may provide a release by resolving

* Hailey M. Noonan will receive her J.D. from Michigan State University College of Law in May 2011, where she was a King Scholar, and served as Articles Editor of the *Michigan State Journal of International Law*. She would like to thank her family for their support, and Professor Mary A. Bedikian for her mentorship, insightful guidance, and excellent instruction in the field of ADR.

¹ See Patient Protection and Affordable Care Act, Pub. L. 111-148 (codified at 42 U.S.C. § 18001) (2010), available at <http://docs.house.gov/energycommerce/ppacacon.pdf>.

² See Michael S. Sparer, *Editor’s Note*, 35 J. HEALTH POL. POL’Y & L. 701, 701 (2010) (stating that the PPACA “contains five provisions designed to significantly reduce the number of Americans without health insurance: (1) the Medicaid expansion will add 16-18 million to the public insurance rolls; (2) the combination of public subsidies and insurance exchanges should enable another 16 million or so to afford private coverage; (3) the legal requirement that individuals have some sort of health insurance should encourage most who have access to coverage to take it (although the penalties for noncompliance are too minimal to actually be certain); (4) the fiscal penalties imposed on employers with more than fifty employees who do not provide insurance coverage will stabilize the employer-

conflict early, swiftly, and without the emotional trauma often associated with litigation. The PPACA provides insured individuals with increased consumer protections, including a more viable opportunity to challenge the denial of their benefits, and insurance providers will need to consider the role ADR will have in solving these disputes.³ In the case of medical malpractice disputes, effective apologies within the context of mediation may provide a promising solution for the early resolution of these disputes, provided confidentiality and other incentives are provided for physicians.⁴

The PPACA makes the role of ADR more important than ever in the realm of healthcare, much as the industrial revolution created a groundswell of opportunity for parties to resolve conflict privately and through the use of an “expert” decision-maker.⁵ As ADR is desirable in the employment and collective bargaining setting because of a dispute resolver’s knowledge of the “shop,” ADR can be used in the healthcare setting in much the same way. Rather than having a judge who may have little understanding of the intricate health insurance apparatus or the particular challenges facing physicians, health insurance providers and healthcare providers can take advantage of a dispute resolver’s specialized knowledge of the different healthcare arenas in which disputes may arise. More specifically, the PPACA creates fertile ground for

sponsored insurance system; and (5) the new federal regulatory regime is likely to minimize the ability of insurers to discriminate against the sick and other high-cost individuals.”); Harry N. Mazadoorian, *ADR and Health Care*, 16 NO. 3 DISP. RESOL. MAG. 4, 4 (2010) (stating that “[a] veritable explosion in the volume and nature of health-care-related disputes is an unquestioned by-product of the anticipated health care revolution.”).

³ See generally, *Patient’s Bill of Rights Under the Affordable Care Act*, HEALTHCARE.GOV, http://www.healthcare.gov/law/provisions/billofright/patient_bill_of_rights.html (last visited Apr. 28, 2011).

⁴ See Jonathan Todres, *Toward Healing and Restoration for All: Reframing Medical Malpractice Reform*, 39 CONN. L. REV. 667, 686 (2006) (stating that “[a] study published in the *Lancet*, the leading British medical journal, found that as many as 37% of medical malpractice plaintiffs reported that they would not have filed lawsuits if their doctors had sincerely apologized instead of stonewalling.”).

⁵ Arbitration and mediation were considered attractive alternatives to litigation even before the PPACA. See generally, *Mediating and Arbitrating Healthcare Disputes: Includes Practical Tips and Model ADR Language*, NAT’L ARBITRATION FORUM (Jan. 2005), http://www.healthlawyers.org/Members/PracticeGroups/HLL/Toolkits/Documents/D_Mediating_Arbitrating_Healthcare_Disputes.pdf.

ADR to be applied in two separate healthcare arenas: 1.) insurance disputes involving denial of coverage, and 2.) medical malpractice disputes involving healthcare professionals.⁶ Although the ADR process of choice will vary, independent external review in the case of insurance disputes and mediation for medical malpractice disputes, the benefits will be the same. These benefits are speed, economy and just result.

I. INCREASED ACCESS TO HEALTHCARE

The previously existing healthcare system created an atmosphere favorable to insurance companies, as a byproduct of fewer regulations than are found in the PPACA. Insurance companies were able to deny patients insurance coverage under many different circumstances. For example, an insurance company could deny coverage to children under the age of nineteen due to a pre-existing condition, rescind the coverage of a sick patient if it was discovered that the patient made any error or technical mistake on his or her application, and create a monetary cap for the amount of insurance a patient could receive over his or her lifetime for essential benefits (like hospital stays).⁷ President Obama's healthcare reform legislation prohibits and/or restricts these practices, which will logically result in an increased number of patients receiving the

⁶ See Mark A. Rothstein, *Health Care Reform and Medical Malpractice Claims*, 38 J.L. MED. & ETHICS 871, 871-72 (2010) for the counter-argument that "one of the leading reasons why individuals bring medical malpractice claims is to ensure the availability of funds for future medical care. Because health care coverage at affordable rates will be accessible in the public or private sector without regard to preexisting conditions, and annual and lifetime caps will be prohibited, significant numbers of injured patients are likely to forego medical malpractice claims. Consequently, even with more patient visits, the total number of medical practice claims is unlikely to rise and might even decline." Rothstein also argues that the vast majority of new healthcare recipients will be low-income individuals, who are less likely to sue. *Id.* at 872. Rothstein does admit that "a breakdown in the interpersonal aspects of patient care is also an important element in motivating injured patients and their families to file a medical malpractice lawsuit" but focuses instead on financial compensation as a motivator for litigation. *Id.* at 872.

⁷ *Provisions of the Affordable Care Act, By Year*, HEALTHCARE.GOV, <http://www.healthcare.gov/law/about/order/byyear.html> (last visited Apr. 28, 2011).

benefits of health insurance where they would have previously been denied coverage.⁸ It is estimated that 32 million additional Americans will now receive healthcare coverage.⁹

The PPACA will provide access to health insurance for the following groups of people: uninsured individuals with pre-existing conditions (who have been uninsured for at least six months due to their pre-existing condition), young adults up to the age of twenty-six years old who are now able to stay on their parents' plan, and individuals who retire before they are eligible for Medicare and who do not have employer-sponsored insurance.¹⁰ Although the PPACA will expand the number of primary care doctors, nurses and physicians assistants to increase the availability of primary care by offering incentives such as scholarships and loan repayments,¹¹ there is no parallel provision to either create or increase the availability of conflict resolution mechanisms.

The PPACA provides requirements for the new consumer protections which must be afforded to every insured individual, and the insurance and healthcare providers must meet these new obligations.¹² Patients who would not have had the opportunity to challenge a denial of coverage, or who would not have been exposed to medical malpractice simply due to lack of interaction with the healthcare system, will certainly need a realistic venue in which to pursue their causes of action. The PPACA's expanded coverage will increase the volume of disputes.¹³ In addition, the actual complexion of disputes is likely to change. The combination of these

⁸ *Id.*

⁹ *Affordable Care Act (PPACA) External Review Regulations: New Opportunities for Independent Review Organizations (IROs)* 3, URAC (Dec. 2010), http://www.urac.org/resources/URAC_IROIB_2010.pdf.

¹⁰ *Provisions of the Affordable Care Act, By Year*, *supra* note 7.

¹¹ *Id.*

¹² *Id.*

¹³ *See Sparer, supra* note 2, at 701.

factors augment the need for ADR, most notably those processes that are consensual and party focused.

II. INSURANCE COMPANIES' INTERNAL AND EXTERNAL REVIEW

a. Patients' New Consumer Protections

Among the many consumer protections granted by the PPACA, insured individuals now have a more meaningful opportunity to challenge a denial of benefits by an insurance company.¹⁴ This enhanced review is mandated by interim final regulations (provided in a July 23, 2010 Federal Register notice), which became effective on September 21, 2010.¹⁵ These regulations apply to group health plans, group health insurance issuers, and individual health insurance issuers for plan years beginning on or after September 23, 2010.¹⁶ A technical release issued on August 23, 2010 provides for an enforcement period (until July 1, 2011) for compliance with some of new provisions on internal claims and appeals.¹⁷

Regulations respecting group health plans require the following changes in the internal review process. First, the definition of “adverse benefit determination” has been expanded to include any rescission of coverage, including an insurance provider’s failure to make a payment (in whole or in part).¹⁸ This greatly widens the door for potential claimants, who would otherwise have been prevented from making a claim for the denial of benefits. Additionally, and possibly most importantly to a claimant, if the plan or issuer fails to “strictly adhere” to the

¹⁴ *Appealing Health Plan Decisions Under the Affordable Care Act*, HEALTHCARE.GOV, <http://www.healthcare.gov/law/provisions/appealing/appealinghealthplandecisions.html> (last visited Apr. 28, 2011).

¹⁵ Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 43,330 (July 23, 2010) (to be codified at 45 C.F.R. pt. 147).

¹⁶ *Id.*

¹⁷ Availability of Interim Procedures for Federal External Review and Model Notices Relating to Internal Claims and Appeals and External Review Under the Patient Protection and Affordable Care Act; Notice, 75 Fed. Reg. 52,597, 52,598 (Aug. 26, 2010).

¹⁸ Internal Claims and Appeals and External Review Processes, 45 C.F.R. § 147.136 (b)(2)(ii)(A) (2010).

requirements of the interim final regulations, regardless of whether the plan or issuer substantially complied, the claimant may initiate any available external review process or remedies available under ERISA or State law.¹⁹

There are many other consumer protections that must be provided. For example, a plan or issuer must notify a claimant of a benefit determination with respect to a claim involving urgent care, as soon as possible, but no later than twenty-four hours after receipt of the claim, unless the claimant does not provide sufficient information to determine whether benefits are covered or payable under the plan.²⁰ This twenty-four hour period provides for a more expedient process, as opposed to the previous seventy-three hour period.²¹ Additionally, individuals in urgent care situations may actually be permitted to proceed with an expedited external review, at the same time as the internal appeals process is being conducted.²² Plans and issuers are also required to provide the claimant (free of charge), with any new or additional evidence, and/or any new or additional rationale for a denial at the internal appeals stage, and give the claimant a reasonable opportunity to respond.²³ Notice must be provided to the claimant in a culturally and linguistically appropriate manner, and the notice must include (among other specific requirements), a description of the available internal appeals and external review processes.²⁴ These particular provisions will require more employee time, and may also require individuals with experience in case administration. Finally, the requirement that plans and issuers must

¹⁹ 45 C.F.R. § 147.136 (b)(2)(ii)(F) (2010).

²⁰ 45 C.F.R. § 147.136 (b)(2)(ii)(B) (2010).

²¹ 75 Fed. Reg. 43,330, 43,333 (July 23, 2010) (stating that “[t]his is a change from the requirements of the DOL claims procedure regulation, which generally requires a determination not later than 72 hours after receipt of the claim by a group health plan for urgent care claims. The Departments expect that electronic communication will enable faster decision-making today than in the year 2000, when the final DOL claims procedure regulation was issued.”).

²² 45 C.F.R. § 147.136 (c)(2)(iii) (2010).

²³ 45 C.F.R. § 147.136 (b)(2)(ii)(C)(1), (2) (2010).

²⁴ 45 C.F.R. § 147.136 (b)(2)(ii)(E)(1)-(4) (2010).

ensure that claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision,²⁵ certainly lends itself to the development of a comprehensive and uniform ADR process for insurance providers, rather than an in-house panel of decision makers, who may run the risk of partiality.

Individual health insurance plans are subject to all of the same requirements as the group health plans as listed above, with some additions.²⁶ The internal claims and appeals process for individual health insurance plans must include initial eligibility determinations, in addition to adverse benefit determinations.²⁷ Additionally, although the Department of Labor regulations permit individual health plans to have two levels of appeals, individual health insurance issuers are only permitted one level of internal appeals.²⁸ This is because in the group health plan market, a third party administrator can conduct the first level of internal appeal, with the employer conducting a second level of internal appeal. However, in the individual health insurance situation, the issuer conducts all levels of the internal appeals.²⁹

b. Insurance Providers' Increased Reliance on ADR Processes

These new consumer protections for claimants will serve to increase their ability to challenge the decisions of insurance providers. Clearly, insurance providers who are not already following these protocols will have to make significant adaptations to their current processes in order to comply with the new regulations. As previously mentioned, there are likely to be a

²⁵ 45 C.F.R. § 147.136 (b)(2)(ii)(D) (2010).

²⁶ 45 C.F.R. § 147.136 (b)(3) (2010).

²⁷ 45 C.F.R. § 147.136 (b)(3)(ii)(A) (2010).

²⁸ 45 C.F.R. § 147.136 (b)(3)(ii)(G) (2010).

²⁹ See 75 Fed. Reg. 43,330, 43,334 (July 23, 2010) (stating that “[t]here is no need for a second level of an internal appeal in the individual market since the issuer conducts all levels of the internal appeal, unlike in the group market, where a third party administrator may conduct the first level of the internal appeal and the employer may conduct a second level of the internal appeal. Accordingly, after an issuer has reviewed an adverse benefit determination once, the claimant should be allowed to seek external review of the determination by an outside entity.”).

greater number of individuals capable of initiating the internal review process under the broader definition of an “adverse benefit determination.”³⁰ Additionally, the insurance provider will need to ensure that it has a sufficient number of employees dedicated to the task to provide claimants with proper notice, an explanation of the evidence considered and rationale used as the basis of the decision on review. The “independence and impartiality” of the persons involved in making the decision will require the insurance provider to ensure that “decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.”³¹

The field of ADR will greatly assist insurance providers in adapting to these new regulations, as it has already encountered issues such as proper notice, consideration of evidence, provision of a rationale, impartiality, and general case management in an extrajudicial setting.³² Whether or not insurance providers choose to contract with outside ADR services, it is likely that the ADR community will take notice of the increased need for its services in this particular niche market. This increasing need may even lead the most predominant ADR service providers to consider offering ADR services for disputes between consumers and insurance companies. For example, the American Arbitration Association may reconsider its previous announcement that “it will no longer accept the administration of cases involving individual patients without a post-dispute agreement to arbitrate...this change will become effective on January 1, 2003.”³³

However, the AAA still currently provides services for “cases in the health care area where

³⁰ See 45 C.F.R. § 147.136 (b)(2)(ii)(F) (2010).

³¹ 45 C.F.R. § 147.136(b)(2)(ii)(d) (2010).

³² See, for example, the various rules and procedures provided to govern arbitration proceedings under the auspices of the American Arbitration Association (AAA), at *Arbitration*, AAA, <http://www.adr.org/sp.asp?id=28749> (last visited Apr. 28, 2011).

³³ *Healthcare Policy Statement*, AAA, <http://www.adr.org/sp.asp?id=32192> (last visited Apr. 28, 2011).

businesses, providers, health care companies, or other entities are involved on both sides of the dispute.”³⁴

c. Insurance Providers’ Increased Need for Independent Review Organizations

Accredited independent review organizations (IROs) conduct external review of adverse benefit determinations by an insurance company, when the insured individual initiates an appeal of the insurance company’s internal review decision.³⁵ Under 45 C.F.R. § 147.136 (b)(2)(ii)(F), it may be easier under the PPACA than ever before to obtain external review, because if a plan or issuer fails to strictly adhere to all the new requirements for internal review, the claimant may initiate external review, even if the error on behalf of the insurance provider was de minimis.³⁶ This is a strong consumer protection measure, because “one study found that – in States that had external appeals – consumers won their external appeal against the insurance company 45% of the time.”³⁷ The current federal guidelines on state standards for external review can be found in 24 C.F.R. § 147.136 (c). The federal guidelines require states to incorporate certain provisions of the NAIC Uniform Model Act, which enhance consumer protections.³⁸

The guidelines also contain requirements for independence and impartiality. For example, “[t]he State process must provide that IROs will be assigned on a random basis or another method of assignment that assures the independence and impartiality of the assignment process (such as rotational assignment). . . .”³⁹ Additionally the State must maintain a list of approved

³⁴ *Id.*

³⁵ See *Affordable Care Act (PPACA) External Review Regulations: New Opportunities for Independent Review Organizations (IROs)* 3, URAC (Dec. 2010), http://www.urac.org/resources/URAC_IROIB_2010.pdf.

³⁶ 45 C.F.R. § 147.136 (b)(2)(ii)(F) (2010).

³⁷ *Appealing Health Plan Decisions*, HEALTHCARE.GOV,

<http://www.healthcare.gov/law/provisions/appealing/Appealing%20Health%20Plan%20Decisions%20/moreinfo.html> (last visited Apr. 28, 2011).

³⁸ See 45 CFR § 147.136 (c) (2010). See also UNIFORM HEALTH CARRIER EXTERNAL REVIEW MODEL ACT (2010), available at http://www.naic.org/documents/committees_b_uniform_health_carrier_ext_rev_model_act.pdf.

³⁹ 45 C.F.R. § 147.136 (c)(2)(vii) (2010).

IROs, that are accredited by a nationally recognized private accrediting organization (such as URAC).⁴⁰ To ensure the independence and impartiality of an IRO, the State must require that “an IRO may not own or control, or be owned or controlled by a health insurance issuer, a group health plan, the sponsor of a group health plan, a trade association of plans or issuers, or a trade association of health care providers.”⁴¹ Furthermore, both the IRO and the individual clinical reviewer

may not have a material professional, familial, or financial conflict of interest with the issuer or plan that is the subject of the external review; the claimant (and any related parties to the claimant) whose treatment is the subject of the external review; any officer, director, or management employee of the issuer; the plan administrator, plan fiduciaries, or plan employees; the health care provider, the health care provider's group, or practice association recommending the treatment that is subject to the external review; the facility at which the recommended treatment would be provided; or the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended.⁴²

These independent and impartiality provisions combined with the broader access to external review may make an increase in the number of IROs inevitable and necessary. To avoid conflicts of interest in the broad network of the healthcare industry, multiple IROs within each state will be required. URAC, an accrediting agency for IROs has recently revised the standards for IRO accreditation in response to the healthcare reform changes, and notes that “there are currently 51 organizations that have earned URAC IRO accreditation or are in-process.”⁴³

IROs provide an extra-judicial decision-making process much like other ADR mechanisms such as arbitration. Panels of physicians reviewing an insurance providers’ decision may operate much like a panel of arbitrators, considering the evidence before them and issuing a

⁴⁰ 45 C.F.R. § 147.136 (c)(2)(viii) (2010).

⁴¹ 45 C.F.R. § 147.136 (c)(1)(ix) (2010).

⁴² 45 C.F.R. § 147.136 (c)(1)(ix) (2010).

⁴³ URAC Releases Revised Independent Review Organization Standards, URAC (Dec. 30, 2010), <http://www.urac.org/press/cmsDocument.aspx?id=737>.

decision.⁴⁴ The binding nature of the decision of an IRO remains to be seen however, and may vary from state to state unless additional federal regulation provides more guidance on this issue. For example, in Michigan the Commissioner of the Office of Financial and Insurance Regulation may refuse to follow an IRO's "recommendation" and instead issue its own decision.⁴⁵ Furthermore, individuals in Michigan are able to appeal the decision of the Commissioner in circuit court,⁴⁶ and it is doubtful that the grounds for circuit court review of the decision are as narrowly construed as the grounds for review of an arbitrator's opinion, which are limited by the Federal Arbitration Act.⁴⁷

Beyond the explicit requirements for enhanced internal and external review for individuals challenging a denial of healthcare coverage, the PPACA will also result in "many millions of additional patient encounters each year. If the rate of adverse events arguably attributable to medical malpractice remains constant, then it might be assumed that the total number of medical malpractice claims will increase."⁴⁸ It could also be assumed that unless the total number of physicians is increased, then physicians will be forced to decrease the amount of time spent per patient visit, leading to increased medical errors.⁴⁹ If this becomes a reality, healthcare providers should be eager to embrace the use of ADR proceedings, particularly

⁴⁴ See *Affordable Care Act (PPACA) External Review Regulations: New Opportunities for Independent Review Organizations (IROs)* 3, URAC (Dec. 2010), http://www.uran.org/resources/URAC_IROIB_2010.pdf (discussing the minimum qualifications for reviewers with accredited IROs).

⁴⁵ *Ross v. Blue Care Network*, 747 N.W.2d 828, 828 (Mich. 2008).

⁴⁶ *Health Coverage Appeals: Internal Grievance Process and Patient's Right to Independent Review Act*, LARA, http://www.michigan.gov/dleg/0,1607,7-154-10555_12902_35510_35694---,00.html#q14 (last visited Apr. 28, 2011).

⁴⁷ The Federal Arbitration Act, 9 U.S.C.A. § 10 (2009) limits vacatur of an arbitration award to cases "1) where the award was procured by corruption, fraud, or undue means; 2) where there was evident partiality or corruption in the arbitrators, or either of them; 3) where the arbitrators were guilty of misconduct in refusing to postpone the hearing, upon sufficient cause shown, or in refusing to hear evidence pertinent and material to the controversy; or of any other misbehavior by which the rights of any party have been prejudiced; or 4.) where the arbitrators exceeded their powers, or so imperfectly executed them that a mutual, final, and definite award upon the subject matter submitted was not made."

⁴⁸ Rothstein, *supra* note 6, at 871.

⁴⁹ *Id.*

mediation, in order to reduce the amount of medical malpractice claims that make it to litigation. Therefore, ADR in various forms will be instrumental under the PPACA to both insurance companies and healthcare providers.

III. ENHANCED OPPORTUNITIES FOR MEDIATION

a. Likelihood of Mediation Reducing Number of Claims Filed

Mediation is an ADR process that may aid in the early resolution of healthcare disputes, particularly medical malpractice disputes, provided confidentiality and other incentives are available to healthcare professionals, notably physicians.⁵⁰ The primary focus of mediation is enhancing communication between the two parties. This is best accomplished through the intervention of a third-party neutral who will assist the parties in channeling emotions, identifying issues of dialogue, addressing perceptions/misperceptions, and generating outcome options.⁵¹ Miscommunication and/or dysfunctional communication are frequently cited as a factor in patient's decision to pursue litigation in a medical malpractice case.⁵² Eric Galton states that "every reliable study regarding the etiology of medical malpractice claims points to

⁵⁰ See Todres, *supra* note 4, at 698 (stating that "[p]roponents of mediation suggest that it is the best alternative to the current medical malpractice liability system because it results in fewer large jury verdicts and reduces the amount of time, money, and emotional capital spent in litigation. Moreover, mediation can be structured to allow more open dialogue between physician and patient about medical decisions and any errors.").

⁵¹ Chris Stern Hyman defines mediation as "a voluntary, confidential conflict resolution process in which an impartial third party, the mediator (or co-mediators), assists the disputants in negotiating a mutually acceptable resolution. Unlike arbitration, in which the third-party arbitrator imposes a resolution, the parties are the decision makers in mediation. The parties are not required to settle and are free at any point to return to litigation. Mediators use their communication expertise to guide the negotiations and help participants identify interests, exchange information, and explore and evaluate options. Mediation soon after the harm that is the subject of the complaint typically offers greater emotional and financial benefits to the parties." Chris Stern Hyman et al., *Interest-Based Mediation of Medical Malpractice Lawsuits: A Route to Improved Patient Safety?*, 35 J. HEALTH POL. POL'Y & L. 797, 798 (2010).

⁵² See Todres, *supra* note 4, at 689 (stating that "[a]fter a patient is injured as a result of medical care, doctors' reluctance to apologize and share information makes them appear incapable of or unwilling to empathize with patients who are suffering. A dehumanized response by doctors undermines the care relationship and destroys the trust that patients have in their doctors").

dysfunctional communication between the healthcare provider and the patient or patient's family as the producing cause of the vast majority of medical negligence lawsuits.”⁵³

Dysfunctional communication may include:

1. Healthcare provider failing to express concern or regret, whether out of fear of liability or personality, resulting in the patient perception that the physician does not care;
2. No explanation;
3. Explanation is delayed, misunderstood, or not heard by the patient;
4. Conflicting explanations from different health care providers⁵⁴

It is apparent that initiating and/or improving the communication between a patient and a physician would be an essential (although not necessarily sufficient) step to avoiding litigation.

Marlynn Wei, an attorney and physician, provides a list of what patients actually desire to hear from physicians:

Patients generally desire (in order of diminishing unanimity): 1) a clear statement that an error has occurred; 2) an explanation of the full detail of the error; 3) a sincere apology; 4) reassurances that the something is being done to make sure the error does not happen again; 5) financial compensation for injury, pain or suffering; and 6) accountability on the part of the responsible physician.⁵⁵

This list is useful because it provides a framework for what successful communication might look like. If a physician makes the desired disclosure properly, the act of disclosing can “preserve trust and compassion in the doctor-patient relationship as an ethical ideal in itself and

⁵³ Eric Galton, *Mediation of Medical Negligence Claims*, 28 CAP. U. L. REV. 321, 322 (2000).

⁵⁴ *Id.* at 322-23.

⁵⁵ Marlynn Wei, Note and Comment, *Doctors, Apologies, and the Law: An Analysis and Critique of Apology Laws*, 40 J. HEALTH L. 107, 121-22 (2007). *See also* David Harlow, *Medical Apology Policies: A First Step in Medical Malpractice Reform?*, BETTER HEALTH (Feb. 16, 2010), <http://getbetterhealth.com/medical-apology-policies-a-first-step-in-medical-malpractice-reform/2010.02.16> (stating that “patients and family members often sue because they want to be sure that ‘nothing like this ever happens to anyone else.’ If a provider can demonstrate that a root cause analysis has been done and systems improvements made so that the same mistakes cannot be repeated, then that impetus for filing suit is removed.”).

help maintain a good relationship in order for the patient and doctor to heal after an adverse event.”⁵⁶

b. Apology Laws as a Way of Ameliorating Conflict

Several states have enacted apology laws in recognition of the value of an apology in the healthcare setting, as well as some physicians’ desire to issue apologies. These laws specify that a physician’s apology is inadmissible in court. The purpose is to encourage physician-patient communication, by permitting physicians to express empathy without increasing their risk of liability.⁵⁷

An often overlooked tool in health care providers’ struggle with the malpractice crisis is the medical apology. Two thirds of the states provide some form of protection for the medical apology (i.e., a simple apology is not admissible in court as an admission of culpability), and settlements reached post-apology are almost invariably lower than they would be otherwise.⁵⁸

Apology laws are particularly attractive because it is believed that the laws will decrease the costs of medical malpractice lawsuits.⁵⁹

c. Limitations of Apology Laws

Colorado’s apology law provides an apt example of the comprehensive language that may be used in these statutes:

⁵⁶ Wei, *supra* note 55, at 118. Wei goes on to note however that “[c]alling for disclosure without providing incentives other than the satisfaction acting morally will likely fall upon deaf ears.” *Id.* at 119.

⁵⁷ Wei, *supra* note 55, at 108 (stating that “[s]o-called ‘apology laws’ have been heralded as the new cure not only for high medical malpractice costs, but also for the rising number of malpractice lawsuits. Supporters claim that apology laws will encourage doctors to disclose errors to patients because they allow defendants to exclude statements of sympathy made after accidents from evidence in a liability lawsuit. Over a dozen states...have passed apology laws.”).

⁵⁸ David Harlow, *Medical Apology Policies: A First Step in Medical Malpractice Reform?*, BETTER HEALTH (Feb. 16, 2010), <http://getbetterhealth.com/medical-apology-policies-a-first-step-in-medical-malpractice-reform/2010.02.16>

⁵⁹ Wei, *supra* note 55, at 108.

In any civil action brought by an alleged victim of an unanticipated outcome of medical care, or in any arbitration proceeding related to such civil action, any and all statements, affirmations, gestures, or conduct expressing *apology, fault, sympathy, commiseration, condolence, compassion, or a general sense of benevolence* which are made by a health care provider or an employee of a health care provider to the alleged victim, a relative of the alleged victim, or a representative of the alleged victim and *which relate to the discomfort, pain, suffering, injury or death of the alleged victim* as the result of the unanticipated outcome of medical care shall be inadmissible as evidence of an admission of liability or as evidence of an admission against interest.⁶⁰

A unique characteristic of Colorado's apology law is that it includes expressions of fault, which, as will be discussed, are essential to an effective apology.⁶¹

Even an apparently comprehensive apology law like Colorado's may encounter some issues, which fail to inspire confidence in a physician desiring to apologize. It is possible that a court could read the privilege narrowly, and "read the law to disallow the evidence to prove fault, but permit its admissibility for other purposes."⁶² Additionally, "by its terms, the Colorado Apology Law makes the apology inadmissible but not non-discoverable" meaning that ultimately "the apology is not fully privileged."⁶³ These possibilities may foster insecurity about the true status of an apology within the context of litigation, and result in healthcare providers discouraging the use of apologies.

In contrast to the Colorado apology law's inclusion of admissions of fault, California's apology law expressly excludes such admissions. California's apology law states:

The portion of statements, writings, or benevolent gestures expressing sympathy or a general sense of benevolence relating to the pain, suffering, or death of a person involved in an accident and made to that person or to the family of that person shall be inadmissible as evidence of an admission of liability in a civil action. *A statement of*

⁶⁰ COLO. REV. STAT. ANN. § 13-25-135 (1) (West 2011) (emphasis added).

⁶¹ *Id.* See also, Edward A. Dauer, *Apology in the Aftermath of Injury: Colorado's 'I'm Sorry' Law*, 34 COLO. LAW. 47 (2005); *infra* p. 18, d. Characteristics of an Effective Apology in a Healthcare Setting.

⁶² Dauer, *supra* note 68, at 48.

⁶³ *Id.*

*fault, however, which is part of, or in addition to, any of the above shall not be inadmissible pursuant to this section.*⁶⁴

This apology law fails to protect precisely the types of apologies that have been found to be the most effective.⁶⁵ Physicians in California would naturally hesitate to issue a full apology, and therefore possibly further damage the physician-patient relationship, and result in escalation of the conflict. However, it has been argued that

the fact a party's statement of fault will be admissible at trial may also encourage settlement because the party who previously stated, 'It was my fault,' may be more inclined to settle when she knows that her statement is admissible and will likely put her at a disadvantage when the issue of liability arises at trial.⁶⁶

Although settlement might be more likely due to a physician's desire to avoid litigation that he or she may lose because of the admission of fault, the admissibility of apologies in litigation would not likely decrease the number of complaints filed, and would certainly make a physician less likely to purposely apologize.

Another drawback to California's apology law is that it creates uncertainty to a greater extent than Colorado's apology law, because it is unclear whether a simple statement of "I'm sorry" without more will be interpreted as a statement of liability, or an expression of sympathy.⁶⁷ The interpretation is pivotal, because one type of statement will be admitted as against the physician, and one will not. A physician may feel the need to consult with a lawyer before issuing an apology, to receive assurances about whether the apology would be admissible or not, and this may result in a delay in apologizing, or a decision to forego the trouble and risk altogether by not apologizing. The Colorado apology law eliminates this particular uncertainty

⁶⁴ CAL. EVID. CODE § 1160 (a) (West 2001) (emphasis added).

⁶⁵ See *infra* p. 18, d. Characteristics of an Effective Apology in a Healthcare Setting.

⁶⁶ William K. Bartels, *The Stormy Seas of Apologies: California Evidence Code Section 1160 Provides a Safe Harbor for Apologies Made After Accidents*, 38 W. ST. U. L. REV. 141, 144 (2000-2001).

⁶⁷ *Id.* at 150.

by making both types of statements inadmissible,⁶⁸ but contains its own uncertainties in its application, as previously discussed.⁶⁹

The limitations of apology laws, due to the variations of the statutory language, and the different ways in which the laws might be applied, indicate that apology laws alone do not provide the required incentives and appropriate context for physicians to issue an apology, and therefore will not make a significant impact in the number of claims filed. On the other hand, mediation may provide the context, as well as the incentives, necessary to increase the use of apologies in medical malpractice cases. The adoption of uniform confidentiality provisions applied to apologies in mediation may mitigate the patchwork application of apology laws, and completely eliminate the need to interpret apology laws in the cases which do not progress past mediation.

d. Characteristics of an Effective Apology in Healthcare Setting

A “sincere apology” is included in Wei’s list of patient desires.⁷⁰ It is important to study the factors of a sincere apology, because if an apology is given ineffectively, it can actually be detrimental to the relationship between the patient and physician, and therefore fail to decrease the amount of medical malpractice claims. “[A]lthough in some circumstances, a halfhearted apology may be better than none at all, there is recent evidence suggesting that, where fault is clear, ‘no responsibility’ apologies may actually make things worse.”⁷¹

There are several examples of an ineffective apology. First, the “safe” or partial apology, such as “I’m very sorry this happened to you” is ineffective even though it does express

⁶⁸ COLO. REV. STAT. ANN. § 13-25-135 (1) (West 2011).

⁶⁹ See discussion *supra* p. 15, c. Limitations of Apology Laws.

⁷⁰ Wei, *supra* note 55, at 121-22.

⁷¹ DOUGLAS N. FRENKEL & JAMES H. STARK, THE PRACTICE OF MEDIATION 231 (2008) (citing Jennifer K. Robbennolt, *Apologies and Legal Settlement: An Empirical Examination*, 102 MICH. L. REV. 460 (2003)).

empathy, mainly because the speaker is avoiding responsibility, or any admission of fault whatsoever.⁷² A second ineffective apology would be the “not responsible” apology, in which the speaker actually specifically rejects responsibility.⁷³ An example of this type of ineffective apology would be an expression of empathy, followed by “but” and then an explanation of the circumstances surrounding the incident, presented in a light most favorably to the speaker.⁷⁴ A final example of an ineffective apology is “the apology of justification,” where “the apologizer equivocates, acknowledging responsibility but then explaining or justifying the wrongful conduct. He says, in effect, *‘I’m sorry I did this, but I had good reasons.’* In extreme cases, he tries to blame the victim as part of the justification.”⁷⁵ The three types of ineffective apologies all “seem to lack any real contrition. They risk leaving the person who is owed an emotional debt feeling shortchanged and angry.”⁷⁶

In contrast, effective apologies must be complete and unconditional.⁷⁷ “[E]ffective apologies are those that (a) appear to be sincere; (b) contain an acknowledgment of the wrongful act and its impact on the victim; (c) accept responsibility; (d) if applicable, promise to refrain from such conduct in the future; and (e) offer compensation for any tangible loss as well.”⁷⁸ In fact, one of the key elements of the Harvard Hospitals’ consensus statement on physician disclosure, is that the physician must take responsibility and then apologize, rather than simply mandating a basic apology.⁷⁹ Taking responsibility, or admission of fault, appears to be a crucial

⁷² DOUGLAS N. FRENKEL & JAMES H. STARK, *THE PRACTICE OF MEDIATION* 231 (2008).

⁷³ *Id.*

⁷⁴ *Id.*

⁷⁵ *Id.*

⁷⁶ *Id.*

⁷⁷ DOUGLAS N. FRENKEL & JAMES H. STARK, *THE PRACTICE OF MEDIATION* 232 (2008).

⁷⁸ *Id.* at 232.

⁷⁹ Wei, *supra* note 55, at 158 (“Harvard Hospitals consensus statement on disclosure in March 2006. This statement recommends that physicians take four steps to communicate adverse events: 1) explain the incident to the patient and family; 2) acknowledge responsibility; 3) apologize; and 4) tell the patient and family what corrections will be made to prevent similar adverse events in the future.... The policy does not have an enforcement mechanism.”)

factor in an effective apology.⁸⁰ The timing of the apology is also important, as “a sincere apology that is delivered too cavalierly or given after months of legal posturing may be perceived to be insincere and could actually increase tension between the parties.”⁸¹ If effective, timely apologies are given, it is possible that as many as 37% of medical malpractice lawsuits could be avoided.⁸² It is not suggested that an apology will eliminate the possibility of litigation in all medical malpractice cases, especially where the injured patient may have “incurred substantial medical bills, loss of current wages, and loss of earning capacity that results in substantial financial hardship that no apology could remedy.”⁸³

An interesting success story for the use of apologies in a healthcare setting is the University of Michigan Hospitals’ physician apology policy, which was launched in 2004.⁸⁴ This policy resulted in a 40% decline in malpractice lawsuits.⁸⁵ The policy encourages “staff to report medical errors and offer an apology and compensation when the health system found a medical error caused injury. Before that, the health system forwarded all claims to a defense

⁸⁰ See Jennifer K. Robbennolt, *Apologies and Legal Settlement: An Empirical Examination*, 102 MICH. L. REV. 460, 494-95 (2003) (stating that “as a general matter, full apologies improved the participants’ perceptions of the situation and the offender, while partial apologies did little to alter such perceptions...overall, a full apology is better than a partial apology and that a partial apology is (often) not different than no apology.”).

⁸¹ Bartels, *supra* note 66, at 150.

⁸² Todres, *supra* note 4, at 686 (stating “A study published in the *Lancet*, the leading British medical journal, found that as many as 37% of medical malpractice plaintiffs reported that they would not have filed lawsuits if their doctors had sincerely apologized instead of stonewalling.”). See also, Vincent et al., *Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action*, 343 LANCET 1609 (1994).

⁸³ Bartels, *supra* note 66, at 155.

⁸⁴ *Medical Malpractice and Patient Safety at UMHS*, UNIV. OF MICH. HEALTH SYSTEM, <http://www.med.umich.edu/news/newsroom/mm.htm> (last visited Mar. 27, 2011). See also Allen Kachalia et al., *Liability Claims and Costs Before and After Implementation of a Medical Error Disclosure Program*, 153 ANNALS OF INTERNAL MED. 213 (2010), available at <http://www.annals.org/content/153/4/213.abstract>. For an additional, and more specific study on the use of mediation in medical malpractice cases, see Hyman et. al., *supra* note 51, at 798, in which “investigators mediated thirty-one cases from a potential pool of sixty-seven referred lawsuits involving eleven nonprofit hospitals in New York City...The study attempted to measure the effect of mediation on settlement, expenses, apology, satisfaction, and information exchange.”

⁸⁵ Mercedes Varasteh Dordeski, *Proposed Law Seeks to Eliminate Liability Stemming From Physician Apologies* (June 4, 2010), http://www.healthcarelawyerblog.com/2010/06/proposed_law_seeks_to_eliminate_liability_stemming_from_physician_apologies.html.

counsel to review and advise whether to settle or go to trial....”⁸⁶ As a result of the policy’s implementation, “claims for compensation, liability costs, and the amount of time it took to resolve claims after the policy was implemented all went down.”⁸⁷ More specifically,

the median time to resolve a claim dropped from about 16 months to just less than a year. The monthly rate of new claims fell from about 7 per 100,000 patient encounters to about 4.5 per 100,000. The number of lawsuits the health system experienced fell from about 38.7 per year to about 17 after the new program began. The annual spending at the U-M health system on legal defense decreased 61 percent. The average cost per lawsuit decreased from \$405,921 to \$228,308 after the policy started. Costs did not change significantly for non-lawsuit claims.⁸⁸

Evidently, if apologies are issued properly, it can have a significant impact on the number of claims filed and pursued. The results of this success story are even more appealing, when considering the likely impact of the new healthcare legislation.

e. Apology Working in Tandem with Mediation

Although it is evident that an apology issued in a mediation setting would likely be helpful in reducing the amount of claims filed, there must be incentives to encourage physicians to apologize in a mediation setting. The majority of physicians do not initiate apologies.

In a study of physicians disclosing clear-cut, harmful errors to standardized patients, surgeons described clear, harmful errors to patients using the words “error” or “mistake” in 57% of cases, “complication” or “problem” in 27% of cases, and did not suggest the error at all in 16% of cases.⁸⁹

“In fact, some doctors believe that to admit a mistake or say that they were affected emotionally is unprofessional.”⁹⁰ This failure to apologize is due to many factors in addition to the desire to

⁸⁶ Tina Reed, *University of Michigan’s Policy Admitting Medical Errors Reduced Costs, Study Finds*, ANNARBOR.COM (Aug. 16, 2010), <http://www.annarbor.com/news/university-of-michigans-medical-error-policy-effectively-cut-costs-study-finds/>.

⁸⁷ *Id.*

⁸⁸ *Id.*

⁸⁹ Wei, *supra* note 55, at 125, citing to David K. Chan et al., *How Surgeons Disclose Medical Errors to Patients: A Study Using Standardized Patients*, 138 SURGERY 851, 854-55 (2005).

⁹⁰ Wei, *supra* note 55, at 125.

avoid liability. The incentives must adequately address the varying factors which prevent a physician from apologizing in the first place. “The reluctance to discuss errors publicly comes from many different sources. Physicians have cited the anxiety of exposing individual fault, costs to their reputation, fear of loss of referrals, and fears of liability and exposure to malpractice litigation.”⁹¹

This variety of factors leans in favor of an apology taking place under the auspices of mediation provided the proper protections are in place for physicians. For example, in mediation, a physician would not be apologizing publicly, or be at risk of ridicule from his/her superior or co-workers unless they were necessary as participants in the mediation. The reputational costs would not be quite as daunting. Furthermore, if a confidentiality agreement is reached during the mediation, a physician need not fear a loss of referrals. Participation in a large number of mediations as a physician is presumably less damaging to a physician’s reputation than being called as a defendant in numerous medical malpractice trials, due to the more private nature of mediation, as opposed to the public record of litigation. Finally, if mediation were used regularly by healthcare providers, it would carry a lesser stigma, if any. If mediation were required or routine procedure after any blatant failure to communicate between the physician and patient, or at a patient’s request, then physicians would possibly feel less guilt about their error, and be more likely to avoid patient error.

Although there is no feasible way to require physicians to issue effective apologies even within the presumably more apology-friendly context of mediation, training could be provided to physicians on how to issue an effective apology within a mediation setting, if the physician

⁹¹ Wei, *supra* note 55, at 128.

desires to apologize.⁹² The training could educate physicians on the potential benefits of such an apology for the patient/physician relationship, including increased trust and the opportunity to prevent future medical malpractice claims.

f. Uniform Mediation Act and Confidentiality

The routine use of mediation may address physician's hesitancy to apologize due to fears of "exposing individual fault, reputational costs, fear of loss of referrals, and fears of liability and exposure to malpractice litigation" provided confidentiality is ensured as part of the private nature of mediation.⁹³ The Uniform Mediation Act (UMA) is an example of efforts to understand and apply standards of confidentiality consistently in mediation. The UMA was completed by the National Conference of Commissioners on Uniform State Laws (with the ABA) in 2001, and amended in 2003.⁹⁴ The UMA provides that "communications are confidential to the extent agreed by the parties" and creates three different privileges.⁹⁵ First, "a mediation party may refuse to disclose, and may prevent any other person from disclosing, a mediation communication."⁹⁶ Secondly, a nonparty participant, such as an attorney, "may refuse to disclose, and may prevent any other person from disclosing, a mediation communication of the nonparty participant."⁹⁷ Finally, "[a] mediator may refuse to disclose a mediation communication, and may prevent any other person from disclosing a mediation communication

⁹² See Wei, *supra* note 55, at 159 (stating that "there may be symbolic importance and moral worth for medical schools to demonstrate their normative commitments, encourage apologies as the virtuous thing to do, and put increasing moral pressure against the silence that surrounds mistakes.").

⁹³ *Id.* at 128 (discussing the reasons physicians choose not to apologize).

⁹⁴ UNIFORM MEDIATION ACT (2003), *available at* <http://www.law.upenn.edu/bll/archives/ulc/mediat/2003finaldraft.pdf>.

⁹⁵ UNIFORM MEDIATION ACT §§ 4-6 (2003).

⁹⁶ UNIFORM MEDIATION ACT § 4 (b)(1) (2003).

⁹⁷ UNIFORM MEDIATION ACT § 4 (b)(3) (2003).

of the mediator.”⁹⁸ Under the first privilege listed, a physician could prevent any participant in the mediation from disclosing an apology issued as a mediation communication.

There are exceptions to the privileges under the UMA, including an exception for a mediation communication that is “offered/sought to prove/disprove a claim or complaint of professional misconduct or malpractice against a mediator, mediation party, nonparty participant, or representative of a party.”⁹⁹ Clearly, this exception to the privileges in the UMA renders it useless as an incentive for physicians to apologize within the context of mediation. Beyond this exception, the UMA is a useful framework for confidentiality in mediation, and if this exception were eliminated for mediations taking place solely in the context of physician-patient relationships, it could be the guarantee of confidentiality that physicians would need to willingly participate in and apologize in mediation.¹⁰⁰ Without appropriately clear and enforceable assurances that statements of culpability will be held confidential, most physicians will not be persuaded to issue an apology.

In states that have not adopted the UMA, it is possible that the general protections afforded to mediation communications may cover apologies, particularly if the apology is given in a way not to suggest professional misconduct, but simply to apologize for the result, and to show empathy for the patient’s repercussions. Although these apologies are not as effective as apologies which admit responsibility,¹⁰¹ these protected apologies may still serve to improve the communication between the healthcare professional and patient. A state mediation

⁹⁸ UNIFORM MEDIATION ACT § 4 (b)(2) (2003).

⁹⁹ UNIFORM MEDIATION ACT § 6 (5) (2003).

¹⁰⁰ This would be the case, provided courts respect the UMA with the proposed change in the context of physician-patient mediations. See James R. Coben & Peter N. Thompson, *Disputing Irony: A Systematic Look at Litigation About Mediation*, 11 HARV. NEGOT. L. REV. 43, 48 (2006) (noting that of 1,223 litigation cases about mediation (1999-2003), there were over 300 opinions “in which courts considered mediation evidence without either party raising confidentiality issues.”).

¹⁰¹ FRENKEL, *supra* note 71, at 231-32.

confidentiality provision was upheld in a controversial case in which priests were accused of child sexual molestation, and then later participated in mediation.¹⁰² The California Court of Appeals deemed the mediation communications inadmissible in collateral litigation proceedings.¹⁰³ In that case, the Archdiocese attempted to release its own records prepared for the mediation, but the “the court concluded that the Evidence Code prevented the disclosure even by the party who made them.”¹⁰⁴ In that case, it is possible that the priests admitted liability or made some type of apology during the course of mediation, but this was not used against them in subsequent proceedings.¹⁰⁵

g. Possible Problems with Increased Mediation and Solutions

There are several possible drawbacks to the use of mediation in medical malpractice cases. Mediation may be inappropriate where a physician is grossly negligent, where it is used as a litigation tactic by a healthcare provider (for information gathering or delay), or where a case may contribute to developing the law if it were pursued in litigation. Mediation may also impose a heavy burden on a physician’s time, especially if it is used routinely. Physicians may also distrust mediators, who they feel may have no sense of a physician’s struggles, and remain insecure about disclosing admissions of fault despite a mediator’s assurances of confidentiality.

In cases where the medical care was grossly negligent, the use of mediation before litigation may prolong the emotional suffering for families, by serving as one additional step

¹⁰² Doe One v. Superior Court, 34 Cal. Rptr. 3d 248 (Cal. Ct. App. 2005).

¹⁰³ *Id.*

¹⁰⁴ Stuart M. Widman, *More Mediation Confidentiality Limits: What the Court May Allow in to Establish a Settlement Agreement*, 24 ALTERNATIVES TO HIGH COST LITIG. 179, 180 (2006).

¹⁰⁵ *See Doe One*, 34 Cal. Rptr. 3d at 248 (holding that “disclosure was barred by mediation confidentiality privilege;”).

before reaching the courthouse, which is where the patient or patient's family may want to be.¹⁰⁶ The patient or patient's family may be wary of the possibility that the hospital or physician will use mediation as a way to obtain information prior to litigation, or seek a lower settlement than the patient may feel entitled to. Medicare makes use of mediation in beneficiary disputes, but refuses to use mediation in cases of "gross and flagrant" medical care, or where "care failed to follow guidelines/usual practice."¹⁰⁷ However, the delays inherent in litigation may be a sufficient incentive for mediation, even in cases of gross negligence. "The financial burden and years of delay in compensation come at a time when the trauma of the injury has created great physical and emotional stress for the patient and his or her family."¹⁰⁸

Another possible drawback to the increased use of mediation may be that the confidential nature of any settlements reached would hinder the improvement in healthcare. "[M]ediation does not ensure that lessons learned in a particular case reach other healthcare providers."¹⁰⁹ "Some argue that being able to resolve disputes without the glare of publicity is a benefit while others see it as favoring the institutional disputant over the individual."¹¹⁰ While this drawback may never be completely mitigated, it can also be argued that it is immensely beneficial, and possibly preferable, for the individual patient to choose whether to engage in mediation or not. At the very least, mediation would provide a patient the opportunity to express himself, and nothing besides a settlement agreement would preclude a patient from pursuing litigation after mediation. Also, mediation would prove useful in situations of miscommunication, where a

¹⁰⁶ *But see* Todres, *supra* note 4, at 677 (stating that "[r]esolving cases quickly helps patients (and healthcare providers) to avoid suffering through years of litigation. These delays not only extend the suffering of patients and healthcare providers, but also hinder learning that could promote safety and help avoid harm to other patients in the future.").

¹⁰⁷ *Mediation: A New Option for Medicare Beneficiaries*, CTR. FOR MEDICARE & MEDICAID SERVICES <http://www.cms.gov/BeneComplaintRespProg/Downloads/3a.pdf> (last visited Apr. 28, 2011).

¹⁰⁸ Todres, *supra* note 4, at 681.

¹⁰⁹ Todres, *supra* note 4, at 699.

¹¹⁰ Harry N. Mazadoorian, *The Promise of ADR in Healthcare Disputes*, 62-APR DISP. RESOL. J. 17 (2007).

patient may not have a litigation-worthy claim, but still desires to improve the physician-patient level of communication.

Finally, if mediation is made more accessible to patients wishing to improve communication with their physician, it may cause a significant strain on a physician's already otherwise hectic schedule. A possible solution may be to create a screening process, in which only valid or "meritorious" complaints result in mediation. If mediation is used on a frequent basis, with confidentiality protections in place, and physicians are educated on the value of effective apologies, then healthcare institutions may find the costs of such a screening panel, and qualified mediators, are offset by the reductions in litigation expenses. An additional benefit to this type of screening panel is that "[p]hysicians may feel less threatened if malpractice cases are screened by medical experts rather than lay people."¹¹¹ This may also help physician "buy-in" to the process of mediation, as it may legitimize the patient's concerns from the physician's perspective, rather than viewing mediation as an obligation or waste of time.¹¹²

One way to address the potential problem of a physician distrusting a mediator, may be co-mediation, with one mediator being an (impartial) physician, and the other not. If only a physician-mediator were used, it is also likely that a patient may feel intimidated, and be hesitant to speak frankly for fear of calling attention to a patient's lack of medical knowledge. Although neither mediator would serve as an advocate for either participant, this arrangement may create a sense of balance in the room, and help participants in the mediation feel more comfortable making disclosures or otherwise discussing their concerns in the mediation context.

¹¹¹ Wei, *supra* note 55, at 155.

¹¹² See Hyman et al., *supra* note 51, at 797 (stating that "[a]bsence of physician participation minimizes the chances that mediated discussion of adverse events and medical errors can lead to improved quality of care. Change will require medical leaders, hospital administrators, and malpractice insurers to temper their suspicion of the tort system sufficiently to approach medical errors and adverse events as learning opportunities, and to retain lawyers who embrace mediation as an opportunity to solve problems, show compassion, and improve care.").

CONCLUSION

The passage of the Obama Patient Protection and Affordable Care Act brings into sharper focus the need for ADR applications in the context of healthcare conflict. Most notably, individuals will have an enhanced opportunity to challenge the denial of benefits, and insurance providers can infuse the required internal and external review processes with the attributes of ADR that contribute to a quick, cost-efficient, and just result.¹¹³ In the medical malpractice arena, the use of mediation, which integrates the process skills of a third-party neutral, can assist in achieving a speedy, interest-based outcome. Mediation also provides parties with a healing component not found in litigation or other adjudicatory processes, which can improve the relationship between healthcare providers and patients and decrease the likelihood of litigation.¹¹⁴ Finally, as mediation grows, the likelihood of states addressing the need to ensure confidentiality in mediation to foster the use of apologies becomes even more compelling. Empirical studies show that apologies, when given sincerely and with recognition of remorse, have a palliative effect on conflict resolution.¹¹⁵ Collectively, these measures are likely to keep the number of healthcare conflicts in check, and enhance overall the conflict resolution experience.

¹¹³ See *supra* notes 18, 35 and accompanying text.

¹¹⁴ See *supra* notes 50-51 and accompanying text.

¹¹⁵ See *supra* note 80 and accompanying text.