DECONSTRUCTING DISPUTE CLASSIFICATIONS: AVOIDING THE SHADOW OF THE LAW IN DISPUTE SYSTEM DESIGN IN HEALTHCARE

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INTRODUCTION

A Hispanic man brings his son to an emergency room in Canada. He waits for a long period of time, over 10 hours, but fails to receive medical care. Frustrated, he goes to another emergency room. After another waiting period of several hours with no medical attention, he takes out a gun. The man threatens to hurt someone if his son is not treated immediately. The man is shot. He dies. Later, it is discovered that he held a toy gun that belonged to his son.

A family of immigrants from Ethiopia brings their baby to an emergency room in Israel. They wait silently for many hours. The medical team, after treating a long line of vocal patients, finally reaches the family, only to discover that the baby the mother is holding in her arms is already dead.

These are two of thousands of comparable stories that have taken place and continue to occur around the globe. A strong tie exists between these occurrences, one that extends beyond the obvious connections. Such accounts represent extreme examples of a category of healthcare-related conflicts that has typically gone unnoticed in the legal and medical literature, both of which have tended to focus on malpractice-related disputes. While malpractice cases have to do with an actual or alleged deviation from the standard of care in the delivery of medical services that has resulted in harm to the patient, the category of disputes that this paper high-

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lights centers on what are typically small-scale conflicts that relate to such mundane matters as long waits or having to vacate a bed. These conflicts often stem from communication problems (or the lack of communication altogether) between members of the healthcare team on the one hand, and patients and their family members on the other. Typically they result in no tangible harm, but give rise to strong feelings of frustration, anger and distrust by both patients and providers. As such, these disputes typically do not constitute a legal cause of action. I therefore term these small-scale conflicts "non-litigable disputes."[1]

Interestingly, the two occurrences mentioned above are not only instructive in drawing attention to the existence and significance of non-litigable disputes, but also shed light on the overlap between these disputes and malpractice claims. While in the case of the father and son, the tragic outcome is in no way related to malpractice (indeed, it is not the sick boy who died), the second incident could very well give rise to an allegation of malpractice. This paper therefore seeks to draw attention to an often neglected dispute type, while at the same time to deconstruct such categorization, thereby questioning some of the assumptions and hierarchies that accompany dispute classifications. In particular, the paper seeks to uncover the implications of the overlap between different categories of disputes for the design of alternative dispute resolution (ADR) mechanisms, the only avenue through which non-litigable disputes can be addressed.

Precisely because ADR processes are distinct from formal law and the validity of disputes does not rely on their constituting a legal cause of action, the notion of dispute classification seems foreign to ADR. Nevertheless, the literature on ADR has engaged in dispute classification, as evidenced in the persistent attempts to "fit the forum to the fuss"[2] (principles for matching disputes with processes) when addressing individual disputes, as well as in the design of dispute resolution systems that address particular dispute types, mainly those that constitute dominant sources of litigation. This is somewhat surprising as conflict management systems, very much like individual ADR processes, have been described in the literature as an integrative source for addressing conflict in an organization or institution. Nevertheless, the reality is that such sys-

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[1] *See* Orna Rabinovich-Einy, *Escaping the Shadow of Malpractice Law*, 74 LAW & CONTEMP. PROBS. (forthcoming 2011).

[2] *See generally* Frank E.A. Sander & Steven Goldberg, *Fitting the Forum to the Fuss: A User-Friendly Guide to Selecting an ADR Procedure*, 10 NEGOT. J. 49 (Jan. 1994).

tems have been adopted in an attempt to divert disputes from courts to internal systems in order to handle such conflicts effectively and discreetly at an early stage. The hospital setting has been no exception, with many internal dispute resolution systems targeting malpractice disputes, while handling other, non-litigable disputes through separate channels.[3] This is problematic because, as this paper will demonstrate, such separation overlooks the ways in which these different categories of disputes sometimes overlap and are related to one another. Consequently, by handling different types of disputes separately, the hospital's ability to learn from these cases, to prevent medical errors and to improve quality of care is diminished. Furthermore, channeling these disputes through different avenues for resolution inevitably creates hierarchies among dispute types with legal disputes gaining prominence over non-litigable ones.

The paper opens with an analysis of dispute classification under ADR theory, and highlights the ways in which the "shadow of the law" has shaped the design of systems for addressing conflict. One significant byproduct of the shadow of the law has been the motivation of dispute system designers to target legal disputes at the expense of other complaints, which do not constitute a legal cause of action. This development is ironic because in the case of non-litigable disputes, alternatives constitute the only available avenues for redress. The article then proceeds to define and characterize non-litigable disputes in Part II.A. This section explores the impact of non-litigable disputes on the wellbeing of patients, their families, and the healthcare team, as well as the effect such friction can have on the quality of health services. Subsequently, Part II.B. sets out to deconstruct the very category that Part II.A. establishes by exploring areas of convergence between what seem like distinct dispute types. The implications of the "spillover" between these two categories of disputes for dispute system design are analyzed in Part III.

One important lesson for the healthcare arena seems to be that if we wish to effectively address malpractice claims, we will have to attend to non-litigable disputes and litigable ones as part of the same dispute pool. Such an approach would undermine current hierarchies between dispute types and send a strong message regarding the need to enhance physicians' communication and problem-solving skills, which have proven essential not only for preventing and addressing non-litigable disputes, but also for

[3] *See infra* notes 36–39 and accompanying text.

preventing the occurrence of medical errors and encouraging the disclosure to patients of those cases in which medical errors have taken place.

The message for the dispute system design field is the need for refinement of dispute categories, by lifting the shadow of the law and moving beyond legal classification. This would allow for broader learning within internal conflict management systems as well as enhancing the applicability of these mechanisms in addressing a broader array of disputes.

I. Dispute Classification and System Design

Dispute categorization is central to the legal system (as it is to rights-based processes more generally). To constitute a legitimate cause of action, a conflict must fit into a category of disputes recognized by law. In some cases, it may be relatively simple to determine whether a dispute fits within the boundaries of a legal category while in other situations, classification may require interpretation and discretion. In many instances, however, wrongs and injuries that take place and that deeply impact people's lives do not constitute legally recognized causes of action.[4] Even where a cause of action exists, the cognitive and psychological processes of recognizing that one's experience falls into such a category is no simple matter and depends on knowledge, resources and power. Obviously, dispute categories, being socially constructed, are not fixed and evolve over time, with new categories emerging and providing legal names to injurious experiences previously unrecognized by the law.[5]

By contrast, in facilitative ADR processes, "naming" the conflict is not essential. In fact, mediators look beyond parties' initial conceptualization of their dispute, seeking to transform their opening positions and understandings by gaining a deeper understanding of their own needs and interests as well as those of their

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[4] Think, for example, of the neighbor disputes in an apartment building over arrangements that relate to the common property in the building. Often these disputes do not constitute legal causes of action but can nevertheless involve deep emotions, frustrations and anger, causing those who can, to move, and resulting in emotional, at times even physical, harm to those who cannot or do not wish to move.

[5] A familiar example is the category of sexual harassment that was only recognized by the Supreme Court after such category was constructed by Prof. Catherine MacKinnon based on the frequent injuries experienced by many women. *See generally* Meritor Savings Bank FSB v. Vinson et al., 477 U.S. 57 (1986).

counterparts.[6] In this way, ADR is intended to be more accessible for the disempowered and less sophisticated disputants for whom the need to accurately classify disputes under a legal cause of action can serve as a real access barrier to justice.[7] But critics have focused on this aspect of ADR as particularly problematic precisely for disputants who are members of disempowered groups because such intervention inevitably means depoliticizing and individualizing the nature of complaints.[8]

In reality, however, the literature on ADR has engaged in dispute classification, evident in the persistence of "fitting the forum to the fuss" as an important "organizing mechanism" in the field.[9] Under this principle, disputes can (and should) be neatly divided by subject matter and matched with dispute resolution processes whose features are suitable in light of the nature of the dispute, party needs, barriers to resolution, and the public interest.[10] The idea was first introduced by Frank Sander and Stephen Goldberg in the mid-1990s and has since been applied across a wide range of contexts, including family disputes,[11] collective trauma,[12] and healthcare.[13] Over the years this principle has proven quite resilient.[14]

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6 *See* CARRIE MENKEL-MEADOW ET AL., DISPUTE RESOLUTION: BEYOND THE ADVERSARIAL MODEL 266–67 (2004).

7 *See generally* William L.F. Felstiner et al., *The Emergence and Transformation of Disputes: Naming, Blaming, Claiming. . .*, 15 LAW & SOC'Y REV. 631 (1980-81).

8 *See* Laura Nader, *Controlling Processes in the Practice of Law: Hierarchy and Pacification in the Movement To Re-Form Dispute Ideolo*gy, 9 OHIO ST. J. ON DISP. RESOL. 1, 13 (1993); *see also* Christine Harrington, *Delegalization Reform Movements: A Historical Analysis, in* RICHARD ABEL, THE POLITICS OF INFORMAL JUSTICE 62 (1982); MENKEL-MEADOW ET AL., *supra* note 6, at 276.

9 *See* Sander & Goldberg, *supra* note 2, at 50.

10 *See id.*

11 *See generally* John Lande & Gregg Herman, *Fitting the Forum to the Family Fuss: Choosing Mediation, Collaborative Law, or Cooperative Law for Negotiating Divorce Cases*, 42 FAM. CT. REV. 280 (2004).

12 *See generally* Michal Alberstein, *ADR and Collective Trauma: Constructing the Forum for the Traumatic Fuss*, 10 CARDOZO J. CONFLICT RESOL. 11 (2008).

13 *See generally* Karl A. Slaikeu, *Designing Dispute Resolution Systems in the Healthcare Industry*, 5 NEGOT. J. 395 (Oct. 1989).

14 *See* Alberstein, *supra* note 12, at 11 (describing it as a "fundamental organizing mechanism" in the field). Indeed, Sander himself returned to the issue several years ago and co-authored an article that seeks to refine the concept. *See* Frank E. A. Sander & Lukasz Rozdeiczer, *Matching Cases and Dispute Resolution Procedures: Detailed Analysis Leading to a Mediation-Centered Approach*, 11 HARV. NEGOT. L. REV. 1 (2006). *But see* Carrie Menkel-Meadow, *Pursuing Settlement in an Adversary Culture: A Tale of Innovation Co-Opted or 'The Law of ADR'*, 19 FLA. ST. U. L. REV. 1, 12, n.52 (1991) (hereinafter *Pursuing Settlement*).

A possible explanation for the role dispute classification has played in ADR is the strong influence of the "shadow of the law."[15] The ADR literature promises to do more than what the law does by addressing conflicts that courts do not and cannot resolve, and by providing remedies that are not available through litigation.[16] In fact, experience has shown that ADR mechanisms mostly rely on disputes supplied by the court system and are often co-opted by the legal mindset.[17] Such cooptation is particularly salient in the law's impact on court-based mediation, turning a process that was supposed to provide a very different alternative to courts into a problematic equivalent for which legal dispute classifications remain central, both in terms of evaluating the legitimacy of the complaint[18] and in terms of the nature of the outcome reached in ADR.[19]

While the impact of the shadow of the law on the resolution of individual disputes has received significant attention, a somewhat neglected area has been the influence of the law on the design of dispute resolution systems. In recent decades, with the spread of internal conflict management systems within organizations and institutions, a new field of "dispute system design" (DSD) has emerged, infiltrating both the theory and practice of ADR.[20] DSD appeared as a field in and of itself with the publication of Ury, Brett & Goldberg's pioneering book *Getting Disputes Resolved*.[21] Ury et al.'s principal insight was that conflicts that took place in closed settings could be addressed most effectively through systemic, pre-designed avenues, and that such systems could also play a key role in the prevention of future disputes.

In the years following the publication of *Getting Disputes Resolved*, writings on the topic have burgeoned with additional books

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

16 *See* Carrie Menkel-Meadow, *Toward Another View of Legal Negotiation: The Structure of Problem Solving*, 31 UCLA L. REV. 754, 791 (1984) (referring to "[t]he limited remedial imagination of courts").

17 *See* Carrie Menkel-Meadow, *Pursuing Settlement, supra* note 14, at 2–3.

18 *See* Nancy A. Welsh, *The Thinning Vision of Self-Determination in Court-Connected Mediation: The Inevitable Price of Institutionalization*, 6 HARV. NEGOT. L. REV. 1, 26 (2001); Carrie Menkel-Meadow, *When Dispute Resolution Begets Disputes of Its Own: Conflicts Among Dispute Resolution Professionals*, 44 UCLA L. REV. 1871, 1872 (1997).

19 *See* Welsh, *supra* note 18, at 26.

20 *See* Amy J. Cohen, *Dispute Systems Design, Neoliberalism, and the Problem of Scale*, 14 HARV. NEGOT. L. REV. 51, 51–52 (2009).

21 *See generally* WILLIAM URY ET AL., GETTING DISPUTES RESOLVED: DESIGNING SYSTEMS TO CUT THE COSTS OF CONFLICT (1988).

and numerous articles being published on what have been termed "conflict management systems"[22] or "internal dispute resolution" (IDR)[23] mechanisms. Alongside the literature, a new profession of dispute system designers and internal conflict handlers emerged in tandem with the proliferation of such units in different entities.[24]

While public sector experimentation with IDR units was driven by legislation,[25] there have also been significant incentives for private entities to voluntarily adopt such mechanisms. IDR processes are typically touted for allowing communication among disputing parties to take place early on, and in an informal and confidential setting, conditions that have contributed to their success in preventing the escalation of conflict into a full-blown dispute.[26] These characteristics, together with the malleability of such processes, which allows parties to tailor-design processes that meet a wide range of disputes and party needs, have made IDR appealing and successful for the private sector as well. In closed settings, such as workplaces, where these systems originally emerged, the prospect of early intervention and the availability of confidential and flexible avenues for addressing disputes, amplifies the benefits associated with ADR, translating into substantial cost savings and other more elusive advantages for both organizations and the individuals involved. Not only are these processes less costly than liti-

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22 *See, e.g.*, DAVID B. LIPSKY ET AL., EMERGING SYSTEMS FOR MANAGING WORKPLACE CONFLICT 3–5 (2003).

23 The term IDR was introduced by Lauren Edelman (*see* Lauren B. Edelman et al., *Internal Dispute Resolution: The Transformation of Civil Rights in the Workplace*, 27 LAW & SOC'Y REV. 497 (1993)), but the processes have received significant attention in the dispute resolution literature under this and other titles. *See generally e.g.*, CATHY A. COSTANTINO & CHRISTINA SICKLES MERCHANT, DESIGNING CONFLICT MANAGEMENT SYSTEMS: A GUIDE TO CREATING PRODUCTIVE AND HEALTHY ORGANIZATIONS (1995); LIPSKY ET AL., *supra* note 22; URY ET AL., *supra* note 21; Frank J. Barrett & David L. Cooperrider, *Generative Metaphor Intervention: A New Approach for Working with Systems Divided by Conflict and Caught in Defensive Perception,* 26 J. APPLIED BEHAV. SCI. 219 (1990); Lisa B. Bingham, *Control over Dispute-System Design and Mandatory Commercial Arbitration*, 67 LAW & CONTEMP. PROBS. 221 (2004); Lisa B. Bingham, *Self-Determination in Dispute System Design and Employment Arbitration*, 56 U. MIAMI L. REV. 873 (2002); John P. Conbere, *Theory Building for Conflict Management System Design*, 19 CONFLICT RES. Q. 215 (2001); Cathy A. Costantino, *Using Interest-Based Techniques to Design Conflict Management Systems*, 12 NEGOT. J. 207 (July 1996); Deborah M. Kolb & Susan S. Silbey, *Enhancing the Capacity of Organizations to Deal with Disputes*, 6 NEGOT. J. 297 (1990); Mary P. Rowe, *The Ombudsman's Role in a Dispute Resolution System*, 7 NEGOT. J. 353 (1991).

24 *See* Ethan Katsh & Orna Rabinovich-Einy, *Technology and the Future of Dispute System Design*, HARV. NEGOT. L. REV. (forthcoming 2012).

25 *See* The Administrative Dispute Resolution Act of 1996, Pub. L. No. 104–320, 104 Stat. 2736 (1990).

26 *See* Orna Rabinovich-Einy, *Beyond IDR: Resolving Hospital Disputes and Healing Ailing Organizations Through ITR*, 81 ST. JOHN'S L. REV. 173, 185 (2007).

gation,[27] but they also allow organizations and individuals employed in such settings to protect their reputations.[28] In addition, by addressing conflict at an early stage, IDR systems can minimize the harm to employee morale that is associated with a workplace fraught with conflict, which may, in turn, contribute to higher rates of satisfaction and employee retention.[29]

Of course, an important benefit (and some might say, the single most important benefit) associated with these systems is that they have allowed workplaces and individual employees to circumvent the courts altogether,[30] keeping unflattering conflicts hidden from the public eye. Indeed, while the literature advocating DSD has focused on this and other benefits associated with the establishment of such systems, DSD has also attracted substantial critique from those concerned with the growing privatization of the dispute resolution landscape.[31]

In the years that followed, another wave of writing on the topic has attempted to deal with these types of second-generation questions on DSD by adopting design features that enhance fairness and accountability.[32] The resulting introduction of substantive fairness to the evaluation of such systems has opened the door to the shadow of the law shaping our understanding of what constitutes a fair outcome. But the shadow of the law has also had a more elusive impact on DSD, shaping the initial design of these mechanisms and the types of conflicts targeted under such systems.

The fact that the law shapes the manner in which internal dispute systems classify disputes may seem surprising at first blush. In the case of ADR processes that are employed post-litigation for the resolution of individual disputes after being referred to ADR

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27 *See* LIPSKY ET AL., *supra* note 22, at 77, 101–02.

28 *See id.* at 162.

29 *See id*. at 7.

30 *See id*. at 6.

31 *See* Owen M. Fiss, *Against Settlement*, 93 YALE L.J. 1073, 1086 (1984); David Luban, *Settlements and the Erosion of the Public Realm*, 83 GEO. L.J. 2619, 2626–27 (1995); Judith Resnik, *Many Doors? Closing Doors? Alternative Dispute Resolution and Adjudication*, 10 OHIO ST. J. ON DISP. RESOL. 211, 226 (1995). *See also generally* Richard Delgado et al., *Fairness and Formality: Minimizing the Risk of Prejudice in Alternative Dispute Resolution*, 1985 WIS. L. REV. 1359 (1985); Nader, *supra* note 8; Harrington, *supra* note 8.

32 *See* Carrie Menkel-Meadow, *Are There Systemic Issues in Dispute System Design? And What We Should [Not] Do About It: Lessons from International and Domestic Fronts*, 14 HARV. NEGOT. L. REV. 195, 201 (2009); Lisa Blomgren Bingham et al., *Dispute System Design and Justice in Employment Dispute Resolution: Mediation at the Workplace*, 14 HARV. NEGOT. L. REV. 1, 24 (2009); Orna Rabinovich-Einy, *Technology's Impact: The Quest for A New Paradigm for Accountability in Mediation*, 11 HARV. NEGOT. L. REV. 253, 279 (2006).

by the court, it is expected that the law remain a fundamental factor shaping the manner in which disputes are addressed through alternative channels. But why should such dynamics be duplicated where ADR is employed pre-litigation, in settings where organizations and institutions have the opportunity and freedom to creatively design conflict resolution systems that need not mimic the classifications, tools and remedies available under the law?

Indeed, the literature on DSD mostly favors systems that target a broad range of conflicts,[33] and it leaves open the questions of whether such systems should be integrative or target particular classes of disputes (and how to classify such disputes at that).[34] In practice, however, many such systems have chosen to focus on specific types of disputes, typically those that are at the center of contentious, unflattering litigation. In the case of sexual harassment disputes, for example, such choice has been openly endorsed by the legal system.[35]

In other cases, such as the establishment of internal avenues at hospitals for addressing malpractice disputes, the legal impetus has been more subtle, with the desire to divert these types of disputes from courts and to address them internally, in a confidential setting, playing an important role in the establishment of such systems.[36] By contrast, other types of disputes and patient complaints that emerge in these settings may or may not be addressed systematically, but even where they are, they are often handled through separate channels.[37] As we can see, it is quite common for legal classifications to receive center stage in the design of internal con-

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33 *See* LIPSKY ET AL., *supra* note 22, at 12–13.

34 *See id.* at 156–58.

35 *See* Lauren B. Edelman et al., *The Endogenity of Legal Regulation: Grievance Procedure As Rational Myth*, 105 AM. J. SOC. 406, 434–36 (1999); U.S. Equal Employment Opportunity Commission, *Raytheon Enters EEOC's National ADR 'Referral Back' Program* (Apr. 21, 2004), http://www.eeoc.gov/eeoc/newsroom/release/4-21-04.cfm (describing the EEOC "Referral Back" Program under which the EEOC refers cases back to employers to be addressed through their IDR systems).

36 *See* Edelman et al., *supra* note 35, at 414, 419; Gary A. Balcerzak & Kathryn K. Leonhardt, *Alternative Dispute Resolution in Healthcare: A Prescription for Increasing Disclosure and Improving Patient Safety,* PATIENT SAFETY & QUALITY HEALTHCARE (July/Aug. 2008), *available at* http://www.psqh.com/julaug08/resolution.html; Henry S. Farber & Michelle J. White, *A Comparison of Formal and Informal Dispute Resolution in Medical Malpractice*, 23 J. LEGAL STUD. 777, 777, 782–83 (1994).

37 *See* Gerald B. Hickson et al., *Development of an Early Identification and Response Model of Malpractice Prevention*, 60 LAW & CONTEMP. PROBS. 7, 12 (1997) [hereinafter Hickson et al., 1997]; Farber & White, *supra* note 36, at 779; Balcerzak & Leonhardt, *supra* note 36 (showcasing the leading IDR programs which largely focus on malpractice disputes).

flict management mechanisms at the expense of other, more inclusive structures for handling disputes internally.

At the same time, for internal systems that address conflict in a particular setting on an ongoing basis, the analysis of dispute patterns through classification of dispute types, party characteristics and additional features, seems indispensable if the organizations in which such systems reside are to maximize the learning potential embedded in conflicts.[38] Indeed, the ability to study dispute patterns over time has been recognized as an important advantage of IDR systems and is often explicitly prescribed as one of the responsibilities of those in charge of such internal units.[39]

While learning requires classification of dispute characteristics in order to recognize patterns (e.g., repetitive complaints of discrimination by female employees who consistently complain of not being promoted to management positions; a series of complaints by junior employees against mid-management that raise questions about such managers' ability to provide effective feedback and evaluation), it is also true that learning is best advanced by studying a broad pool of disputes since it is difficult to know in advance where relevant information exists and different types of disputes—whether they constitute a legal cause of action or not—could point to a similar source of a problem. There is, therefore, a tension between the tendency to classify disputes and target those types of disputes for which there is threat of legal action, and the desire to enhance learning that is best promoted by a broad approach to the scope of disputes addressed by IDR systems. In this competition, the shadow of the law seems to prevail, providing incentives for organizations to focus their resolution and learning efforts on disputes that expose them or their employees to legal liability. For other types of disputes, the tendency is to ignore them, address them on an ad hoc individual basis, or address them through systemic measures, but even then, rigorous learning is rarely sought.[40]

A close examination of doctor-patient conflicts in the hospital setting shows why classification and targeting of legal disputes can be problematic in terms of learning. Malpractice-related disputes are often handled systematically and studied by risk-management units, while patient complaints relating to other matters tend to be framed in individual terms, as part of customer service in an at-

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38 *See* Rabinovich-Einy, *supra* note 32, at 266, 272–73, 278–81.

39 *See* Marsha L. Wagner, *The Organizational Ombudsman as Change Agent,* 16 NEGOT. J. 99, 107–08 (2000).

40 *See* Hickson et al., 1997, *supra* note 37, at 12, 24; Rabinovich-Einy, *supra* note 1.

tempt to restore customer satisfaction.[41] Despite the fact that some of the literature on patient complaints has established a link between the complaints and risk of malpractice suits,[42] the medical environment continues to see these various conflicts as occupying different terrains.[43] In the following sections, the paper explores the connection between small-scale patient complaints and malpractice claims, revealing the ways in which these different categories of disputes sometimes overlap and are related to one another, and, consequently, should be addressed through an integrative system if learning is to be enhanced and quality of care improved.

II. Doctor-Patient Disputes

A. Casting Light on Non-Litigable Disputes

Malpractice claims have been the center of attention for both suppliers and consumers of healthcare services. For decades, policy-makers, healthcare providers and physicians have tried to advance reforms that would address the ills associated with the proliferation of malpractice suits.[44] The problems engendered by malpractice claims have included a rise in professional insurance costs,[45] an ensuing brain drain in certain medical expertise areas,[46] and the emergence of defensive medicine,[47] while the underlying problems of high rates of medical mistakes and resulting deaths have largely persisted.[48] Alongside the focus on the negative as-

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41 *See, e.g.*, Julie Hyer & Roger Hite, *Using Complaints to Analyze and Address Patient Needs*, *available at* http://www.shawresources.com/artusingcomplaints.html (last visited Sept. 19, 2010).

42 *See* Gerald B. Hickson et al*., Patient Complaints and Malpractice Risk*, 287 JAMA 2951, 2951 (2002) [hereinafter Hickson et al., 2002].

43 *See supra* note 37.

44 *See* Thomas B. Metzloff & Frank A. Sloan, *Foreword*, 60 Law & Contemp. Probs. 1, 1 (1997); Florence Yee, *Mandatory Mediation: The Extra Dose Needed to Cure the Medical Malpractice Crisis,* 7 Cardozo J. Conflict Resol. 393, 397–403 (2006).

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

46 *See* Michelle Mello, *Caring for Patients in a Malpractice Crisis: Physician Satisfaction and Quality of Care*, 23 Health Affairs 42, 43 (2004).

47 *See* Jonathan Todres, *Toward Healing and Restoration for All: Reframing Medical Malpractice Reform*, 39 Conn. L. Rev. 667, 683–84 (2006).

48 Edward A. Dauer & Leonard J. Marcus, *Adapting Mediation to Link Resolution of Medical Malpractice Disputes with Health Care Quality Improvement*, 60 Law & Contemp. Probs. 185, 185 (1997) (malpractice litigation has been criticized for failing to achieve the very goals it was designed to promote: corrective justice for the individual plaintiff and deterrence for society

pects of malpractice litigation, some researchers have questioned whether the reports on the nature of malpractice litigation are at all accurate.[49] Both sides of this debate, however, have focused their attention on malpractice claims, while other types of disputes between healthcare professionals and patients (or their families) have received peripheral attention.[50] Many of these "other" (those which are not malpractice) conflicts comprise the category I term "non-litigable disputes."

Non-litigable disputes are comprised of small-scale conflicts between members of the healthcare team on the one hand (typically doctors and nurses), and the patient and/or her family members on the other hand. These disagreements relate to such matters as a patient being required to vacate a bed, transfer to another department (or institution altogether), or a doctor's tone of voice when addressing a question posed by the patient or his family member.[51] Many of these disputes arise from the long waits associated with hospital care, in particular emergency room medical treatment, where patients often have to wait hours before receiving treatment, and sometimes before being spoken to by a doctor. Even where initial care is given, patients face lengthy waits for test results and expert opinions. The fear associated with the circumstances that brought these patients to the hospital to begin with is augmented by delays, a sense of uncertainty, lack of control, and the inherent power and knowledge imbalance that exists between healthcare professionals and patients.[52]

Despite the wide range of disputes that can fall under the rubric of "non-litigable," these conflicts share several common features. For one, in these conflicts, litigation is typically not an option because they do not constitute a legal cause of action (hence their name). In addition, these claims typically stem from communication problems and/or are exacerbated by miscommunication (or the lack thereof altogether).[53] In some cases, these conflicts are

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as a whole); Carol B. Liebman & Chris Stern Hyman, *A Mediation Skills Model to Manage Disclosure of Errors and Adverse Events to Patients*, 23 HEALTH AFFAIRS 22, 22 (2004).

49 *See* TOM BAKER, THE MEDICAL MALPRACTICE MYTH 63 (2005) (questioning common claims about a flood of litigation by demonstrating that many injured parties do not file malpractice claims at all); NEIL VIDMAR, MEDICAL MALPRACTICE AND THE AMERICAN JURY: CONFRONTING THE MYTHS ABOUT JURY INCOMPETENCE, DEEP POCKETS AND OUTRAGEOUS DAMAGE AWARDS 182 (1995) (refuting common claims according to which jury awards in malpractice litigation being unpredictable and capricious).

50 *See* Rabinovich-Einy, *supra* note 1.

51 *See id.*

52 *See id.*

53 *See id.*

portrayed by medical professionals and administrators as inevitable consequences of the limited resources under which many medical institutions and professionals operate. Since healthcare providers, at least in public hospitals, operate in an environment that is understaffed and under-budgeted, patients will face long waits, and the over-extended staff will communicate in a short, often curt, manner.[54] These dynamics are made more extreme by an architecture that does not allow for private, quiet conversations. Each argument therefore becomes a public spectacle, to the agony of staff and patients alike.

Consequently, it is a common occurrence that hospital corridors are fraught with vocal conflicts between staff and patients (and/or their families). Since this is typically presented as an inherent part of doctor-patient relations ("that's the way doctors speak") and of the delivery of urgent medical services ("there's no time," "there aren't sufficient staff members"), the impact of this state of affairs on all involved is often overlooked or accepted as a given.[55]

One rare instance in which attention was focused on non-litigable disputes is Anne Fadiman's riveting account of the countless misunderstandings and clashes that arose between a Hmong immigrant family and the American doctors and nurses who treated their epileptic young daughter.[56] In that case, miscommunication and misunderstandings went far beyond language barriers, exposing some of the deep problems that exist in the modern healthcare system and in doctor-patient (as well as doctor-family members) relations. In one telling passage, Fadiman describes "American medicine at its best and at its worst": topnotch care was being delivered to comatose Lia, but the doctor, when updating the patient chart, continuously referred to her as a male.[57] Over and over, we read how doctor instructions and explanations are misunderstood by Lia's parents, with the doctors failing to detect such misunderstandings, and we follow the ensuing consequences with apprehension. While the common focus on malpractice can be attributed to the heavy expenditures associated with it, Fadiman's book is a

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54 *See id.*

55 Naturally, it is difficult to point to what is not out there, but this dearth of research has been noted previously. *See* Barbara Beardwood et al., *Complaints Against Nurses: A Reflection of 'the New Managerialism' and Consumerism in Health Care?*, 48 SOC. SCI. & MED. 363, 364 (1999) (stating that "[t]he research in the area of complaints against health care workers has been limited and has been inclined to concentrate on studies of medical malpractice.").

56 *See generally* ANNE FADIMAN, THE SPIRIT CATCHES YOU AND YOU FALL DOWN (1998).

57 *See id.* at 147.

good illustration of costs—emotional and financial—associated with the persistence of non-litigable disputes.

As evidenced in the Fadiman account, non-litigable disputes, despite their small-scale nature, can exact a heavy toll. For patients and their families, these arguments are incredibly stressful, adding to the other worries that surround a visit to the doctor, in particular when the matter is urgent. Their worries are exacerbated by a growing sense of distrust stemming from the deficient communication with staff.

Disagreements with the staff can heighten feelings of frustration leading in some cases to violent outbursts towards medical staff by patients and their families.[58] While attempts to address violence through added security and other punitive measures are a necessary and important development in recent years, it seems that these measures do not address those cases in which violence stems from miscommunication, frustration and fear. Paradoxically, we find that those disputes that are deemed "non-litigable" can escalate into violent rows that eventually end up in court through criminal proceedings against the person who assaulted a member of the healthcare staff.

But the impact of non-litigable disputes is by no means limited to the recipients of medical care. Some doctors and nurses who treat patients at hospitals have described their work environment as a battlefield, portraying a sad picture of distressed healthcare professionals who feel worn out by the need to address patients under extremely difficult conditions.[59] While it is true that those fields in medicine that have experienced a brain drain are the ones in which malpractice litigation has surged, it is worth noting that these are also the fields in which interaction between patients and staff is typically conducted under urgent and stressful circumstances.[60] It is not surprising therefore that we find a high attrition rate of healthcare providers in high-risk specialties.[61]

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58 *See* Alex James et al., *Violence and Aggression in the Emergency Department,* 23 EMERG. MED. 431, 433 (2006) (finding that 11.9% of violent incidents resulted from long waits); Frederick Paola et al., *Violence Against Physicians*, 9 J. GEN. INTERNAL MED. 503, 505 (1994) (finding that 18% of violent attacks by patients on the medical team were preceded by an argument with the physician and 9% resulted from long wait periods).

59 *See* Rabinovich-Einy, *supra* note 1.

60 *See generally* Sara C. Charles et al*., Sued and Nonsued Physicians' Self-Reported Reactions to Malpractice Litigation*, 142 AM. J. PSYCHIATRY 437 (1985).

61 Michelle M. Mello et al*., Effects of a Malpractice Crisis on Specialist Supply and Patient Access to Care,* 242 ANNALS OF SURGERY 621, 621 (2005).

Even where doctors and nurses continue to work in their field, the implications of a high volume of non-litigable disputes are significant. Where doctors and nurses work in an environment in which there is high friction (and noise), and they try to preempt arguments with patients, they tend to avoid eye contact and detailed conversations with patients and families, thereby breeding further anxiety, distrust and conflict. Worse, perhaps, is that such an environment could actually lead to the delivery of sub-optimal medical services. To deliver high-quality treatment, the staff needs information from the patient and family members and needs the recipient of treatment to cooperate.[62] Such an open exchange requires trust, time and a degree of openness, conditions that are difficult to sustain under the circumstances described above.[63]

Over the years, there have been attempts to address non-litigable disputes through the establishment of complaint avenues and ADR channels in hospitals.[64] There has also been the effort to enhance physician communication skills through appropriate training during the course of their studies as well as in later stages.[65]

The adoption of internal complaint handling mechanisms in hospitals is related to the more general trend of IDR. Hospitals have been no exception and, like other institutions, have been an arena in which IDR mechanisms, such as ombudsmen, mediation, arbitration or a panel of neutrals, have been introduced[66] in the hope that these mechanisms could provide an effective avenue for addressing patient complaints (and in some cases, internal disputes among hospital employees as well). At times, mediation has been offered to facilitate difficult conversations between staff and patients or their families and even among medical staff on such matters as bioethical dilemmas.[67]

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62 *See* Mor & Rabinovich-Einy, *supra* note 45.

63 *See* Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 470–73 (2002) (describing the centrality of trust for the doctor-patient relationship).

64 *See* Balczerak & Leonhardt, *supra* note 36 (in their description of the Internal Neutral Mediator Model); Hickson et al., 1997, *supra* note 37, at 11; Farber & White, *supra* note 37, at 779.

65 *See* David R. Graber et al., *Academic Deans' View on Curriculum Content in Medical Schools*, 72 ACAD. MED. 901, 901 (1997); Bobbi McAdoo, *Physicians: Listen Up and Take Your Communication Skills Training Seriously*, 29 HAMLINE J. PUB. L. & POL'Y 287, 290–93 (2008) (describing the impressive effort to introduce communication skills training into the curriculum of medical schools in the years since the publication of "To Err is Human").

66 *See* Susan J. Szmania et al., *Alternative Dispute Resolution in Medical Malpractice: A Survey of Emerging Trends and Practices*, 26 CONFLICT RESOL. Q. 71, 79–80 (2008).

67 *See generally* NANCY N. DUBLER & CAROL B. LIEBMAN, BIOETHICS MEDIATION: A GUIDE TO SHAPING SHARED SOLUTIONS (2004); Robert Gatter, *Unnecessary Adversaries at the*

Despite impressive achievements by some IDR programs in healthcare in terms of cost savings, claim rates,[68] and even in bringing about a deeper change in parties' understanding of the dispute[69] and in the organizational culture,[70] these initiatives have yet to become widespread. Similarly, despite the multitude of courses and training offered, recent research clearly demonstrates that real communication problems prevail between healthcare professionals and patients.[71] While it is certainly plausible that the persistence of communication problems and, consequently, of non-litigable disputes, between doctors and patients is rooted in professional culture or generated by having to operate in an environment with limited resources, this paper highlights another possible cause: that our understanding of the sources of each dispute type and the avenues through which they should be addressed has been incomplete. We have tended to overlook the overlap between non-litigable disputes and malpractice claims. This is not surprising, as the existence of non-litigable disputes has rarely gained attention. Even where non-litigable disputes have been noted, they have been set up as a category of patient complaints distinct from actual or potential malpractice claims.

However, as the section below demonstrates, non-litigable and malpractice disputes actually do share similar roots, and particular circumstances may give rise to conflicts that could be classified under either category of dispute, depending on the severity of the circumstances, party sophistication, and the manner in which the occurrences are dealt with.

End of Life: Mediating End-of-Life Treatment Disputes to Prevent Erosion of Physician-Patient Relationships, 79 B.U. L. REV. 1091 (1999); I. Glenn Cohen, *Negotiating in the Shadow of Death*, 11 DISP. RESOL. MAG. 12 (2004).

68 *See* Balcerzak & Leonhardt, *supra* note 36.

69 *See* Szmania et al., *supra* note 66, at 74–75.

70 *See id.* at 77.

71 Coby Anderson & Linda L. D'Antonio, *Empirical Insights: Understanding the Unique Culture of Health Care Conflict*, 11 DISP. RESOL. MAG. 15, 17 (2004) (citing a healthcare professional who described how the conflict resolution skills taught in medical school get "untaught" in the residency period). Naturally, although this could be a result of the quality of particular trainings and courses offered (*see generally* Donald J. Cegala & Stefne Lenzmeier Broz, *Physician Communication Skills Training: A Review of Theoretical Backgrounds, Objectives and Skills*, 36 MED. EDUC. 1004, 1004 (2002)), the view offered in this article is that there is a deeper explanation for this failure.

B. Deconstructing the Distinction Between Non-Litigable Disputes and Malpractice Claims

1. General

Malpractice claims and non-litigable disputes seem at first blush to be in stark opposition to one another. While the first category of disputes constitutes a clear cause of action and is often the subject of legal proceedings, the latter are aired outside the legal arena—in a hospital corridor during a row with the nurses on duty, on the phone with a department head, or at the complaint handler's office (unless of course they deteriorate into a violent row and then may be dealt with through criminal proceedings). Also, while conflicts that raise malpractice allegations typically involve concrete harm and substantial damages, non-litigable disputes largely involve intangible costs and harm that are difficult to recognize, let alone monetize. Finally, malpractice claims are understood to be claims that relate to the quality of clinical prognosis or treatment rendered, while non-litigable disputes relate to other peripheral issues that arise in tandem with the medical treatment itself—the healthcare team's approach and attitude while providing treatment, the wealth of resources available to the staff rendering treatment, and decision-making by healthcare personnel on non-clinical matters. Alongside this dichotomy, we find connections between the two categories, as described in the following sections.

2. Areas of Convergence

a. Source of Disputes

Significantly, some of the same trends have given rise to both non-litigable and malpractice disputes. In particular, the power shift in patient-doctor relations has not only made patients more vocal on matters that give rise to non-litigable disputes, but has also laid the foundation for closer scrutiny of doctors' clinical interventions and has made patients more vocal about their concerns in terms of accuracy of medical prognosis and the appropriateness of caregivers' recommended course of action.[72]

In addition, over the years, it has become more and more evident that a connection exists between communication skills and the delivery of appropriate, high-quality medical services. While

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[72] *See* Mor & Rabinovich-Einy, *supra* note 45; Paul J. Barringer et al., *Administrative Compensation of Medical Injuries: A Hardy Perennial Blooms Again*, 33 J. HEALTH POL. POL'Y & LAW 725 (2008).

clinical skills have traditionally been viewed as distinct from communication capabilities, with the former being viewed as a key for qualitative medical treatment and the latter as relatively unimportant, with time it has become increasingly evident that such separation is false. Poor communication skills are no longer viewed solely as poor bedside manner and as a source of non-litigable disputes, but as a potential source of malpractice liability.[73] Doctors and nurses need to obtain full and accurate information from patients and their families, share such information fully among the care team, and ensure that patients and their families understand the prognosis, treatment plan and instructions correctly. Therefore, some researchers, policymakers and administrators have emphasized the need to improve doctor communication skills so as to enhance their data gathering skills,[74] while others have highlighted the connection between patient complaint trends and risk management efforts.[75]

Another arena in which a tie has been established between communication skills and malpractice relates to communication between the staff and patients or their families after the occurrence of a medical mistake. In those cases, research has demonstrated that the factor that determines whether a patient or her family decides to sue is related to the manner in which the occurrence of the mishap is disclosed.[76] Where little or no communication took place, or where no satisfactory explanation was given, likelihood of lawsuit was higher.[77] In fact, these revelations have spurred research on the applicability of mediation-based communication skills for conducting such disclosure conversations, which has resulted in the development of protocols for medical mistake disclosure communications[78] and practical training on these issues.[79]

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73 *See* Mor & Rabinovich-Einy*, supra* note 45.

74 *See supra* note 65.

75 *See* Hickson et al., 2002, *supra* note 42.

76 *See* Hickson et al., 1997, *supra* note 37, at 9–12.

77 *See* Kathleen M. Mazor et al., *Communicating With Patients About Medical Errors: A Review of the Literature*, 164 ARCH. INTERN. MED. 1690 (2004); Bernard B. Virshup et al., *Strategic Risk Management: Reducing Malpractice Claims Through More Effective Patient-Doctor Communication*, 14 AM. J. MED. QUALITY, 153 (1999); Wendy Levinson et al., *Physician-Patient Communication: The Relationship with Malpractice Claims Among Primary Care Physicians and Surgeons*, 277 JAMA 553 (1997); Christine W. Duclos et al*., Patient Perspectives of Patient-Provider Communication After Adverse Events*, 17 INT'L J. QUALITY IN HEALTH CARE 479 (2005).

78 *See* Liebman & Hyman, *supra* note 48.

79 When Things Go Wrong: Responding to Adverse Events, A Consensus Statement of the Harvard Hospitals (March 2006) (a document that was intended to serve the development of

These common sources—the changing equilibrium in doctor-patient relationships and the connection between communication skills and the eruption of conflict—could provide an explanation for those areas of convergence between malpractice and non-litigable disputes described below. In these cases, close scrutiny reveals that conflicts cannot be neatly ascribed to one of the categories from a conceptual viewpoint; instead, what explains their categorization are the awareness and knowledge of the parties, the availability of accessible and effective resolution avenues, and the nature of communication that takes place between the medical staff, on the one hand, and the patient and/or his family on the other.

In the following sub-sections, the paper explores areas in which convergence exists between non-litigable and malpractice disputes, a state of affairs that undermines the effort to achieve a "clean" classification of disputes. As this paper demonstrates further below, forcing such classification on areas in which such spillover exists can undermine efforts to address and prevent conflicts.

b. Instances of Spillover Between Dispute Types

i. Extreme Cases of Non-Litigable Disputes

How do we categorize the case of the family of Ethiopian origin described above? Do we categorize it as a non-litigable dispute arising from long waits and lack of communication of the staff with the family of the sick baby? Was the wait time reasonable in light of the patient load and scarce resources at the hospital or was there negligence involved with staff making assumptions regarding the level of urgency in light of the family's quiet and subdued manner? Could urgent medical assistance have saved the baby's life? We can see how the issue of a "long wait," which is typically associated with non-litigable disputes, becomes a matter of potential malpractice in extreme cases with tragic results.

In another example, a patient at the oncology department who suffers from advanced cancer is receiving treatment. Her doctor, who is on vacation, leaves clear instructions for her treatment and asks another doctor at the department to "take over." The substitute doctor, after reviewing the file, does not agree with the course of treatment chosen and insists on an alternative approach. The doctor does not explain his choice to either the nurse or the patient and her spouse. The nurse, who openly questions whether the doc-

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specific policies and practices relating to provider communication in the aftermath of an adverse event) [hereinafter When Things Go Wrong].

tor should change the course of treatment, is harshly silenced by him. The patient and her spouse, confused and distrustful, decide to leave the hospital immediately. Several days later, the patient is hospitalized after having passed out. It turns out that she had suffered for several days from what seemed like a slight cold which evolved into a major illness. She put off calling the department because she felt she could not trust the staff. A week later she dies of complications. While the treatment rendered post-hospitalization was appropriate, one could question to what degree the conduct of the substitute doctor was appropriate.

Do we categorize this conflict as a non-litigable dispute resulting from the miscommunication between the substitute doctor and the patient (perhaps between the original doctor and the substitute one, or between the substitute doctor and the nurse?) Was the original treatment wrong? What about the alternative one chosen by the substitute doctor? Should a substitute doctor insist on changing the course of treatment where such treatment is reasonable? Can doctors be deemed negligent if they do not take active steps to ensure that their patients follow medical instructions, take medication and receive treatment? Is sustaining trust part of a doctor's professional obligation?

Non-litigable disputes are typically small-scale conflicts characterized by feelings of fear and frustration on all sides, loss of trust by patients and family members in the medical team, and fatigue by the medical staff. In extreme cases, such as the ones described above, however, the harm inflicted as a result of broken communication and the long wait incurred by the patient is or can be substantial and could potentially expose hospital staff to legal liability. The distinction between non-litigable and malpractice claims in these cases therefore becomes blurry where circumstances that typically give rise to non-litigable disputes result in major harm.

ii. "Light" Malpractice Cases

Another area in which the distinction between non-litigable and malpractice claims is blurred is the mirror image of the previous category: those instances in which a medical mistake occurred but such mistake resulted in very little harm. In such cases, while the circumstances seem to give rise to a potential malpractice claim, the dispute could be framed as a non-litigable dispute, referring to such issues as the manner in which the team should have discussed the issue with the patient, while emphasizing the fact that in effect there was no serious or irreparable harm that took place.

An example of these types of conflicts would be when the wrong medication is administered resulting in minor side effects but no major effects and no long term harm. The care team might have to disclose this information to the patient, but would understandably be nervous about such disclosure and may therefore provide limited information in a curt fashion or refrain from communicating about the incident altogether.[80] The patient, trying to understand why she was experiencing the symptoms she suffered from, would feel frustrated by the way in which she had been addressed by the care team, especially the manner in which the doctor had brushed her off. The doctor, on the other hand, would be frustrated by having to delve into this incident where no harm was incurred. It may seem to the doctor that the patient is fishing for a potential claim, which she views as completely baseless. Whether the patient or her family classify this conflict as an event constituting malpractice or merely as a non-litigable dispute (the doctor was rude or had not communicated the problem in a full and accessible manner) depends to a large extent both on whether the patient and her family members are able to name the dispute as a potential or actual malpractice claim,[81] which may in turn, depend on the existence of a middleman, such as a lawyer, who will categorize the dispute in such manner.[82]

The following example is also instructive. A young woman arrives at the emergency room with intense back pain. A surgeon examines her, an x-ray is taken, she receives pain relievers and the doctor decides to release her. The woman continues to complain of acute pain and her father refuses to leave when she is in such a state. Both daughter and father are vocal, with the father making mild threats towards the staff. The doctor is skeptical that the pa-

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80 *See* Lauris C. Kaldjian et al., *Disclosing Medical Errors to Patients: Attitudes and Practices of Physicians and Trainees*, 22 J. GEN. INTERNAL MED. 988 (2007), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2219725/ (despite a claim by the vast majority of physicians surveyed that they would disclose a medical error that resulted in minor harm to a patient, only 41% reported having done so, indicating that many of them do not in fact do so). *See also* When Things Go Wrong, *supra* note 79, at 6 (stating that "[t]here is general agreement among patients and caregivers that it is not appropriate to inform patients of minor (harmless) errors. Near misses, errors that could have caused harm but were intercepted, are a special case and responses need to be individualized. Caregivers and administrators need to discuss and agree on the threshold for informing and the rationale for choosing that threshold. This can be a difficult task, but consistency requires a clear institutional policy.").

81 *See* Felstiner et al*., supra* note 7, at 634–35.

82 *See id.* at 645–47. For the role of lawyers in the transformation of disputes more generally, see Carrie Menkel-Meadow, *The Transformation of Disputes by Lawyers: What the Dispute Paradigm Does and Does Not Tell Us*, 1985 MO. J. DISP. RESOL. 25 (1985).

tient could be suffering from pain after having received such a high dosage of painkillers and is outraged by both the daughter's and father's conduct. He asks the nurse to call security to escort the two outside the hospital. The nurse is uneasy about releasing a patient in pain. Despite their irritating conduct, she senses the complaints are sincere. After an intense conversation with the doctor, she convinces him to call in a back specialist who decides to hospitalize the patient, orders a CT, following which she is operated on urgently. Was the decision to release the patient without having a back specialist examine her negligent? Can the patient sue for the extended period of time during which she suffered pain until a back specialist was called in? It is interesting to see the impact that the demeanor of the patient and her family can have on the staff's approach and, consequently, the staff's interpretation of the patient's medical condition.[83]

We see then that there are areas in which there is some overlap between what at first seem like contradictory types of disputes—malpractice claims and non-litigable disputes. This is perhaps not surprising given the common roots these types of disputes share. The question arises as to the significance of such convergence and why we should worry about the fact that there is no "clean" distinction between these dispute types.

C. The Impact of Spillover Between Categories

The convergence of certain types of malpractice and non-litigable disputes has a potentially negative impact on the manner in which both types of problems are addressed and has been a force in breeding additional conflict between patients and doctors.

Ignoring the dual nature of these types of disputes means that they are not addressed fully. If these conflicts are categorized as non-litigable, they are typically viewed as ones that cannot be prevented and should be addressed ad-hoc through apology and clarification. In these cases, it is often thought, conflict is a result of deeply ingrained structural characteristics: the lack of sufficient manpower and resources in delivering medical services[84] and the

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[83] On the role of heuristics in physicians' diagnoses see generally Pat Croskerry, *The Importance of Cognitive Errors in Diagnosis and Strategies to Minimize Them*, 78 ACAD. MED. 775 (2003); Donald Redermeier, *The Cognitive Psychology of Missed Diagnoses*, 142 ANNALS OF INTERNAL MED. 115 (2005).

[84] *See* Rabinovich-Einy, *supra* note 1.

professional culture of medicine.[85] This also means that lessons in terms of malpractice exposure are not learned. The view of the circumstances that give rise to malpractice remains narrow, ignoring the connection between staff demeanor and conduct on non-clinical matters and potential problems in rendering medical treatment. Opportunities for deep learning on the various sources of medical mistakes and malpractice cases and the means for preventing them and improving the quality of medical services are therefore missed.

On the other hand, where these borderline conflicts are seen as potentially exposing the medical staff to malpractice claims, the deep-rooted problems in communication and demeanor of the medical staff that accompany such disputes are not addressed and may even worsen. Medical staff become concerned with legal liability across a wider range of circumstances—not only the typical situation of clinical mistreatment—and therefore act and communicate in a defensive manner with patients and their family members across a wide range of issues and under a variety of circumstances. Such conduct and mode of communication by doctors and nurses, in turn, can serve as fertile ground for breeding further non-litigable disputes.[86]

Staff, in an attempt to maintain authority and shield their actions from scrutiny, may adopt a mode of communication that is closed, hierarchical and curt.[87] Such mode of communication is bound to frustrate patients and family members who would like as much information as possible to be delivered in an accessible and open manner. Also, where information conveyed is "thin," there is more room for miscommunication. Each side to the conversation brings its own assumptions and expectations and fills the gap in the conversation differently, at times mistakenly. We can therefore expect such interaction to breed additional conflict stemming from both the demeanor of the staff and misunderstandings arising from the concise information conveyed, often unclear to non-professionals and indecipherable by concerned patients and family members.

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85 Anderson & D'Antonio, *supra* note 71, at 17 (citing a healthcare professional who described how the conflict resolution skills taught in medical school get "untaught" in the residency period); Marc R. Lebed & John J. McCauley, *Mediation Within the Health Care Industry: Hurdles and Opportunities*, 21 GA. ST. U. L. REV. 911, 914–15 (2005); Virginia L. Morrison, *Heyoka: The Shifting Shape of Dispute Resolution in Healthcare*, 21 GA. ST. U. L. REV. 931, 936–38 (2005) (describing a healthcare culture that views collaboration as a sign of weakness); Szmania et al., *supra* note 66, at 73.

86 *See* Rabinovich-Einy, *supra* note 1.

87 *See id.*

Paradoxically, the common mode of communication employed by doctors actually drives patients and their family members to pursue malpractice claims in some of these cases. Research has shown that one of the single most influential factors that shape the decision of whether to file a claim or not is the manner in which the staff communicated with the patient or family members in the aftermath of a medical mishap.[88] Indeed, these findings have generated efforts to enhance doctor communication skills[89] and even to generate specific protocols for the manner in which such conversations should take place.[90]

The following section explores some of the implications that emerge from the realization that: (a) non-litigable disputes are a widespread phenomenon in the healthcare arena that is typically not being addressed; and (b) there are instances in which non-litigable disputes overlap with malpractice claims, a state of affairs that renders some of the efforts to address conflict in healthcare unsatisfactory. These instances can breed further conflict, and, perhaps most significantly, can hinder attempts to reduce instances of malpractice and to improve the quality of healthcare services. This realization has important implications for both the design of dispute resolution systems in healthcare, as well as for healthcare provider professional training and culture in terms of dispute prevention.

III. Revisiting Dispute Classification in DSD: The Benefits of a Broad Pool of Disputes in the Physician-Patient Context

A. Generating Learning

The distinction between non-litigable and malpractice disputes has meant that each of these problems has typically been dealt with through separate avenues. As described above, non-litigable disputes have either been addressed through ad-hoc, on the ground measures (intervention by a department head, head nurse and the like)[91] or through the establishment of informal and formal ave-

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88 *See generally* Hickson et al., 1997, *supra* note 37; Mazor et al., *supra* note 77; Virshup et al., *supra* note 77; Levinson et al., *supra* note 77; Duclos et al., *supra* note 77.

89 *See* Graber et al., *supra* note 65, at 901.

90 *See* When Things Go Wrong, *supra* note 79; Liebman & Hyman, *supra* note 48.

91 *See* Hickson et al., 1997, *supra* note 37, at 12, 24.

nues for handling patient complaints (typically ombudsmen).[92] Complaints that give rise to malpractice claims have, however, been handled through separate channels, mostly the legal department and by those charged with risk management responsibilities.[93] Such separation mirrors the seemingly clear distinction between non-litigable and malpractice claims.

Once we realize, however, that there are important commonalities and areas of convergence between these different dispute types, the wisdom of handling such disputes through distinct channels becomes questionable. For one, by forcing a categorization on the dispute and channeling it to one particular resolution avenue, we are necessarily missing important lessons relating both to the occurrence of such disputes and to their effective resolution and prevention.

When, for example, the story of the wrongly administered medication is classified merely as a potential malpractice claim that has caused no harm, a hospital may study the circumstances that have caused the mistake internally but would perhaps choose not to involve the patient and his family in such investigation since no harm was caused and no threat of potential lawsuit exists. By classifying this as a case that does not require post-event communication with the patient, the healthcare team may be missing important lessons on the patient's perspective regarding the manner in which communication took place with him prior to the administration of the wrong medicine, insights that the healthcare team itself may not be able to generate.

Similarly, when the case of the patient whose treatment was altered by the substitute physician is categorized as a regrettable outcome resulting indirectly from miscommunication, both within the care team and between the doctor and the patient, the opportunity to gain a deeper understanding of the connections between communication, trust and the ultimate goal of providing effective medical care are missed. Also, it may very well be that precisely because healthcare professionals and ombudsmen handling such disputes recognize on some level that a spillover between the categories does exist, they will not address such disputes satisfactorily as pure non-litigable disputes. Where exposure to medical malpractice is perceived as existing under the surface but is not openly acknowledged and recognized, it is difficult to believe that open and non-defensive communication can take place even when ad-

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92 *See* Fraber & White, *supra* note 36, at 779; Rabinovich-Einy, *supra* note 1.

93 *See* Hickson et al., 1997, *supra* note 37, at 12.

dressing "purely" non-litigable disputes. In its place, we can expect defensiveness, which, as we have seen, is more likely to breed further conflict rather than resolve such disputes.

If learning is to take place in IDR systems, the shadow of the law on dispute classification must be avoided. Obviously, disputing systems need to classify disputes if they are to address them satisfactorily and learn from them over time. That should not, however, allow legal categories to drive dispute system design, leading designers to focus on disputes that expose organizations to legal liability while providing other non-litigable disputes with inferior options for redress. In doing so, dispute system designers not only betray the promise of ADR, but may also miss an opportunity to generate learning across such categories.

B. Undermining Existing Hierarchies

While communication skills for nurses are often seen as an important aspect of their professional capabilities,[94] doctors' professional skills have traditionally been relegated to the clinical domain.[95] Over the years, this dichotomy has been somewhat softened with the change in power equilibrium between doctors and patients, which has empowered patients to ask more questions and demand fuller and more satisfying answers. Similarly, the rise of a consumer mentality in the delivery of healthcare services has made consumer satisfaction an important concern of both administrators of health institutions and of individual caretakers.[96] Finally, a move for enhancing communication skills in doctor education and training has been on the rise in the last few decades, as a result of the realization that quality of communication between doctors and patients can be linked to both the occurrence of malpractice as well as to the likelihood to sue in the aftermath of a medical mistake.[97]

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94 *See* Rabinovich-Einy, *supra* note 1.

95 *See* Delese Wear & Brian Castellani, *The Development of Professionalism: Curriculum Matters*, 75 ACAD. MED. 602, 602 (2000) (stating that "[f]or 50 years the professionalism literature has sounded uncannily the same: medical education places too great an emphasis on the biological/technical aspects of medicine at the expense of the psychological.").

96 *See* Louise G. Trubek, *New Governance and Soft Law in Health Care Reform*, 3 IND. HEALTH L. REV. 137, 157–58 (2006).

97 See generally Mazor et al., *supra* note 77; Virshup et al., *supra* note 77; Levinson et al., *supra* note 77; Duclos et al*., supra* note 77; Liebman & Hyman, *supra* note 48; When Things Go Wrong, *supra* note 79.

Despite the rise in emphasis on need for communication skills, whatever their source, communication problems between doctors and patients still persist,[98] albeit with some variations in areas of medical expertise[99] and institutional alignment.[100] Perhaps more significantly, even where communication skills have been viewed as important, a hierarchy of sorts between clinical medical skills, on the one hand, and personal communication skills on the other has persevered. Doctors still view communication skills as distinct from their professional clinical skills and knowledge and, consequently, as being subordinate to, and of lesser significance than medical-professional expertise and knowledge.[101]

But the distinction and hierarchy between communication skills and clinical knowledge mirrors the division between non-litigable and malpractice disputes. As we have seen, these distinctions are not as sharp as they often seem and, in fact, oftentimes these seemingly distinct categories actually overlap in important ways. It would therefore seem that a change in the professional medical ethos, situating communication skills alongside other clinical skills and substantive knowledge, could prove an important step in raising awareness among healthcare professionals to the ties that exist between communication skills and malpractice, serving not only to improve the quality of medical services delivered but also to reduce the occurrence of non-litigable disputes.

CONCLUSION

Over thirty years have passed since Mnookin & Kornhauser published their seminal article coining the term "the shadow of the law."[102] A decade later, Brett, Ury & Goldberg published their pioneering book on dispute system design.[103] While the 1990s and

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98 *See* Rabinovich-Einy, *supra* note 1.

99 *See* Mohammadreza Hojat et al., *Physician Empathy: Definition, Components, Measurement, and Relationship to Gender and Specialty*, 159 AM. J. PSYCHIATRY 1563, 1566 (2002) (finding significant differences in empathy scores among physicians in different specialties). Even though the article deals specifically with empathy, the definition of core features of empathy relates to communication and interpersonal skills and is therefore applicable in our context.

100 *See* Jonathan R. Cohen, *Apology and Organizations: Exploring an Example from Medical Practice*, 27 FORDHAM URB. L.J. 1447, 1468–70 (2000).

101 *See* Wear & Castellani, *supra* note 95, at 602, 604; M. Robin DiMatteo, *The Physician-Patient Relationship: Effects on the Quality of Healthcare*, 37 CLINICAL OBSTETRICS & GYNECOLOGY 149, 149 (1994).

102 Mnookin & Korhauser, *supra* note 15.

103 URY ET AL., *supra* note 21.

the first decade of the twenty-first century have generated a plethora of articles demonstrating the ways in which the law and its shadow have shaped ADR processes, the impact of the shadow of the law on DSD has remained uncharted territory. In an attempt to begin filling that void, this paper has suggested that the shadow of the law has played an active role in the design of dispute resolution systems in healthcare, being a force that limits the scope of disputes handled through IDR systems at hospitals. While ADR holds promise for addressing a broad range of disputes regardless of whether they constitute a legal cause of action or not, it seems that the "shadow of the law" has overemphasized the importance of the consideration of diverting disputes from the court system in the design of conflict management systems. A more nuanced approach could open the field to new types of disputes and new opportunities for learning from complaints and problems that arise in closed settings.

While it may very well make sense to limit the scope of disputes handled under IDR systems in certain contexts, the medical arena highlights the problematic effects such decisions can have. The focus on malpractice disputes in DSD has come at the expense of other, more common small-scale non-litigable disputes. This, in turn, has come at a cost to the ability to learn from past mistakes and to reduce the number of errors and the rate of conflicts and lawsuits. Most importantly, it has hindered the goal of advancing professionals' skills and the ultimate goal of delivering high quality medical services. The lesson for the field of dispute system design is the need for awareness of the reach of the shadow of the law, in particular the need to transcend legal categories, and take advantage of the more comprehensive classification schemes that are available outside the legal arena, which, in turn, could generate deeper, more meaningful learning in organizational settings.