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Contextualizing ADR in Managed Care: A Proposal Aimed at Easing Tensions and Resolving Conflict

*Kathy L. Cerminara**

I. INTRODUCTION

Health care is dominated by conflicts and tensions. Conflicts arise between health care providers and health care payors, patients and health care providers, and patients and health care payors.¹ Tensions mount as health insurance premiums rise despite efforts to contain costs. Suspicions linger that cost concerns negatively affect the quality of care patients receive. Health care effectively is managed care, and allocation tensions, expressed and unexpressed, general and particularized, characterize the system.

From the patient's point of view, the tensions permeating the health care industry must be disconcerting. Health care is, after all, supposed to cure, not create, problems. Patients seek help from the medical profession and the health care system in times of weakness, times when comfort and care are needed. Most patients seeking comfort and care,

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1. All of these relationships, like all relationships, involve conflict, producing tensions and possibly disputes. This Article will focus on conflict, disputes and tensions that arise between patients and any of three possible adversaries: individuals providing care, institutions providing care, or entities financing care.

however, step into a bureaucratic, time-crunched setting in which even health care providers who want to serve as empathetic caregivers encounter barriers to doing so. The resulting conflicts and tensions serve as antitheses to what patients require in times of medical need.

The health care industry, because of these conflicts, does not meet most patients' initial expectations. Moreover, when patients attempt to voice their displeasure with the status quo tensions increase, multiplying levels of frustration for most involved. The uninsured seek access to medical care, inviting obvious resource allocation tensions between supply and demand. The insured similarly experience conflict and tension; when insured Americans complain about their care or their coverage, some find the legally available responses to their complaints inadequate because of tensions between state and federal regulation.²

Managed care has transformed the provision of health care in America in ways many patients still do not understand or accept. It has increased tensions by making the rationing of care more explicit than it had been previously. It may magnify conflict by imparting a businesslike, "cost matters" image to a setting patients previously considered professional and somehow special. It has added layers of approvals and paperwork to transactions and decisions previously only communicated between patient and physician. The result is a system through which patients must muddle as best they can.

Troubleshooting the American health care industry involves consideration of all these conflicts and tensions. Many of these tensions emerged or at least became magnified over the past few decades, as health care payors began to manage care on a large scale. At about that same time, patients also began to realize the inadequacy of available legal remedies in certain cases. Suggestions for empowering patients³

2. Obvious examples arise in the struggles to determine whether state medical malpractice law or federal employee benefits law governs disputes over care provided pursuant to employer-sponsored health insurance. *See, e.g.*, *Shea v. Esensten*, 208 F.3d 712 (8th Cir. 2000); *Shea v. Esensten*, 107 F.3d 625 (8th Cir. 1997).

3. Throughout my work, I have spoken of my overall goal as examining various ways through which to empower patients in the health care system. *See, e.g.*, Kathy L. Cerminara, *The Class Action Suit as a Method of Patient Empowerment in the Managed Care Setting*, 24 AM. J.L. & MED. 7 (1998). Empowerment can, of course, have various meanings. In one sense, a patient is empowered when he or she wins substantively on an issue about which he or she had fought with a health care provider or payor. In another sense, however, a patient is empowered when, regardless of whether he or she wins substantively, he or she is able to voice concerns and present his or her side of a story. *Cf.* E. ALLAN LIND & TOM R. TYLER, *THE SOCIAL PSYCHOLOGY OF PROCEDURAL JUSTICE* 3 (1988) (describing similar distinctions in various definitions of the term "justice").

It may not always be possible, or right, for patients to prevail substantively. Thus, my focus in attempting to empower patients is to ensure that they are able to voice their concerns and present

have ranged from encouraging impact litigation in the form of class action lawsuits⁴ to calling for legislation that would help ameliorate the power imbalance between patients and other actors in the industry.⁵ Other legislators, academics and consumer advocates have promoted alternative dispute resolution as efficient, effective and empowering.

However, troubleshooting in such a case-by-case fashion may not be the optimal focus of efforts to ease tensions and deal with conflict in the managed care system. Tensions and conflicts will always exist, especially in a system of limited resources. Rather than approaching each source of tension or flashpoint of dispute as trouble, and seeking to eliminate it, this Article suggests that corporate officers in the health care industry implement a more broad-based approach to working through tensions and conflicts with patients.⁶ A multi-faceted approach to conflict management, rather than piecemeal efforts at dispute resolution, could assist in easing tensions and conflicts.⁷ By facilitating information flow to patients, this conflict management approach could help ease tensions arising from the bureaucratic process accompanying utilization review efforts and medical necessity documentation.⁸ By imparting to patients a sense of procedural justice, this approach could also help patients for whom coverage of care is denied accept that “[they] can’t always get what [they] want.”⁹

In elaborating on this proposal, this Article will further examine various forms of alternative dispute resolution (ADR) that have been used in a multitude of health care settings.¹⁰ Thereafter, it will review some of the reasons cookie-cutter incorporation of such ADR measures will not prove optimal in attempts to improve the health care system.¹¹ Rather, with such efforts, well-meaning regulators and health care corporations merely erect barriers to resolution of the conflicts and

their stories—that they play roles rather than being spectators—in the changing health care system.

4. Cerminara, *supra* note 3, at 7-9.

5. See Karen A. Jordan, *Coverage Decisions in ERISA Plans: Assessing the Federal Legislative Solution*, 65 MO. L. REV. 405, 464-72 (2000); see also Kathy L. Cerminara, *Protecting Participants in and Beneficiaries of ERISA-Governed Managed Health Care Plans*, 29 U. MEM. L. REV. 317 (1999) (discussing legislation mandating disclosure of information about health plan terms).

6. See *infra* Part IV.

7. See *infra* Part IV.A.

8. See *infra* Part IV.A.

9. THE ROLLING STONES, *You Can't Always Get What You Want*, *on* LET IT BLEED (PGA/AbKco 1970).

10. See *infra* Part II.

11. See *infra* Part III.

tensions permeating health care.¹² The fourth section of this Article will set forth broad outlines of a conflict management proposal and will explain why corporate entities controlling health care would benefit from addressing, in a contextualized manner, all types of conflict, not simply disputes.¹³

In sum, this Article attempts to broaden the conversation about the resolution of health care disputes with a modest proposal. That proposal, simply put, is that health care executives should attempt to resolve the tensions patients experience and the sources of patient conflict at various points along the health care decision making process rather than simply at flashpoints of dispute. Doing so will better satisfy patients' needs for a sense of procedural justice, thus benefiting health care entities in a variety of ways.

II. ADR HAS BEEN PROPOSED, USED, PRAISED AND CRITICIZED IN MANY HEALTH CARE SETTINGS

Partially in recognition of conflicts and tensions in the industry, it has become popular to propose alternative methods of resolving patients' disputes with health care entities. In 1998, for example, a Commission on Health Care Dispute Resolution, a joint effort of the American Arbitration Association, the American Bar Association and the American Medical Association, recommended that ADR can and should be used to resolve health care coverage and access disputes.¹⁴ Indeed, some governmental agencies, private health care payors and health care providers have incorporated various forms of ADR into the procedures available to (and often required of) patients voicing complaints.¹⁵ Some procedures are internal, contained within the corporate structure of a

12. *See infra* Part III.

13. *See infra* Part IV.

14. Robert E. Meade, *Health Care Due Process, in* INSURANCE COVERAGE LITIGATION: RECOVERING IN THE 1990'S AND BEYOND 1999, at 551, 597-98 (PLI Litig. & Admin. Practice Course, Handbook Series No. HO-002W, 1999).

15. In many dispute resolution systems, "complaints" differ from "grievances," with the former signifying more serious disputes and the latter signifying relatively insignificant matters. Carole Roan Gresenz et al., *A Flood of Litigation?*, RAND (1999), available at <http://www.rand.org/publications/IP/IP184/>. Throughout this Article, the term "complaints" is meant to be all-inclusive, covering the broad expanse of matters about which patients might voice displeasure. This Article will use the word "complaint" to encompass both expressions of disputes and of feelings of conflict, while it will use the word "dispute" to mean a tangible and unresolved expression of unresolved conflict centered around one or more issues and positions. CATHY A. COSTANTINO & CHRISTINA SICKLES MERCHANT, *DESIGNING CONFLICT MANAGEMENT SYSTEMS: A GUIDE TO CREATING PRODUCTIVE AND HEALTH ORGANIZATIONS 5* (1996). As will be seen in Part IV, the very range of subjects of complaints requires some recognition in the dispute resolution process.

health care entity,¹⁶ while others exist entirely outside the corporate methods of dispute resolution.¹⁷

Generally, ADR resolves disputes without resorting to the courtroom.¹⁸ However, various forms exist, some involving the courts and some taking place entirely outside of the court setting.¹⁹ Some forms of ADR focus on parties' interests, and some focus on parties' rights.²⁰ Some invite into the process others who are not party to the dispute but who have expert knowledge in the subject matter of the dispute. Generally, it is possible to separate ADR methods into three

16. Before pursuing disputes in court, patients often are required to comply with internal review procedures. "Internal complaint or review procedures" means the levels of complaint-filing and internal reconsideration that usually take place in any corporate setting when an individual is dissatisfied with a product or service. When a person seeks payment on an insurance claim and is denied, for example, he or she usually can and must request reconsideration of the denial within the insurance company's corporate structure before proceeding to complain about the denial outside of the corporate structure. See, e.g., NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS HEALTH CARRIER EXTERNAL REVIEW MODEL ACT § 7(B) (2000) (on file with author). Internal procedures can be quite useful in resolving disputes "[i]f both parties trust the integrity and judgment of these decision makers." CHRISTOPHER W. MOORE, *THE MEDIATION PROCESS: PRACTICAL STRATEGIES FOR RESOLVING CONFLICT* 9 (2d ed. 1996).

17. See, e.g., Managed Health Care Consumer Assistance Program, 2001 N.J. Sess. Law. Serv. 14 (West); see also *infra* Part II.D (discussing Florida's managed care ombudsman program).

18. ADR emerged as a viable force in the American legal system beginning "in the late 1960s as a populist attempt to return the dispute resolution process to disputants." Deborah R. Hensler, *Science in the Court: Is There a Role for Alternative Dispute Resolution?*, 54 *LAW & CONTEMP. PROBS.*, Summer 1991, at 178; see generally Carrie Menkel-Meadow, *What Will We Do When Adjudication Ends? A Brief Intellectual History of ADR*, 44 *UCLA L. REV.* 1613 (1997) (describing the seminal Pound Conference in 1976). It can take place in any of several settings, from one that is private and contractually agreed-upon (such as commercial or securities arbitration), to one resembling an administrative proceeding (such as labor arbitration), to one subsumed within the judicial system. In the 1980s and 1990s, the idea of the multi-door courthouse, providing access to the courts through judicially annexed ADR procedures as well as directly through the usual judicial process, began increasingly to take hold. See Robert A. Baruch Bush, *Alternative Futures: Imagining How ADR May Affect the Court System in Coming Decades*, 15 *REV. LITIG.* 455 (1996); see also Larry Ray & Anne L. Clare, *The Multi-Door Courthouse Idea: Building the Courthouse of the Future . . . Today*, 1 *OHIO ST. J. ON DISP. RESOL.* 7 (1985). History suggests, however, that ADR in general and the idea of the multi-door courthouse in particular has deeper roots. See Valerie A. Sanchez, *Towards a History of ADR: The Dispute Processing Continuum in Anglo-Saxon England and Today*, 11 *OHIO ST. J. ON DISP. RESOL.* 1 (1996) (discussing multiple dispute processing methods used in Anglo-Saxon England in the seventh through eleventh centuries).

19. Arbitration, for example, can be court-ordered or contractually required. See Deborah R. Hensler, *ADR Research at the Crossroads*, 2000 *J. DISP. RESOL.* 71, 72.

20. COSTANTINO & MERCHANT, *supra* note 15, at 45. Costantino and Merchant include, additionally, power-based methods of ADR such as violence, war and strikes in their description of ADR methods. *Id.* This Article will not consider such ADR methods because patients generally do not have great sources of power in the health care system.

categories: adjudicatory, consensual and advisory. Overlapping methods fall into a fourth, crossover, category. Each type of ADR has been used in the health care setting and will be examined in this Article, with a focus on factual scenarios that involve patients and patients' concerns.²¹

A. Adjudicatory ADR Methods: Arbitration and External Review

The type of ADR that springs to mind for the casual reader is likely arbitration. Arbitration closely resembles the trial process and for this reason it is termed an adjudicatory method of ADR.²² It often takes place, however, wholly or mostly outside of the judicial setting, in an agreed-upon setting or in a setting chosen by the arbitrator or one of the parties.²³ It involves one or more arbitrators,²⁴ who serve the same functions that judges serve in hearings. Each party to the dispute presents evidence, although the rules of evidence most often do not apply, and the arbitrator reaches (or the arbitrators reach) a decision that may or may not bind the parties, depending on whether a right to appeal has been preserved by virtue of law or agreement.²⁵

Examples of arbitration in the health care setting are numerous and range from the medical malpractice setting²⁶ to the patient-health care payor dispute context. One well-known example of a mandatory arbitration system that exists to resolve disputes with health plan members is the Kaiser Foundation Health Plan, Inc. ("Kaiser"). Kaiser, a large, not-for-profit health maintenance organization based in

21. Other possible sources of conflict and tension, resulting in disputes, in health care are the relationships between physicians and hospitals or other health care entities and employers and employees. As noted previously, this Article will focus on disputes between patients and others in the industry.

22. MOORE, *supra* note 16, at 9 (noting that, in arbitration, "an impartial and neutral third party" decides contested issues for disputants); *see also* Jack M. Sabatino, *ADR as "Litigation Lite": Procedural and Evidentiary Norms Embedded Within Alternative Dispute Resolution*, 47 EMORY L.J. 1289, 1296 (1998) (calling arbitration an "adjudicative process").

23. SUSAN M. LEESON & BRYAN M. JOHNSTON, *ENDING IT: DISPUTE RESOLUTION IN AMERICA* 50-55 (1988) (noting that one question for parties to decide is where an arbitration will be held and stating that disputing parties often give the arbitrator authority to decide).

24. MOORE, *supra* note 16, at 9.

25. *Id.* at 52.

26. Pre-lawsuit screening requirements in medical malpractice litigation may resemble arbitration, or an adjudicatory method of ADR. *See* Thomas B. Metzloff, *The Unrealized Potential of Malpractice Arbitration*, 31 WAKE FOREST L. REV. 203, 216-17 (1996). Alternatively, they may constitute mandated mediation. *See* FLA. STAT. ANN. § 75-9 (West 2001), *discussed in* Woods v. Holy Cross Hosp., 591 F.2d 1164 (11th Cir. 1979). They even may occupy their own category of ADR. *See* John F. Bales, *Medical Malpractice Developments*, at 563 (PLI Comm. Law Practice Course, Handbook Series No. A4-4455, 1994) (categorizing pre-suit requirements separately).

California,²⁷ has arbitrated disputes with its members since 1971.²⁸ In 1997, the California Supreme Court ruled that Kaiser's arbitration system was seriously flawed and refused to compel arbitration in a case alleging medical malpractice by Kaiser's doctors.²⁹ Thereafter, Kaiser employed an attorney to establish an Office of the Independent Administrator (OIA) and create a new arbitration system in an attempt to correct the problems the court noted.³⁰

The original Kaiser arbitration system was designed, written, mandated and administered by Kaiser itself, although members and subscribers were not aware of this.³¹ The contractual provision describing the arbitration program to Kaiser members and subscribers set forth a schedule for the designation and appointment of three arbitrators and required the panel of arbitrators to "hold a hearing within a reasonable time thereafter."³² In spite of this provision, delays occurred in ninety-nine percent of all Kaiser medical malpractice arbitrations.³³ On average, it took 863 days for a hearing to be held in a Kaiser arbitration.³⁴

Under the current Kaiser arbitration system administered by the OIA, much has changed. First, the OIA independently operates the arbitration system.³⁵ Thus, Kaiser no longer occupies the dual roles of party and administrator in the adversarial, adjudicatory proceedings. Second, the revised Kaiser arbitration system has improved the speed of the process.³⁶ Parties may choose whether to proceed before a panel of three arbitrators or a single arbitrator.³⁷ Whereas it previously took an average of 863 days for a hearing to begin, it now takes an average of 213 days until the end of a hearing³⁸ from the time the arbitration

27. Kaiser's involvement in managed care dates back to the 1930s and 1940s, when industrialist Henry Kaiser established prepaid medical plans for his employees in California and the Pacific Northwest. WILLIAM M. MERCER, INC., INTEGRATED HEALTH PLANS: MANAGED CARE IN THE 90S, at 3 (1990).

28. Office of the Independent Administrator, *First Annual Report*, i, at <http://www.slhartmann.com.oia/index.htm> (last modified Sept. 10, 2001) [hereinafter OIA Report].

29. *Engalla v. Permanente Med. Group, Inc.*, 938 P.2d 903, 908 (Cal. 1997).

30. OIA Report, *supra* note 28, at 1-2.

31. *Engalla*, 938 P.2d at 909.

32. *Id.* at 909 n.3.

33. *Id.* at 912.

34. *Id.* at 913.

35. OIA Report, *supra* note 28, at 1-2, app. at 79.

36. *Id.* at 5.

37. *Id.*

38. *Id.* at i, 20-21.

process begins.³⁹ Even though most of the cases arbitrated are medical malpractice claims,⁴⁰ the system also provides for arbitration of benefits determinations in the same manner.

Other managed care organizations and insurers similarly incorporate arbitration systems into their benefits determinations decision making processes. In Florida, the Department of Insurance and the Agency for Health Care Administration (AHCA) each have representatives on a Statewide Provider and Subscriber Assistance panel, which handles appeals on both quality of care and coverage disputes with managed care plans.⁴¹ This statewide review panel functions as an arbitration panel in the sense that it hears and makes decisions on appeals from the decisions made in the plans' internal review processes.⁴² Its decisions, however, take the form of recommendations to the agency with appropriate jurisdiction,⁴³ which is the insurance department over payment issues and AHCA over quality of care issues. In the vast majority of cases in which the agency concurs with the panel's decision and issues a regulatory order to the managed care organization, the managed care organizations comply with such orders.⁴⁴

The latter example, the statewide review panel, illustrates the blurring of the line between an arbitration system and an independent external review of care or coverage decisions. There exists a trend toward providing for independent external review of health care claims at patients' requests when care or coverage is denied, generally following an internal appeals process.⁴⁵ Such external review seems to be an example of arbitration in the health care setting, although not explicitly identified as such. Federal legislators have proposed external review of denials of claims for health care benefits based on conclusions that the items or services in question were not medically necessary, were

39. *Id.*

40. *Id.* at ii. More than ninety-four percent are medical malpractice claims and less than one percent are benefits or coverage claims. *Id.*

41. FLA. STAT. ANN. §§ 408.7056(2), 408.7056(11) (West Supp. 2001); see Wes Allison, *Florida's HMO Appeals Board is Rarely Used*, ST. PETERSBURG TIMES, Mar. 23, 2001, at 1A, available at http://www.sptimes.com/News/032301/State/Florida_S_HMO_appeals.shtml (discussing the efficacy, or lack thereof, of Florida's Statewide Provider and Subscriber Assistance Panel); see also FLA. SENATE COMM. ON HEALTH, AGING AND LONG-TERM CARE, INTERIM PROJECT REPORT 2002-138 (Sept. 2001) (describing program and making recommendations) [hereinafter FLA. SENATE COMM. REPORT].

42. FLA. STAT. ANN. § 408.7056(3).

43. *Id.* § 408.7056(7).

44. See FLA. SENATE COMM. REPORT, *supra* note 41.

45. MOORE, *supra* note 16 (discussing internal review procedures).

investigational or were experimental.⁴⁶ The same proposed legislation would make available external review of denials of claims for benefits when the denials involve medical judgment.⁴⁷ In Texas, a patient disagreeing with certain decisions of a health insurer, a health maintenance organization or another managed care entity must submit his or her claim to review by an independent review organization if the entity against whom the claim is made requests such a review.⁴⁸ In Arizona, health care insurers are required to provide external independent reviews of utilization review decisions regarding coverage or medical necessity under the coverage document.⁴⁹

Some insurers and managed care organizations voluntarily provide external review. For example, in Massachusetts, both Blue Cross/Blue Shield and Tufts Health Plan have offered it.⁵⁰ The Medicare system similarly provides external review opportunities to patients seeking to dispute determinations made by the agency.⁵¹ Beginning in 1989, the Health Care Financing Administration (HCFA) (now the Center for Medicare and Medicaid Services) required the Center for Health Care Dispute Resolution to review all cases in which the manager of care does not rule fully in favor of the enrollee.⁵²

Most such independent external reviews are actually forms of arbitration because they result in adjudicatory-type, evidence-based

46. Bipartisan Consensus Managed Care Improvement Act of 1999, H.R. 2990, 106th Cong. § 1103(a)(2) (1999). The American Association of Preferred Provider Organizations (AAPPO) has approved external review guidelines for preferred provider organizations (PPOs) permitting enrollees to request external review in the same circumstances. See AAPPO, *AAPPO Guidelines for Independent Review*, available at <http://www.aappo.org/guidelines.htm> (last modified July 17, 2001). The National Committee for Quality Assurance (NCQA) has delayed until July 2002 instituting an external appeals requirement as part of its accreditation process. See *Independent Appeals Requirement Delayed by NCQA Until July 2002*, 9 Health L. Rep. (BNA) No. 22, at 840 (June 1, 2000).

47. H.R. 2990.

48. TEX. CIV. PRAC. & REM. CODE ANN. § 88.003 (Vernon Supp. 2001); see *infra* Part III.B.2 (providing further discussion on the Texas statute).

49. ARIZ. REV. STAT. §§ 20-2533, 20-2537 (2000) (permitting patients to initiate external independent review when coverage is denied).

50. Liz Kowalczyk, *HMOs Doubt Patients Need Outside Review of Decisions*, BOSTON GLOBE, Apr. 22, 2000, at C1, available at 2000 WL 3323457 (discussing low numbers of patients taking advantage of voluntarily offered external review options).

51. Ann H. Nevers, *Consumer Managed Care Appeals: Are the Available Procedural Protections Fundamentally Fair?*, 33 J. HEALTH L. 287, 323 (2000).

52. *Id.*; see also Roderick B. Mathews, *The Role of ADR in Managed Health Care Disputes*, DISP. RESOL. J., Aug. 1999, at 9, 10 (discussing the Center for Health Care and Dispute Resolution and how it provides independent and external review of appeals for Medicare enrollees).

proceedings before panels or individuals⁵³ who will make determinations regarding the matters at hand.⁵⁴ In most instances, the reviewers are persons seen as having expertise in the medical matter at issue.⁵⁵ In some instances, the degree of reviewer independence may be debatable.⁵⁶ The effects of such independent external review vary; in some instances the decision is binding on both the health care entity and the patient.⁵⁷

B. Consensual ADR Methods: Mediation

Mediation has been employed in the health care arena for years, both as a recognized form of ADR and as a problem-solving technique used on an ad hoc basis.⁵⁸ Far from adjudicatory, mediation is completely consensual, constituting assisted negotiation⁵⁹ and resulting in definitive

53. In New York, for example, panels conduct external review of questions of experimental or investigational treatment while individuals review questions of medical necessity. N.Y. INS. LAW § 4914 (McKinney 2000).

54. The Center for Health Dispute Resolution (CHDR), however, reportedly uses both mediation and arbitration in resolving the Medicare disputes referred to it. *See Nevers, supra* note 51, at 323; *see also Gresenz et al., supra* note 15, at 10 (noting that some external reviews are advisory in nature). This Article focuses on adjudicatory, rather than advisory and consensual forms of external review.

55. In Arizona, for example, independent reviewers of claims of “medical necessity under the coverage documents” must be physicians or other health care professionals. ARIZ. REV. STAT. ANN. §§ 20-2537(D), 20-2538(B) (West Supp. 2000); *see also* COLO. REV. STAT. ANN. § 10-16-113.5(2)(c)(II) (West 2000) (describing professional requirements for independent expert physician reviewers of health care coverage denials).

56. In Iowa, for example, the insurance commissioner creates a list of independent review entities (which employ individual independent reviewers) by soliciting entity names from potential corporate players in the external review process. *See* IOWA CODE ANN. § 514J.6 (West Supp. 2001). Once a patient requests external review, the corporate health care entity initially chooses an independent review entity for each dispute. *Id.* § 514J.7(1)(a). The independent review entity cannot be corporately related to the health care entity. *Id.* Moreover, the patient may object to the health care entity’s choice. *Id.* § 514J.7(1)(b). Nevertheless, there could arise situations under this process in which the independent reviewer was not truly independent.

57. *E.g.*, N.Y. INS. LAW §§ 4914(b)(4)(A)(iv), (B)(iv) (McKinney 2000). In Illinois, in contrast, the statute states that HMOs must submit to an independent physician review when disagreeing with the patient’s primary care physician on a medical necessity determination. 215 ILL. COMP. STAT. ANN. 125/4-10 (West 2000). If the independent physician reviewers say that the procedure or treatment in question is medically necessary, then the HMO must cover it. *Id.* Presumably, the patient can continue to dispute an adverse determination. *See also* OHIO REV. CODE ANN. §§ 3923.67, 3923.68 (West Supp. 2001) (discussing external review procedure where insured is denied medical coverage or where terminal illness or experimental treatments are involved).

58. It similarly has been used formally and informally for centuries in various types of disputes. *See* MOORE, *supra* note 16, at 20-22.

59. *Id.* at 8 (describing mediation as “an extension or elaboration of the negotiation process that involves the intervention of an acceptable third party who has limited or no authoritative decision making power”); *see also id.* at 15. The presence and involvement of a third party

resolution of a dispute only if the parties agree. While mediation primarily addresses substantive issues of dispute between parties, it also has the potential to smooth out various aspects of the parties' relationships with one another. For example, it may help "establish or strengthen relationships of trust and respect,"⁶⁰ or it may assist parties in terminating a relationship in a way that "minimizes costs and psychological harm."⁶¹ Mediation has been used in a variety of health care settings, from allegations of low-quality care and bioethical decision making to insurance coverage denial conflicts.⁶²

In Massachusetts, for example, the Board of Registration in Medicine (the "Board"), in conjunction with the Program for Health Care Negotiation and Conflict Resolution, has conducted a pilot project called the Voluntary Mediation Program.⁶³ Through this program, the Board, which is responsible for licensing and regulating physicians in Massachusetts, can refer patient complaints about physicians to mediation.⁶⁴ These referrals, however, are subject to the consent of both the complainant and the physician.⁶⁵ The parties meet in person with one or two mediators to exchange explanations of their positions and to work out a mutually satisfactory resolution.⁶⁶ Of the ten complaints mediated between 1993 and 1996, nine were successfully resolved, only four with monetary transfers.⁶⁷

Legal associations also have participated in health care mediation efforts. The American Health Lawyers Association (AHLA), and its predecessor organization the National Health Lawyers Association, began an ADR service in 1992. AHLA offers mediation training to members and other attorneys and reports that the program has grown

"outsider" is critical. *See id.* at 15-16 (describing mediation as "essentially dialogue or negotiation with the involvement of a third party").

60. *Id.* at 15.

61. *Id.*

62. *See generally id.* at 31-32 (providing a general discussion of medical-malpractice-related mediation efforts and listing other areas where mediation is applied).

63. Edward A. Dauer & Leonard J. Marcus, *Adapting Mediation to Link Resolution of Medical Malpractice Disputes with Health Care Quality Improvement*, LAW & CONTEMP. PROBS., Winter 1997, at 185, 205.

64. *Id.*

65. *Id.* at 206.

66. *Id.*

67. *Id.* at 207-11; *see also* Edward A. Dauer et al., *Transformative Power: Medical Malpractice Mediations May Help Improve Patient Safety*, DISP. RESOL. MAG., Spring 1999, at 9-11 (also discussing the Massachusetts program as offering encouraging insights into the potential of medical malpractice mediation).

steadily since its inception.⁶⁸ Similarly, the American Bar Association Commission on Legal Problems of the Elderly has worked from a model provided by the National Institute for Dispute Resolution to mediate nursing home care disputes.⁶⁹

Bioethical disputes also provide fertile ground for mediation.⁷⁰ A great deal of work in this area has been done at Montefiore Medical Center in New York. There, physicians and other caregivers found themselves confronting patients and patients' family members who had to make difficult decisions in situations ranging from end-of-life care to organ donation. As a result, the medical center created the Bioethics Consultation Service (BCS) to mediate bioethical conflicts⁷¹ among patients, patients' family members, and medical professionals.⁷² Members of the service, a nurse-attorney, an attorney and a philosopher, all of whom have been trained in dispute resolution and mediation, discuss cases with patients (if possible), their families, medical staff, and others involved in the patients' care or the decision making process.⁷³ The members of the service then act as neutral third parties⁷⁴ in assessing the facts of the dispute, identifying the parties' positions and the relevant ethical principles, and assisting the decision maker in making the required decision.⁷⁵

The use of mediation in bioethical disputes has been debated. At least one author, Professor Diane E. Hoffmann, has suggested that mediation should be treated with caution in the end-of-life treatment

68. Peter M. Leibold, Executive Notes, *Alternative Dispute Resolution: A Significant Contribution to the Public Interest*, HEALTH L. NEWS, Sept. 2000, at 4.

69. See RESOLUTION OF CONSUMER DISPUTES IN MANAGED CARE: INSIGHTS FROM AN INTERDISCIPLINARY ROUNDTABLE 111 (Naomi Karp & Erica Wood eds., American Bar Association, 1997) [hereinafter RESOLUTION OF CONSUMER].

70. See Chad Bowman, *Disputes Over End-of-Life Care Treated Increasingly With Mediation*, 9 Health L. Rep. (BNA) 1527 (Oct. 5, 2000) (describing the American Medical Association's recommendation of the use of mediation to resolve disputes over end-of-life care).

71. Some might see such situations as presenting "bioethical dilemmas." In reality, according to Nancy Dubler, most bioethical dilemmas are more properly characterized as garden-variety conflicts that arose because of differing perceptions, understandings, interpretations and value systems. Nancy Neveloff Dubler, *Heroic Care Cases: When Difficult Decisions About Care Are Near, Mediation Can Help Bridge Communications Gap*, DISP. RESOL. MAG., Spring 1999, at 7.

72. *Id.* at 7-8.

73. *Id.* at 7.

74. While employees of the medical center may find their neutrality challenged because they work for the institution in which the patient is being treated, the medical center uses them because of their knowledge of medical matters and access to information available only to employees. See NANCY NEVELOFF DUBLER & LEONARD J. MARCUS, *MEDIATING BIOETHICAL DISPUTES* 51-52 (United Hospital Fund of New York 1994).

75. *Id.* at 34.

setting.⁷⁶ Most, however, suggest that the use of mediation in the end-of-life setting can help preserve the physician-patient relationship to a greater extent than the usual ethics committee model, resembling adjudication.⁷⁷ Certainly it offers an opportunity to those involved to work out sensitive end-of-life issues with compassion.

*C. Advisory ADR Methods: Early Neutral Evaluation,
Summary Jury Trial*

A few advisory forms of alternative dispute resolution exist, and while they likely have been used in health care matters, there seems to be no documented evidence of such use. The advisory forms of ADR consist of an early neutral evaluation system and the summary jury trial.⁷⁸ In early neutral evaluation, an expert or a judge in the subject under discussion hears the positions of both sides, early in a dispute (preferably before discovery has commenced).⁷⁹ Thereafter, that evaluator will advise the parties of what he or she believes the appropriate resolution of the matter to be.⁸⁰ In a litigation setting, a former judge might, for example, advise the parties how he or she believes a jury would rule based on what he or she has heard. The parties may then use this knowledge to resolve their dispute short of trial.⁸¹

Similarly, a summary jury trial can be used to predict the likely outcome of a dispute in court.⁸² In a summary jury trial, both sides present a summary of the evidence they would present in an actual trial

76. Diane E. Hoffmann, *Mediating Life and Death Decisions*, 36 ARIZ. L. REV. 821, 826 (1994). Professor Hoffmann expresses concern, in part, that mediation based on consensus may avoid "application of societal standards in reaching an agreement." *Id.* at 877. She favors using mediation to resolve end-of-life disputes as long as mediation is appropriate for the disputes being mediated, but merely urges caution in the decision to employ mediation. *Id.*

77. Robert Gatter, *Unnecessary Adversaries at the End of Life: Mediating End-of-Life Treatment Disputes to Prevent Erosion of Physician-Patient Relationships*, 79 B.U. L. REV. 1091 (1999).

78. See generally Hensler, *supra* note 18, at 180-81 (briefly summarizing the advisory ADR processes).

79. Sabatino, *supra* note 22, at 1298.

80. *Id.*

81. *Id.* (describing early neutral evaluation as a "variant on evaluative mediation" and noting that its use early in the litigation process when cases have been filed is to "set a benchmark for the parties to discuss settlement before the case advances too far into discovery").

82. *Id.* at 1298-99; see also Shirley A. Wiegand, *A New Light Bulb or the Work of the Devil? A Current Assessment of Summary Jury Trials*, 69 OR. L. REV. 87 (1990) (stating that "the purpose of a summary jury trial is to provide the parties with a realistic assessment of their chances at trial without the time and expense of a full-blown trial").

to an actual jury.⁸³ The jury deliberates, and then returns an advisory verdict. As with the results of the early neutral evaluation, the parties then can use the advisory verdict to facilitate the resolution of their dispute without actually proceeding to trial.⁸⁴

These two methods of ADR seem to be primarily utilized in situations where the parties have already begun to litigate their disputes and seek to avoid undergoing the time and expense of a trial.⁸⁵ Thus, it is easy to imagine health-care-related cases in which judges suggested one or both of these ADR options to parties before them, the parties then participated in the process, and the cases settled without a record because there was no trial and therefore no written opinion issued.⁸⁶

D. Cross-Category ADR Methods: Arb-Med, Med-Arb and Ombudsman Programs

Finally, ADR methods exist that are explicitly and unabashedly a combination of more than one of the previously described methods.⁸⁷ Mediation-arbitration (“med-arb”) and arbitration-mediation (“arb-med”) comprise combinations of the adjudicatory and consensual ADR processes. An even more interesting and varied conglomeration of ADR methods appears in ombudsman programs.⁸⁸

83. Lucille M. Ponte, *Putting Mandatory Summary Jury Trial Back on the Docket: Recommendations on the Exercise of Judicial Authority*, 63 *FORDHAM L. REV.* 1069, 1070 (1995).

84. Thomas D. Lambros, *The Judge's Role in Fostering Voluntary Settlements*, 29 *VILL. L. REV.* 1363, 1373 (1983–84); see also Ann E. Woodley, *Strengthening the Summary Jury Trial: A Proposal to Increase Its Effectiveness and Encourage Uniformity in Its Use*, 12 *OHIO ST. J. ON DISP. RESOL.* 541, 547–48 (1997), discussed in Thomas D. Lambros, *The Summary Jury Trial—Ending the Guessing Game: An Objective Means of Case Evaluation, A Comment on Professor Woodley's Proposal*, 12 *OHIO ST. J. ON DISP. RESOL.* 621 (1997).

85. See, e.g., Sabatino, *supra* note 22, at 1298–99 (describing both methods as taking place after cases have been filed).

86. Determining, by examination of court files, whether such health-care-related cases exist and how successfully they were resolved after either early neutral evaluation or a summary jury trial would be a fascinating research project, but is beyond the scope of this Article.

87. One may suspect that many of the others remain less than pure also. For example, it is probably the case that an ombudsman often mediates between the party seeking advice and the party against whom a complaint has been lodged. Similarly, it is likely that arbitrators, like many judges, sometimes slip into a mediation role if they attempt to settle matters before them.

88. Use of the term “ombudsman” in this Article is not intended to denote male identity. While one occasionally sees the term “ombudsperson” used, e.g., *COSTANTINO & MERCHANT*, *supra* note 15, at 205, professional organizations in the field use the original term “ombudsman” as taken from the Swedish, *justitieombudsman*. See Larry B. Hill, *American Ombudsmen & Others; or, American Ombudsmen and 'Wannabe' Ombudsmen* (Apr. 18, 1997), available at <http://www.abanet.org/adminlaw/ombuds/wannabe.html>. For familiarity and ease of reference, I similarly will use the term “ombudsman” rather than “ombudsperson” in this Article. See also *Real People Real Problems: An Evaluation of the Long-Term Care Ombudsman Programs of the*

In mediation-arbitration, a neutral party begins working with the parties to assist the parties in negotiating a solution. At some point, however, the mediator takes on an arbitrator's function instead of the neutral function he or she had at the beginning.⁸⁹ Thereafter, the mediator-arbitrator has the power to enter a binding decision for one side or the other.⁹⁰

At a hospital in Detroit, for example, members of a Comprehensive Support Care Team ("Team") have met with patients and their families to attempt to informally and consensually work out conflicts.⁹¹ Under that system, if disputes cannot be worked out informally in a mediation setting, matters go to the hospital ethics committee, which has the power to recommend a particular outcome based on its view of the way a court would rule on the dispute.⁹² A member of the Team also co-chairs the ethics committee.⁹³

In contrast, in arbitration-mediation, an arbitrator begins a hearing by receiving evidence and acting as the decision maker. At some point, however, the arbitrator steps out of the decision maker role and attempts to mediate an agreement between the two parties.⁹⁴ The cross-category methods of med-arb and arb-med have been subject to much criticism for their merging of what many view as incompatible roles. When a neutral party begins to mediate a dispute, some wonder if the parties will feel free to confide in the mediator or disclose weaknesses if there is the risk that the mediator at some point will switch hats and become a decision maker. Similarly, but perhaps with less vehemence, concerns in arb-med have been expressed about an arbitrator's ability to break out of the decision making role and become a neutral mediator of

Older Americans Act (A Summary) n.1, available at <http://www.nap.edu/readingroom/books/rprp/summary.html> (last modified Dec. 26, 2000) (noting that "the term 'ombudsman' carries no meaning with respect to the gender of the occupant of the position").

89. Sabatino, *supra* note 22, at 1299.

90. *See id.*; *see also* Barry C. Bartel, Comment, *Med-Arb as a Distinct Method of Dispute Resolution: History, Analysis and Potential*, 27 WILLAMETTE L. REV. 661 (1991) (analyzing the advantages and disadvantages of the med-arb process of resolving disputes).

91. Karen A. Butler, *Harvesters: Alternatives to Judicial Intervention in Medical Treatment Decisions*, 1996 J. DISP. RESOL. 191, 209.

92. *Id.*

93. *Id.* The New York State Task Force on Life and the Law proposed a similar med-arb role for ethics committees, except that it proposed that the committees' decisions be binding on the parties in certain circumstances. *Id.* A court could, of course, review the committees' decisions. *Id.* at 210.

94. Alan Bloom et al., *Alternative Dispute Resolution in Health Care*, 16 WHITTIER L. REV. 61, 65 (1995).

negotiations between the parties.⁹⁵ The latter seems to be less likely to engender role confusion, although there may exist a tendency on the part of the decision maker to retain substantive opinions about each party's likelihood of success when moving into the presumptively neutral setting. Concerns to this effect about either med-arb or arb-med could conceivably be cured by providing for a change of personnel at the switch over point of the process.⁹⁶

Ombudsman programs exemplify another form of ADR that does not fit neatly into any one category. Ombudsmen, or committees serving the functions of ombudsmen, exist to assist dissatisfied parties with negotiating the applicable grievance system or understanding the policies or procedures governing the decision making in question.⁹⁷ Under some definitions, ombudsmen exist to advise those who are complaining, rather than to work within a structured setting to achieve some resolution.⁹⁸ In others, they also are intended to help pursue the resolution of matters brought before them.⁹⁹

Two different types of ombudsmen exist. First, some companies or institutions employ ombudsmen to work with internal complaints. This type of ombudsman, the organizational ombudsman, is also known as a private-sector, or a corporate, ombudsman.¹⁰⁰ "An organizational ombuds[man] is a confidential and informal information resource, communications channel, complaint-handler and dispute-resolver, and a person who helps an organization work for change."¹⁰¹ While

95. See Thomas J. Brewer & Lawrence R. Mills, *Combining Mediation & Arbitration*, DISP. RESOL. J., Nov. 1999, at 32-33 (stating that med-arb proceedings may pose "important ethical issues" when mediation and arbitration are conducted simultaneously by the same person); see also Elizabeth A. Hunt, *Arb-Med: ADR in the New Millennium*, 42 ORANGE COUNTY LAW. 29 (2000) (discussing that a mediator may have difficulty with neutrality once a decision has been made, but ultimately, the parties make their own agreement in the mediation phase).

96. Of course, in that event, some of the cost-saving benefit of ADR is lost.

97. Cf. *Real People Real Problems*, *supra* note 88, at 1-2 (describing the range of ombudsman programs for long-term care facilities in various states).

98. RESOLUTION OF CONSUMER, *supra* note 69, at 105.

99. The Ombudsman Committees of the Administrative Law and Dispute Resolution Sections of the American Bar Association have proposed, for example, a definition of the term which would include among the ombudsman's duties "tak[ing] appropriate action to aid in the resolution of the specific issue or a broader, underlying problem." *Ombudsmen Define Themselves*, 1999 ABA ADMIN. & REG. L. NEWS, available at WL, 24-SUM ADMRLN 17.

100. See The Ombudsman Association History, at http://www.ombuds-toa.org/toa_history.html (2000).

101. Mary Rowe & Dean M. Gottehrer, *Similarities and Differences Between Public and Private Sector Ombudsmen*, at <http://www.abanet.org/adminlaw/ombuds/g&rsimilar.html> (last modified Nov. 10, 2000) (remarks of Mary Rowe).

employees of corporate or public organizations,¹⁰² they usually report at or near the top of the organizational flowchart, outside ordinary management reporting channels, to best retain their independence.¹⁰³ “Their purpose is to foster values and decent behavior—fairness, equity, justice, equality of opportunity, and respect,” with an emphasis on ensuring respect for those with less power.¹⁰⁴ They keep inquiries strictly confidential, and they typically do not investigate formally or make management decisions; instead, they offer and explain options to people who approach them with problems.¹⁰⁵ They may, and often do, work for system changes in the organization.¹⁰⁶

The second type of ombudsman, the public sector ombudsman, is more public-service-oriented. These classical ombudsmen independently review governmental actions by “receiving and investigating complaints about the administrative acts of agencies.”¹⁰⁷ These ombudsmen are concerned with ensuring that governmental entities have followed the law.¹⁰⁸ Rather than generating options for a complainant, or assisting in resolution, they typically have little power over agency action.¹⁰⁹ However, they do have the power to investigate and make recommendations.¹¹⁰

In the spirit of public sector ombudsman programs, some governmental entities have created hybrid forms of ombudsman offices in the health care area. One example is the creation of state long-term-care ombudsman programs in accordance with the Older Americans Act.¹¹¹ As a result of this Act, ombudsman programs have been established in each state, the District of Columbia and Puerto Rico;

102. Many corporate organizations have ombudsmen. *See, e.g.*, The Ombudsman Association History, *supra* note 100 (listing ombudsmen from various corporations). Managed care plans and hospitals appear increasingly to be using ombudsman services. *See* Eleanor D. Kinney, *Tapping and Resolving Consumer Concerns About Health Care*, 26 AM. J.L. & MED. 335, 354-55 (2000); *see generally Exploring Alternatives*, available at <http://www4.od.nih.gov/ccr> (last modified Aug. 21, 2001) (providing an example of an organizational ombudsman office established in a public agency, this website gives an overview of the National Institutes of Health Office of the Ombudsman, The Center for Cooperative Resolution, and explains the role of this office).

103. Rowe & Gottehrer, *supra* note 101 (remarks of Mary Rowe).

104. *Id.* (remarks of Mary Rowe).

105. *Id.* (remarks of Mary Rowe).

106. *Id.* (remarks of Mary Rowe).

107. *Id.* (remarks of Dean M. Gottehrer).

108. *Id.* (remarks of Dean M. Gottehrer).

109. *See* Hill, *supra* note 88.

110. Rowe & Gottehrer, *supra* note 101 (remarks of Dean M. Gottehrer). Public sector ombudsmen often also can issue public reports. *See* United States Ombudsman Association, *About USOA*, at <http://www.usombudsman.org/aboutUSOA/association.htm> (Jan. 2, 2001).

111. Older Americans Act of 1965, 42 U.S.C. §§ 3001–3023 (1994 & West Supp. 2001).

these programs were designed to provide patient advocacy and to represent the interests of residents of long-term-care facilities.¹¹² Some states also implemented ombudsman programs for Medicaid managed care enrollees.¹¹³ In Connecticut and New Jersey, the state legislatures created offices of managed care ombudsmen to advise patients of their rights and guide them through the appeals process regarding coverage questions.¹¹⁴

Similarly, in 1996 the Florida Legislature created both district and statewide managed care ombudsman committees within the Agency for Health Care Administration (AHCA).¹¹⁵ Each district committee is intended to comprise between nine and sixteen members who volunteer to assist AHCA in protecting enrollees in managed care programs by receiving and assisting with the resolution of complaints regarding quality of care.¹¹⁶ As part of an entity engaged in protecting enrollees, they arguably have an advocacy function. However, the committees do not possess any authority other than to assist AHCA, which means they primarily assist patients who call with complaints to negotiate existing grievance processes and understand the provisions of their health care coverage documents.¹¹⁷

III. ADR PROPOSALS ARE NOT THE OPTIMAL SOLUTIONS TO MANAGED-CARE-RELATED HEALTH CARE CONCERNS

The various ADR proposals that have been made and implemented thus far address the question of health care conflict resolution in an ad hoc, piecemeal way. Some malpractice suits must go to arbitration. Some coverage and care decisions are submitted to external review.

112. See *Real People Real Problems*, *supra* note 88.

113. See Jane Perkins et. al., *Executive Summary, Ombudsprograms and Members Advocates: Consumer-Oriented Approaches to Problem Solving in Medicaid Managed Care*, at <http://nhelp.org/pubs/mc1998ombudxsum.html> (Sept. 29, 1998) (discussing member advocates).

114. Garrett Condon, *Patients' Advocate a First in State*, HARTFORD COURANT, Aug. 8, 2000, at A1, available at 2000 WL 23014159 (discussing Connecticut); Lindy Washburn, *New Law Creates a Health Advocate; Plan Offers Way to Contest HMOs*, RECORD, N. NEW JERSEY, Feb. 3, 2001, at A1, available at 2001 WL 5236706 (discussing New Jersey).

115. FLA. STAT. ANN. §§ 641.60, 641.65 (West 1997 & 2001).

116. FLA. STAT. ANN. § 641.65(6). The majority of the district-level committees were never actually staffed. Melissa Harris, *Law to Oversee HMOs Falls Flat: Florida's 5-Year-Old 'Ombudsman' Plan Lacks Cash, Volunteers*, ORLANDO SENTINEL, Aug. 29, 2001, at A1, available at 2001 WL 9205684.

117. This conclusion is based upon my own work as a member of the District 11 Managed Care Ombudsman Committee, which serves Miami-Dade and Monroe Counties in Florida. See generally FLA. SENATE COMM. ON HEALTH, AGING AND LONG-TERM CARE, INTERIM PROJECT REPORT 2002-137, at 3 (Sept. 2001) (describing charge of district-level managed care ombudsman committees).

Some disputes are mediated. Some patients' health-care-related complaints receive more textured treatment, for example through ombudsman programs. But there is little or no consistency and perhaps even less predictability in the system. A patient moving from one health care plan to another, or attempting to express more than one type of complaint often faces entirely different procedures from setting to setting or complaint to complaint.¹¹⁸ The patient receives little or no assistance in negotiating the maze.

Perhaps such variability is inevitable while patients obtain health care coverage from a variety of sources. But more important than the confusion caused by this variability are concerns about the root cause of the calls for ADR processes. Even if one assumes that many methods of ADR are less expensive and time-consuming than litigating disputes,¹¹⁹ and that most of them permit patients more process control than does litigation,¹²⁰ incorporation of ADR procedures as accomplished thus far likely will not strike at the root of patients' conflicts and disputes in health care.¹²¹

In one sense, for example, health care and governmental entities actually erect barriers to the effective conflict resolution by engaging in adjudicatory ADR procedures. By mandating adjudicatory procedures such as arbitration, health care entities infringe upon patients' abilities to participate freely in conflict and dispute resolution. Similarly, governmental entities' mandates of external review of certain health care decisions, although often a result of patient consumer advocacy,¹²²

118. See Kinney, *supra* note 102, at 380 (describing current systems as "uncoordinated, inaccessible, inequitable and non-inclusive").

119. Empirical figures on expense do not definitively indicate that ADR is less expensive than litigation. See, e.g., Jack B. Weinstein, *Some Benefits and Risks of Privatization of Justice Through ADR*, 11 OHIO ST. J. ON DISP. RESOL. 241, 276 (1996). As Engalla proves, whether ADR participants experience less delay before resolution is governed by the efficiency and functioning of the ADR system in question. See *supra* text accompanying notes 27-40 (describing the history of the Kaiser arbitration system).

120. See LIND & TYLER, *supra* note 3, at 99; Tom R. Tyler, *The Psychological Consequences of Judicial Procedures: Implications for Civil Commitment Hearings*, 46 SMU L. REV. 433, 483 (1992) (discussing the importance of process control on participants' feelings about the procedures in which they engage).

121. Eleanor D. Kinney provides a similar conclusion, with a slightly different focus. See Kinney, *supra* note 102, at 383 (outlining six principles to be honored in attempting to "tap and resolve" consumer health care concerns).

122. See also Tracy E. Miller, *Center Stage on the Patient Protection Agenda: Grievance and Appeal Rights*, 26 J. L. MED. & ETHICS 89 (1998) (discussing external review and the grievance process); cf. Louise G. Trubek, *Informing, Claiming, Contracting: Enforcement in the Managed Care Era*, 8 ANNALS HEALTH L. 133, 133 (1999) (describing internal grievance and external review systems as some of the patient and consumer protections intended "to correct the

have magnified deep-rooted conflicts about the scope and focus of health care. Patients seeking to access external review systems to resolve disputes find that their attempts at ADR create numerous conflicts and sub-disputes before resolving anything.

Piecemeal incorporation of adjudicatory ADR procedures thus creates and fosters further conflict, rather than easing conflict and tensions in the health care setting. When ADR procedures are incorporated in this manner, their focus appears to be more related to current beliefs about efficiency (and to current fad) than to concerns about easing conflict in the health care setting. Such a focus is not optimal, will not satisfy many patients' desires for procedural justice, and will do nothing more than increase layers of bureaucracy and confusion for patients.

A. *Free Participation Concerns*

As noted previously, health care entities such as Kaiser¹²³ sometimes mandate that their patients use arbitration in challenging health plan decisions pertaining to coverage or care. Such corporate mandates raise concerns about enforceability that can create and exacerbate, rather than ease, tensions and conflict.

It is instructive in this regard to examine the employment arena, where employers have similarly mandated arbitration of employee disputes.¹²⁴ Mandating arbitration has not proven to be the magic bullet reducing litigation of employment disputes.¹²⁵ Moreover, mandating arbitration pre-dispute¹²⁶ likely will raise concerns about enforceability

imbalance that occurs when the incentives for cost containment in managed care organizations . . . negatively impact patients' health care quality and access").

123. See *supra* notes 27-40 and accompanying text (describing the history of the Kaiser arbitration system).

124. It is instructive to look at employment disputes because of the agency concerns that arise in both the health care and employment contexts. Of course, employer-employee disputes arise internally within an organization, whereas health care entity-patient disputes are external to the organization. See Aimee Gourlay & Jenelle Soderquist, *Mediation in Employment Cases is Too Little Too Late: An Organizational Conflict Management Perspective on Resolving Disputes*, 21 *HAMLIN L. REV.* 261, 268 (1998) (distinguishing between internal and external conflict management). Nevertheless, the parallels between unionized employee arbitration and arbitration of patient disputes in health care are striking and deserve exploration despite the external-internal distinction.

125. *Id.* at 263-64.

126. The considerations differ for post-dispute agreements to arbitrate a particular dispute only. See Colin P. Johnson, Comment, *Has Arbitration Become a Wolf in Sheep's Clothing? A Comment Exploring the Incompatibility Between Pre-Dispute Mandatory Binding Arbitration Agreements in Employment Contracts and Statutorily Created Rights*, 23 *HAMLIN L. REV.* 511 (2000).

of the mandates, inviting more, rather than less, conflict over vital issues such as private enforcement of publicly guaranteed rights and assurance of knowing waivers of rights.

1. The Validity of Pre-Dispute Arbitration Agreements

Most Americans obtain their health care coverage either directly through their employers or as beneficiaries of someone obtaining coverage through his or her employer.¹²⁷ In practical terms, this means that in any individual case an employer decides to provide, or at least to partially provide, health care coverage for its employees. The employer purchasing insurance may negotiate with a number of potential covering entities in order to choose one or more coverage schemes. Each of these coverage schemes may require different payments from the employer and its employees, and each likely provides different benefits in exchange for those payments. The insuring employer signs a contract with each covering entity outlining the terms pursuant to which its employees will receive coverage. That insurance contract is negotiated based on a group rate and covers all members of the employer's group (or employees), much as a labor union might negotiate a collective bargaining agreement with an employer and thus agree to its terms on behalf of the members of the bargaining unit.¹²⁸

Some employers do not purchase health insurance but instead self-insure. A self-insured employer draws up a plan describing the medical care it intends to cover for its employees, and then usually hires an insurance company or other entity to administer that contract.¹²⁹

Whether an employer purchases insurance or self-insures, all employees typically receive promotional material and perhaps a summary plan description¹³⁰ when deciding which form of health care coverage they would like to receive as an employee benefit, assuming

127. See Clark Havighurst, *The Backlash Against Managed Health Care: Hard Politics Made Bad Policy*, 34 IND. L. REV. 395, 400 (2001) (noting that "one reason consumers feel disempowered in today's health care market is that most receive health benefits through their employer rather than by purchasing the plan themselves").

128. See generally PHILLIP JACOBS, *ECONOMICS OF HEALTH AND MEDICAL CARE* 24 (4th ed. 1997) (providing a pictorial representation of, and a description of, the employer-provided health care system); see also *id.* at 32 (providing another pictorial representation).

129. A self-insured plan (also termed a self-funded plan) provides benefits without purchasing insurance to cover the costs of those benefits. See *FMC Corp. v. Holliday*, 498 U.S. 52, 54 (1990) (discussing a self-funded plan in the preemption context).

130. ERISA plan administrators must prepare a summary plan description (SPD) describing the terms of the plan for distribution to plan participants and beneficiaries. See 29 U.S.C. §§ 1021-1022 (1994 & West. Supp. 2001) (imposing duty and describing SPD, respectively).

they have a choice.¹³¹ Employees rarely, if ever, receive copies of the actual insurance contracts.

A coverage contract may contain an arbitration provision, which binds a patient wishing to dispute a health plan decision or action to arbitrate that dispute rather than, or at least prior to, instigating legal action.¹³² The provision could require patients to arbitrate all claims, both of coverage and of care, or it could require them to arbitrate only precisely delineated, contract-based disputes. It could also require arbitration of claims of any variation between these extremes.

Depending on the contractual language, patients could be required to arbitrate statutory disputes¹³³ or contractual disputes.¹³⁴ Mandated arbitration of statutory disputes, however, should not be enforceable based upon precedent in the employment law arena.

In the employment law arena, the Supreme Court has enthusiastically endorsed arbitration as a method of dispute resolution, citing efficiency, speed, confidentiality, and public policy as codified in the Federal Arbitration Act.¹³⁵ The Supreme Court has gone so far as to uphold

131. Recent studies indicate that about sixty-four percent of families who are offered employer-sponsored insurance have a choice of plans. Only about fifty percent of employees who are offered such insurance have a choice of plans through their employer, but the percentage of families with a choice rises when the choices of each spouse in a two-income family are taken into account. Less than fifty percent of families can choose between a health maintenance organization (HMO) and plans with fewer restrictions. Sally Trude, *Issue Brief No. 27—Who Has a Choice of Health Plans?*, at <http://www.hschange.org/CONTENT/55> (last visited Oct. 29, 2001).

132. Such agreements usually require arbitration rather than going to court. See generally Elizabeth Rolph et al., *Arbitration Agreements in Health Care: Myths and Reality*, LAW & CONTEMP. PROBS., Winter 1997, at 153.

133. A statutory claim could arise, for example, through breach of a statutorily imposed standard of care, see for example, FLA. STAT. ANN. § 766.102 (West 1997 & Supp. 2001), or a statutorily imposed fiduciary duty, see for example, 29 U.S.C. § 1109 (1994 & West Supp. 2001).

134. A contract dispute may arise when a patient questions whether a treatment was medically necessary as defined in the contract. With respect to quality of care issues, an interesting question arises when the standard of care is set forth in statute, as it is in Florida. See *supra* note 133 (setting forth the standard of care, considering all relevant circumstances, as “acceptance and appropriate by reasonably prudent similar health care providers”). Specifically, there could arise a dispute over whether the patient’s claim was statutory or contractual in a situation in which the parties provided by contract for a specified standard of care. Cf. *Dukes v. United Healthcare*, 57 F.3d 350, 359 & n.5 (3d Cir. 1995) (noting that nothing in its decision applied to cases in which a plan specifies by contract an applicable standard of care outside of the statute).

135. Federal Arbitration Act, 9 U.S.C. §§ 1–307 (1994 & West Supp. 2001); see also Administrative Dispute Resolution Act of 1996, 5 U.S.C. §§ 571–595 (1994 & West Supp. 2001) (encouraging the use of ADR within federal agencies); see generally *Gilmer v. Interstate/Johnson Lane Corp.*, 500 U.S. 20 (1991) (holding that a claim under the ADRA can be subjected to compulsory arbitration pursuant to an arbitration agreement in a securities registration application).

contractual arbitration provisions requiring the pursuit of statutory claims, as opposed to claims arising out of the terms of the contract itself, through arbitration rather than the courts.¹³⁶ In only one category of cases has the Court refused to require arbitration of statutory claims: cases involving collective bargaining agreement provisions purporting to relegate union members' statutory rights to the arbitration process rather than to the court system for resolution.¹³⁷

Indeed, in the collective bargaining setting, the Court has been reluctant to permit labor unions to waive the jury trial rights of their members, bound by a union-negotiated collective bargaining contract, regarding statutory claims. Claims stemming from the contract, such as claims that the employer did not provide a promised number of vacation days, or claims that an employer discharged an employee in violation of the contract, can go to arbitration if the union so agrees because the union has the authority to speak regarding these matters.¹³⁸ However, statutory rights that employees possess independent of their contractual rights, such as the right to be free from discrimination, are in a separate category and cannot be negotiated away by another.¹³⁹

In the labor negotiation setting, the union's position nearly amounts to a conflict of interest when the question of arbitration of statutory rights arises. In the bargaining process, the union might be willing to trade off certain rights for other contractual benefits when an employee

136. *Gilmer*, 500 U.S. at 35; *see also* *Rodriguez de Quijas v. Shearson/Am. Express, Inc.*, 490 U.S. 477 (1989) (compelling arbitration of a securities claim); *Shearson/Am. Express, Inc. v. McMahon*, 482 U.S. 220 (1987) (compelling arbitration of securities claims and claims under the Racketeer Influenced and Corrupt Organizations Act (RICO)); *Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc.*, 473 U.S. 614 (1985) (compelling arbitration of antitrust claims). In these cases, collectively known as the Mitsubishi trilogy, the Court established a presumption under the FAA that statutory claims are arbitrable and required the parties opposing arbitration to prove that Congress specifically intended that a claim not be arbitrable to succeed in that opposition. Richard A. Bales, *Compulsory Employment Arbitration and the EEOC*, 27 PEPP. L. REV. 1, 14 (1999).

137. *See, e.g.*, *Alexander v. Gardner-Denver Co.*, 415 U.S. 36 (1974); *see also* *Barrentine v. Ark.-Best Freight Sys.*, 450 U.S. 728 (1981) (construing the Fair Labor Standards Act and emphasizing *Alexander's* concern with the nature of collective bargaining agreements). The combination of *Gilmer* and a more recent case, *Wright v. Universal Maritime Service Corp.*, at the very least casts doubt on *Alexander's* continuing validity. *Wright v. Universal Mar. Serv. Corp.*, 525 U.S. 70 (1998). In *Wright*, the Court refused to determine whether *Gilmer* had overruled *Alexander* and instead discussed the clarity required to render valid contractual arbitration provisions. *Id.* at 77. This Article will presume that *Alexander* continues to be good law, as, indeed, it has not been overruled. *Wright* did not expressly overrule it, and the Court in *Gilmer* took pains to expressly distinguish it rather than overrule it. *Gilmer*, 500 U.S. at 35.

138. *See Wright*, 525 U.S. at 78-79.

139. *Alexander*, 415 U.S. at 51-52.

might not be so willing.¹⁴⁰ The Court stated that when Congress endows individual employees with statutory rights, the right to a jury trial regarding those rights cannot be prospectively waived in the “majoritarian process” of collective bargaining.¹⁴¹

The manner in which most Americans receive their health care coverage mandates the same protections for recipients of health care coverage as union members receive in the area of dispute arbitration. Like union employees, insured Americans receiving health care coverage through the workplace do not negotiate their own contracts. Instead, an agent, their employer, negotiates a group contract for them, in the same way a union negotiates a collective bargaining agreement for employees. Unlike employees bound by collective bargaining agreements that have been approved by the union membership, non-union employees have a choice of whether to accept health care coverage provided through an employer. However, given health care economics, that choice is an illusory one indeed.

Like a union in the context of negotiating a collective bargaining agreement, an employer is susceptible to certain conflicts of interest when negotiating a health care coverage contract for its employees.¹⁴² For example, the employer may be either more or less willing to trade off price for quality than its employees. The employer may see the waiver of a right to a judicial forum for various claims as an acceptable tradeoff for a reduction in price or compliance with an extra quality indicator. With regard to claims arising out of the coverage contract, one might argue that the employer has the authority to agree to such a tradeoff. However, the employer, like the union, should not be empowered to negotiate away the employees’ right to quality care, or to statutory protections such as freedom from breach of fiduciary duty.

In sum, employees who receive health care coverage pursuant to insurance contracts negotiated by their employers occupy a position analogous to workers whose workplace conditions and rights are governed by a collective bargaining contract negotiated by a union. An employer, under reasoning analogous to the Supreme Court’s labor arbitration authority, could bind employees/insureds to arbitrate

140. *Gilmer*, 500 U.S. at 35.

141. *Accord Brisentine v. Stone & Webster Eng’g Corp.*, 117 F.3d 519 (11th Cir. 1997); see *Alexander*, 415 U.S. at 51-52 (discussing the statutory right of protection from discrimination).

142. See *Engalla v. Permanente Med. Group, Inc.*, 938 P.2d 903, 919 n.11 (Cal. 1997) (noting an “inverse agency relationship” between employer and employees in the negotiation of a health care plan and indicating that the employee may be able to argue that the agreement entered into was unconscionable if it later turned out that the employer, when negotiating the health plan, was not acting in its employees’ interest but was instead considering its own interest in cost savings).

contractual health care disputes. Such contractual disputes could even include disputes about whether a particular procedure was “medically necessary,” if that term appeared in the contract as describing the types of procedures the insurer would cover. But the employer could not negotiate away rights granted to employees/insureds by virtue of statute. For example, an employer could not negotiate away an employee’s/insured’s right to a trial alleging that the insurer breached a fiduciary duty owed to the patient under ERISA.¹⁴³ Similarly, an employer could not negotiate away an employee’s/insured’s right to a jury trial alleging the provision of health care in violation of state statutes regulating the medical standard of care.

Thus, arguably, arbitration mandates contained within the terms of a health plan are only partially enforceable. On one hand, the Court has most recently endorsed arbitration, causing one to wonder whether its union-related decisions are outdated.¹⁴⁴ On the other hand, time has not diminished the concerns about the majoritarian process of achieving agreements the Court asserted in the labor relations cases.¹⁴⁵ While statutory rights can be prospectively waived,¹⁴⁶ concern for the preservation of individual rights in a majoritarian setting should still remain strong.¹⁴⁷ There is no reason to permit agency waiver of a right to a jury trial on a statutory claim, unless it is merely a change of

143. Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001–1191 (1994 & West Supp. 2001). The patient plaintiffs in one of the consolidated managed care class actions pending in Florida apparently did not argue the union analogy when attempting to avoid mandatory arbitration of their ERISA claims. See *In re Managed Care Litig.*, 2001 WL 66439 at *2 (S.D. Fla. June 12, 2001) (granting motion to compel arbitration of claims asserted by patients of defendant PacifiCare Health Systems, Inc.), amended by 150 F. Supp. 2d 1330 (S.D. Fla. 2001) (denying defendant Humana’s motion to dismiss RICO claims, and dismissing, without prejudice, all of plaintiff’s ERISA claims).

144. See *supra* notes 135–36 and accompanying text (supporting broad application of arbitration). Cf. *Circuit City Stores, Inc. v. Adams*, 121 S. Ct. 1302, 1318 (2001) (Stevens, J., dissenting) (describing the Court’s arbitration cases “in the last several decades” as having “pushed the pendulum far beyond a neutral attitude and endorsed a policy that strongly favors private arbitration”).

145. See *Madden v. Kaiser Found. Hosps.*, 552 P.2d 1178 (Cal. 1976) (en banc) (rejecting the argument that an agency problem invalidates state employee group medical plan’s agreement to arbitrate medical malpractice claims). Other considerations have been held to invalidate mandatory arbitration provisions in certain health care cases arising under California law. See, e.g., *Cruz v. Pacificare Health Sys., Inc.*, 111 Cal. Rptr. 2d 395, 398–99 (Cal. Ct. App. 2001) (holding that health care class action seeking injunctive relief and disgorgement of profits under state consumer protection statutes were not subject to arbitration).

146. *Gilmer v. Interstate/Johnson Lane Corp.*, 500 U.S. 20 (1991); see also *Adams*, 121 S. Ct. at 1312 (stating that while workers in general are covered by the Federal Arbitration Act, Congress can enact more specific legislation for a particular class of workers).

147. See *Alexander v. Gardner-Denver Co.*, 415 U.S. 36, 51–52 (1974).

attitude and public policy toward alternative dispute resolution in general and arbitration in particular.¹⁴⁸

2. The Real Reasons Why Concerns About Validity Matter

Ultimately, of course, this agency concern merely scrapes the tip of an iceberg representing concerns about patients' agreement to arbitration within a health care coverage contract. For any waiver of a right to a jury trial (on a statutory or a contractual claim) to be valid, the waiver must, for example, be clear.¹⁴⁹ Even if clear, if a health care coverage contract containing an arbitration provision is presented to a patient in circumstances tending to suggest the patient had no choice but to sign it, concerns about contracts of adhesion can arise.¹⁵⁰ In certain instances, pre-dispute agreements to arbitrate have been held unconscionable.¹⁵¹

These types of concerns, although not likely to constitute legal reasons to invalidate arbitration mandates,¹⁵² present serious concerns in terms of their effects on patients' feelings of participation in health care conflict and dispute resolution processes. For more than legal reasons, they raise serious questions about procedural justice—that is, about the health care dispute resolution system's ability to make patients feel like actors, rather than the subjects of action. Procedural justice research

148. The Court itself has noted the tension between these two positions, as recently as 1998. See *Wright v. Universal Mar. Serv. Corp.*, 525 U.S. 70 (1998); see also Rosetta E. Ellis, Note, *Mandatory Arbitration Provisions in Collective Bargaining Agreements: The Case Against Barring Statutory Discrimination Claims From Federal Court Jurisdiction*, 86 VA. L. REV. 307, 320-21 (2000) (noting that *Wright* "fail[ed] to address the ambiguity created by *Alexander* and *Gilmer* and . . . deferred authority back to the circuit courts").

149. Drafters of provisions purporting to require arbitration of a statutory claim, in particular, must be "particularly clear" in including the claim among those to be arbitrated. *Wright*, 525 U.S. at 79. The standard is whether the waiver of the right to a judicial forum for statutory claims is "clear and unmistakable." *Id.* at 80 (quoting *Metro. Edison Co. v. NLRB*, 460 U.S. 693, 708 (1983)).

150. See Richard C. Reuben, *Constitutional Gravity: A Unitary Theory of Alternative Dispute Resolution and Public Civil Justice*, 47 UCLA L. REV. 949, 1030-34 (2000) (discussing cases involving arbitration clauses in contracts of adhesion).

151. See *id.*; see also *Engalla v. Permanete Med. Group, Inc.*, 938 P.2d 903, 919 n.11 (Cal. 1997). The court in *In re Managed Care Litigation*, dismissed summarily plaintiffs' unconscionability argument, but only because it viewed the argument as one claiming the arbitration clauses in question were unconscionable per se. *In re Managed Care Litig.*, 135 F. Supp. 2d 1253 (S.D. Fla. 2000). The court still examined each clause to see if it was so unfair or oppressive as to be unenforceable. *Id.* at 1269.

152. In *Gilmer*, for example, the Court took a strong position against invalidation for such reasons. *Gilmer v. Interstate/Johnson Lane Corp.*, 500 U.S. 20 (1991). But see *Circuit City Stores, Inc. v. Adams*, 121 S. Ct. 1302, 1318 (2001) (Stevens, J., dissenting) (contending that the disparity in bargaining power has been a reason to exempt employment contracts from mandatory arbitration).

suggests that patients will feel more trust and confidence in a system in which they can play a role rather than in a system acting upon them.¹⁵³

In this field of research, social psychologists explain that people judge social experiences in a variety of ways. For example, people may react favorably to an experience because the experience turns out well for them.¹⁵⁴ A concrete example in the health care setting may be evident in an insurance coverage dispute. After resolution of such a dispute, a patient may react favorably to the dispute resolution experience if he or she wins and the treatment in question is deemed covered by insurance.

Alternatively, rather than forming judgments based on outcomes, people may form judgments about experiences based upon whether the procedures governing their dispute are just and fair.¹⁵⁵ Thus, procedural justice research examines how people perceive social experiences as compared with existing norms about proper procedures.¹⁵⁶ In the case of the insurance coverage dispute, even a patient who loses, and thus will not enjoy insurance coverage for the disputed treatment, may think positively of the dispute resolution experience if he or she perceived the experience as fair and just.¹⁵⁷

Procedural justice research indicates that “decisions are more likely to be accepted when the procedure used to generate the decision allows participation by those affected.”¹⁵⁸ In general, according actors participation most effectively involves delegating some control over the process to them, such as the presentation of evidence and arguments.¹⁵⁹ This seems to hold true even if the actors in question exercise no control over the decision reached.¹⁶⁰

Much procedural justice research has focused on legal proceedings. Early procedural justice theorists, for example, attempted to determine whether an adversary or an inquisitorial legal system best produced

153. See LIND & TYLER, *supra* note 3, at 94 (stating that more process control on part of litigant results in higher procedural fairness rating).

154. *Id.* at 1 (stating that some people judge their social experiences in terms of the outcomes they receive).

155. *Id.*

156. *Id.* at 3.

157. One should also distinguish between whether dispute resolution procedures actually render decisions or the decisionmaking process more fair or whether the procedures cause those involved to believe decisions or the decisionmaking process is more fair. See *id.* (distinguishing between objective and subjective procedural justice). Like Lind and Tyler in their work, this Article will concentrate on the latter. See *id.* at 4.

158. *Id.* at 8.

159. *Id.* at 9, 35-36 (stating that some people feel the need to retain more control than others).

160. *Id.* at 93, 96-99.

positive feelings of procedural justice among disputants.¹⁶¹ Later researchers investigated the varying effects of dispute resolution methods on participants' feelings about process.¹⁶² In the area of civil commitment, researchers have investigated reactions to the commitment process.¹⁶³ Other studies¹⁶⁴ have focused on individual's feelings about process resulting from encounters with the legal system through law enforcement authorities, irrespective of whether a dispute was involved.

Procedural justice also has emerged as a powerful theory in areas other than the law. Researchers have examined, for example, the procedural justice effects of various methods of issue resolution in the political arena.¹⁶⁵ In the workplace, organizational procedural justice research has suggested that workers' subjective perceptions of the justice with which they are treated impacts their work performance in a variety of ways.¹⁶⁶ There seems to be no reason that procedural justice judgments do not also factor into patients' attitudes toward and

161. J. THIBAUT & L. WALKER, *PROCEDURAL JUSTICE: A PSYCHOLOGICAL ANALYSIS* (1975).

162. LIND & TYLER, *supra* note 3, at 99 (describing studies).

163. Tyler, *supra* note 120, at 434. Civil commitment hearings are proceedings at which professional or judicial decision makers judge a person's mental competence for purposes of determining whether the individual should be committed to a mental health facility. BLACK'S LAW DICTIONARY 266 (7th ed. 1999).

164. See LIND & TYLER, *supra* note 3, at 56-57 (describing the study).

165. *Id.* at 147-63. Lind and Tyler suggest, for example, that the public will accept even difficult budget decisions more readily if those decisions were reached as a result of a process seen as fair. *Id.* at 163. Such a conclusion has interesting implications for the health care plan contracting process between health care organizations and employers seeking to obtain health care coverage for their employees. Perhaps if employees (and, indirectly, their beneficiaries) were more involved in cost/benefit tradeoffs up front, in this contracting process, they would express less dissatisfaction when coverage is later denied. Indeed, this may tend to support levels of satisfaction for cafeteria plans, in which employees are able to make their own tradeoffs as they choose among benefits with a budget.

166. *Id.* at 177-200. The construction of the Panama Canal, of all things, appears to offer an example of this principle in action, decades before procedural justice became a known field. After much managerial upheaval in a difficult project facing seemingly insurmountable odds, President Theodore Roosevelt in 1907 appointed a new chairman and chief engineer, George Goethals, who instituted a new approach. DAVID MCCULLOUGH, *THE PATH BETWEEN THE SEAS: THE CREATION OF THE PANAMA CANAL 1870-1914*, at 508-10 (1977). Among the changes Goethals instituted were increases in the availability of information and "his own court of appeal." *Id.* at 537. Specifically, every Sunday morning he met personally with any worker on whatever that worker perceived to be a serious problem. *Id.* Workers of all types first met with an aide of Goethals' for an initial screening. *Id.* "[O]ften these preliminary interviews were enough to resolve the problem—the mere process of free expression gave the needed relief." *Id.* He personally, however, would meet with any person not satisfied with the results of such an initial meeting. *Id.* at 537-38. Whether or not matters could be resolved to their satisfaction, workers, because they were treated with respect, responded by giving their best, and morale rose. *Id.* at 538.

satisfaction with the health care industry. Given this, any procedure that breeds concern about agency problems, patients' knowledge, adhesion and unconscionability raises concerns that patients will feel negatively in a procedural justice sense.

B. ERISA Preemption Concerns

In some instances, rather than having arbitration forced on patients so as to raise procedural justice concerns, patients and patient consumer advocates have lobbied for ADR mandates in health care. In some states, for example, citizens have lobbied legislatures to require independent external review of patient disputes with managed care organizations.¹⁶⁷ On a federal level, Congress has considered legislative proposals incorporating external review provisions as part of an attempt to interject patient protections into the managed care system.¹⁶⁸ In these instances, rather than feeling directed into arbitration, patients (speaking generally) are forcing health care entities to consult independent physicians when they are unhappy with the decisions of those entities.

Many times patient insistence has produced the desired result. Some governmental agencies require external review of various health care determinations.¹⁶⁹ Some state legislatures have required participation in independent external review or have required that independent external review be made available in claims resolution procedures.¹⁷⁰ In the federal government, legislators are contemplating mandated independent external review.¹⁷¹ Even without additional legislation, regulators on the federal level have issued at least one proposal for mandating external review in health care disputes.¹⁷²

167. See generally Trubek, *supra* note 122.

168. See generally Phyllis C. Borzi & Sara Rosenbaum, *Pending Patient Protection Legislation: A Comparative Analysis of Key Provisions of the House and Senate Versions of H.R. 2990, ALI-ABA CONTINUING LEGAL EDUC., ERISA FIDUCIARY RESPONSIBILITY ISSUES UPDATE: QUALIFIED PENSION AND 401(K) PLANS, ESOPS, AND MANAGED CARE PLANS*, June 15, 2000, at 1 n.1 (detailing and comparing various pieces of proposed patient protection legislation).

169. See Nevers, *supra* note 51, at 311.

170. Thirty-eight states plus the District of Columbia have instituted some form of external review. *State Legislation: Despite Deadlock in Congress, States Moving Forward on Key Managed Care Issues*, 9 Health L. Rep. (BNA) 1003 (June 29, 2000).

171. See generally Borzi & Rosenbaum, *supra* note 168.

172. The Department of Labor proposed draft regulations to be promulgated at 29 C.F.R. 2560, 63 Fed. Reg. 48390 (Sept. 9, 1998), and issued them on November 20, 2000 to take effect in 2002. *New Rules Issued on Health Appeals*, available at <http://www.nytimes.com/aponline/national/AP-Health-Care-Appeals.html>; see also 6 Health L. Rep. (BNA) 1253 (Oct. 18, 2000); Report of the President's Commission on Consumer Protection and Quality in Health Care

Attempts at mandates, however, do not help patients resolve disputes more expeditiously or with less conflict. Rather, they actually encourage conflict and divisiveness by resulting in disparate treatment of various classes of patients depending on whether they obtain their health care coverage through their employment or elsewhere. Health care plans obtained through employment are governed by the Employee Retirement Income Security Act of 1974 (ERISA).¹⁷³ State government attempts at mandating external review, to the extent they impact ERISA-governed health plans, have met a variety of legal challenges, described below, that result in confusing categorization of both claims and patients.

1. The Basics of ERISA Preemption

Concerns about ERISA preemption loom large any time a state regulates in the field of health care coverage obtained as an employee benefit. To the extent that states pass laws affecting all managed care entities, insurers and health maintenance organizations, inevitably some of the affected entities will be providing, and arranging for coverage of, health care to patients who received their health care coverage through their workplace.¹⁷⁴ Thus, broadly worded statutes that purport to mandate the inclusion of external review provisions in all health plans or insurance contracts impact ERISA-governed health plans. If such statutes "relate to" those affected ERISA plans within the meaning of ERISA's preemption provision,¹⁷⁵ they generally will be invalid.

ERISA preemption on its face does not seem complex. ERISA provides first that it preempts "any and all state laws insofar as they . . . relate to any employee benefit plan."¹⁷⁶ There is one exception: if the state law in question regulates insurance, ERISA will not preempt it.¹⁷⁷ However, some employers who provide health care coverage do not actually purchase that coverage from insurance companies or other coverage providers. Instead, they self-insure, or cover the expenses of medical care themselves. State laws that regulate insurance do not

(supporting independent review in cases involving questions of medical necessity and experimental or investigational treatment).

173. Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001–1461 (1994).

174. The inevitability arises because a majority of Americans today receive their coverage through their own jobs or as beneficiaries of others' employer-sponsored health care plans. See ROBERT L. BENNEFIELD, *THE HAVES AND HAVE NOTS 1* (U.S. Dep't of Commerce 1998) (noting that 70.1% of Americans in 1997 received health care coverage either through their employment (61.4%) or through individual purchase (8.7%)).

175. 29 U.S.C. § 1144 (1994).

176. *Id.* § 1144(a).

177. *Id.* § 1144(b)(2)(A).

regulate self-insured plans; instead, ERISA preempts those laws insofar as they might apply to the self-insured setting.¹⁷⁸

Despite its facial simplicity, attempts to flesh out the particulars of ERISA preemption have resulted in confusion. The Supreme Court initially took an extremely expansive view of the term “relates to,” but fairly recently modified that view, instructing courts to examine both the preemption provision and the objectives of the ERISA statute as a whole when applying the preemption provision in individual cases.¹⁷⁹ Clearly that state regulation with indirect economic effects on the costs of health care plans will not be preempted by ERISA.¹⁸⁰ It is also conversely clear that state regulation attempting to dictate the terms under which a health plan must operate will be preempted.¹⁸¹ The question is where along the intervening continuum a state’s mandate for the inclusion of external review procedures might fall.

2. Conflicting Views of Preemption As Applied to External Review Mandates

However, the question of where state mandate of external review enters the picture is not easily answered. There currently exists a split among the circuits leading the Supreme Court to review the issue. The Fifth Circuit and the Seventh Circuit have taken divergent approaches to a perplexing question that leaves most court-watchers, including many judges, stymied.

In *Corporate Health Insurance, Inc. v. Texas Department of Insurance*,¹⁸² the United States Court of Appeals for the Fifth Circuit considered this specific issue. Texas passed a law providing in part for

178. *Id.* § 1144. Specifically, the law provides that self-insured plans shall not be “deemed” to be insurance companies for purposes of the preemption analysis.

179. *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers*, 514 U.S. 645, 655 (1995).

180. *Id.* at 660. In *Travelers*, the Supreme Court ruled that ERISA did not preempt a New York law that required hospitals to collect surcharges from patients with commercial insurance but not from patients insured by Blue Cross/Blue Shield plans. *Id.* at 649. The law also imposed varying surcharges on HMOs depending on the number of Medicaid recipients they enrolled. *Id.*

181. *E.g.*, *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983) (ruling that ERISA did not preempt a New York disability benefits law to the extent that the law did not cover areas already regulated by ERISA); *see also* *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) (concluding that a Massachusetts insurance law mandating mental health coverage in group insurance contracts was only saved from ERISA preemption by the ERISA savings clause). The *Shaw* Court’s expansive reading of ERISA’s preemption provision has been narrowed somewhat, but nothing suggests that the outcome of *Shaw* would be different under the Court’s current approach to ERISA preemption. *See* Edward A. Zelinsky, *Travelers, Reasoned Textualism, and the New Jurisprudence of ERISA Preemption*, 21 *CARDOZO L. REV.* 807, 808 (2000).

182. *Corp. Health Ins., Inc. v. Tex. Dep’t of Ins.*, 215 F.3d 526 (5th Cir. 2000).

independent review of “adverse determinations” by managed care entities.¹⁸³ The statute also provided for independent review of “claims,” which differed from “adverse determinations.”¹⁸⁴ “Claims,” at least according to the Court of Appeals for the Fifth Circuit, were contentions that the managed care entity violated the applicable standard of care in providing medical care.¹⁸⁵ “Adverse determinations,” however, were decisions that “the health care services furnished or proposed to be furnished to an enrollee [were] not medically necessary or . . . not appropriate.”¹⁸⁶ In other words, according to the court, adverse determinations included determinations by managed care entities as to coverage, rather than actions that represented a physician’s departure from the applicable standard of care under the aegis of the managed care entity.

Using this dichotomy, the court determined that the independent review provision applicable to claims was not preempted by ERISA, but found that the independent review provision applicable to adverse determinations was preempted by ERISA.¹⁸⁷ It did so for two reasons. First, it noted that the provision mandating independent review of “claims” applied only if the managed care entity requested it.¹⁸⁸ As such, the entity could not argue that the state was imposing duties in addition to or at odds with its duties under ERISA with regard to that statutory provision.¹⁸⁹ Nothing was imposed upon the health care entity; matters would end up in independent review only if the entity whose decision was being challenged requested such review.¹⁹⁰ Second, the court ruled that independent review of claims did not impose duties that fell within the purview of ERISA regulation.¹⁹¹ Claims involved determinations of whether physicians had acted properly under the applicable standard of care, a matter traditionally under state regulation.¹⁹² Independent review of adverse determinations, by contrast, did not concern “negligent decisions by a

183. *Id.* at 531, 537.

184. *Id.* at 536.

185. *Id.*

186. TEX. INS. CODE ANN. § 20A.12A(a)(1) (Vernon Supp. 2000-01); *see also Corp. Health Ins., Inc.*, 215 F.3d at 537 (quoting section 20A.12A(a)(1)).

187. *Corp. Health Ins., Inc.*, 215 F.3d at 536-37.

188. *Id.*

189. *Id.*

190. *Id.*

191. *Id.*

192. *Id.*; *see also id.* at 534-35 (pointing out that managed care providers operate in a traditional sphere of state authority).

physician.”¹⁹³ Such independent review instead “allow[ed] a patient who has been denied coverage to appeal to an outside organization.”¹⁹⁴ Requiring the addition of a procedure through which a patient may appeal a denial of coverage requires revision of the administrative scheme governing benefits, and is within ERISA’s purview.

Although the court believed that the Texas law regulated insurance and thus could be “saved” under ERISA’s preemption savings clause, it ruled that the law directly conflicted with ERISA’s enforcement scheme by providing an alternative way for a patient to obtain coverage or benefits.¹⁹⁵ Due to this direct conflict, the independent review provisions applying to adverse determinations (but not those applying to claims) were preempted by ERISA.

In contrast, in *Moran v. Rush Prudential HMO, Inc.*,¹⁹⁶ the Seventh Circuit Court of Appeals held that ERISA does not preempt an Illinois statute mandating independent physician review of a health maintenance organization’s (HMO’s) medical necessity determinations.¹⁹⁷ Such a statute is saved from preemption because it

193. *Id.* at 537.

194. *Id.*

195. *Id.*

196. *Moran v. Rush Prudential HMO, Inc.*, 230 F.3d 959 (7th Cir. 2000), *cert. granted*, *Rush Prudential HMO, Inc. v. Moran*, 121 S. Ct. 2589 (2001) (No. 00-1021).

197. In *Moran*, a patient suffered from nerve compression and wanted to undergo microneurolysis surgery performed by a surgeon who was not a member of her health maintenance organization’s (HMO’s) network. *Moran*, 230 F.3d at 963. Although her primary care physician requested approval of the surgery, her HMO refused to authorize it, causing the patient to undergo the surgery and pay for it herself; the surgery and post-operative care cost nearly \$95,000. *Id.* at 964. Before finally refusing authorization, the HMO had considered the opinions of two thoracic surgeons affiliated with it who examined the patient and agreed with the out-of-network surgeon’s diagnosis but recommended another, less extensive, standard, surgical procedure. *Id.* at 963. The HMO informed the patient it would have paid for that procedure. *Id.* at 964.

After undergoing the surgery, the patient submitted a copy of her bill and treatment and documentation to her HMO and asked for coverage. *Id.* The HMO consulted with three additional doctors, two of whom were skeptical of the need for the microneurolysis surgery and one of whom opined definitively that it was unnecessary. *Id.*

Even before undergoing the surgery the patient had made a written demand that the HMO comply with Illinois law and submit to independent physician review for the dispute between her primary care physician and the HMO about the medical necessity of the surgery. *Id.*; see 215 ILL. COMP. STAT. ANN. 125/4-10 (West 2000). The HMO initially refused to do so, but eventually complied with a state court ruling requiring it to do so. *Moran*, 230 F.3d at 964-65. The independent physician concluded that microneurolysis surgery was medically necessary but said that he would have used a different technique in performing it. *Id.* at 965.

After all of these reviews and opinions, the HMO again concluded that the surgery had not been medically necessary and denied coverage. *Id.*

The patient took the HMO to court to enforce another portion of Illinois’ independent review statute, which requires HMOs to cover treatment if the independent physician who had reviewed

regulates insurance, under the court's view of HMOs as members of the insurance industry.¹⁹⁸ The Illinois statute, by operation of law, adds a mandatory term (an independent review requirement) to every insurance contract between HMOs and Illinois subscribers.¹⁹⁹ Thus, rather than substituting the medical judgment of a third party physician for that of the HMO, constituting an alternative method by which to seek benefits under the terms of a plan, the statute merely added to each HMO contract an internal mechanism for making medical necessity determinations.²⁰⁰ A patient eventually might have to rely upon ERISA to enforce the terms of the contract, but the HMO would have to undergo the state's statutorily mandated procedure as part of the state-law-imposed terms of its insurance contract.²⁰¹

3. The Real Reasons Why ERISA Preemption Concerns Matter

ERISA preemption concerns, and the legal confusion resulting from conflicting decisions such as *Corporate Health Insurance* and *Moran*, symbolize the complexity of the barriers to conflict resolution in the health care system. The average patient likely does not think about ERISA preemption when thinking about health care. The average patient likely does not know, or care, about ERISA at all. Yet when that patient attempts to resolve a health care dispute, ERISA preemption concerns almost inevitably increase the layers of issues to be resolved.

Take, for example, the issue that lies at the root of ERISA preemption analysis: whether a patient engaged in a dispute with a managed care organization is seeking coverage (payment of a benefit) or care (treatment).²⁰² A patient asking her managed care organization for preauthorization of a hospital admission, that her physician says is medically necessary, believes she is asking for the authorization of

the request for coverage had opined that the treatment was medically necessary. *Id.*; see 215 ILL. COMP. STAT. ANN. 125/4-10 (West 2000).

198. *Moran*, 230 F.3d at 969.

199. *Id.* at 969-70.

200. *Id.*

201. *Id.* at 970-72.

202. The dichotomy between coverage and care first surfaced in ERISA preemption cases in 1995, with *Dukes v. U.S. Healthcare, Inc.* decided by the United States Court of Appeals for the Third Circuit. *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995). Recently, in *Pegram v. Herdrich*, the United States Supreme Court seemed to acknowledge the same sort of distinction and, indeed, to approve of it, although in a non-preemption context. See *Pegram v. Herdrich*, 530 U.S. 211, 237 (2000); Edward A. Zelinsky, *Pegram and Preemption: Patients' Rights and The Case for Doing Nothing*, TAX NOTES 1053, 1055 (Aug. 21, 2000). But see William M. Sage, *UR Here: The Supreme Court's Guide for Managed Care*, 19 HEALTH AFF., Sept.-Oct. 2000, at 219, 221 (describing "the line between coverage and care" as "continu[ing] to fade after *Pegram*").

medical care. The managed care organization refusing the preauthorization says it is making a benefits, or coverage, decision when it disagrees with the physician's determination that hospitalization is medically necessary. If the patient is correct in her belief that care is at issue, state law, including state-mandated external review, will apply. If the managed care organization is correct, the state's attempted mandate of external review will be ineffective because it is preempted by ERISA.

It appears as if this example concerning preauthorization of hospitalization²⁰³ would constitute an "adverse determination" under the Texas statute at issue in *Corporate Health Insurance*.²⁰⁴ Consistent with its earlier precedent,²⁰⁵ the Fifth Circuit ruled in *Corporate Health Insurance* that such decisions constituted coverage decisions and thus were preempted.²⁰⁶ It is difficult to see, however, how such "adverse determinations" fall easily and completely on the coverage rather than the quality of care side of the line, and one might wonder if this aspect of *Corporate Health Insurance* will survive as time passes and the health care system develops further.²⁰⁷

The line between coverage and care thus appears to be both preserved and smudged under current law. The court in *Corporate Health Insurance* attempted to draw that line in ruling that ERISA preempted some but not all external review mandates in Texas.²⁰⁸ According to that court, some managed care decisions relate to quality of care and some are coverage decisions; review of such decisions may impact either coverage or care, and thus may or may not be preempted.²⁰⁹ In *Moran*, however, the court ruled that a statute imposing an external review requirement amended insurance contracts by operation of law. As an amendment to the contract, the external review requirement

203. This example derives from the facts of *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (5th Cir. 1992). In *Corcoran*, the United States Court of Appeals for the Fifth Circuit recognized that medical and administrative decisions sometimes overlap, as they did on those facts, but ruled that medical decisions made in the context of coverage determination still related to coverage rather than to quality of care. *Id.* at 1331.

204. Under the statute, adverse determinations are decisions that "the health care services furnished or proposed to be furnished . . . are not medically necessary or are not appropriate." TEX. INS. CODE ANN. § 20A.12A(a)(1) (Vernon Supp. 2000-01).

205. See *Corcoran*, 965 F.2d at 1331.

206. The Supreme Court in *Pegram*, however, seemed to hint that such decisions concerned quality of care, at least for purposes of ERISA fiduciary duty law. See *Pegram*, 530 U.S. 211 (2000).

207. See Sage, *supra* note 202.

208. See *Corp. Health Ins., Inc. v. Tex. Dep't of Ins.*, 215 F.3d 526, 531 (5th Cir. 2000).

209. *Id.* at 539-40.

merely described procedures to be followed in determining coverage, and did not implicate attempts to ensure quality of care.²¹⁰ In fact, the distinction between coverage and care makes little sense,²¹¹ especially to patients, who know only that they must obtain authorization from their managed care organizations to access care.

The courts' holdings in *Corporate Health Insurance* and *Moran* thus conflict on an extraordinarily important and complex preemption issue which determines whether state-mandated external review procedures will apply when patients receive health care benefits through employment.²¹² The U.S. Supreme Court has granted certiorari in *Moran*,²¹³ but until it rules, the law is unclear.

The prevailing confusion and categorization create a multitude of problems. The source of a patient's health care coverage should not determine whether external review can be mandated, regardless of whether the patient or the health care entity would like to see that external review occur. Tensions thus arise because different patients experience different levels of and types of review. Moreover, whether a decision involves coverage or care is a matter of great dispute in the courts, and thus another source of tension.

Governmental mandates of external review, even if they are what patients purport to want, exacerbate the conflict and tensions present in the health care system. How Americans obtain their health care coverage is one source of such exacerbation. Another source is the muddled state of the law, leaving decisions about preemption, coverage and care to conflicting, complex authority.

210. See *Moran v. Rush Prudential HMO, Inc.*, 230 F.3d 959, 971 (7th Cir. 2000), cert. granted, 121 S. Ct. 2589 (2001) (No. 00-1021).

211. See generally William M. Sage, *Therapeutic Coverage: Embedding Medical Professionalism in Health Insurance Contracts* (Sept. 11, 2000) (unpublished manuscript, on file with author) (discussing false evidence in medicine and insurance functions in the law governing health care with possible solutions). E. Haavi Morreim provides a thoughtful analysis of the distinctions between and the qualities shared by coverage and medical treatment decisions in today's health care system. See E. Haavi Morreim, *Playing Doctor: Corporate Medical Practice and Medical Malpractice*, 32 U. MICH. J.L. REFORM 939 (1999).

212. See *Illinois HMO External Review Law Upheld Under ERISA; High Court Appeal Predicted*, 9 Health L. Rep. (BNA) 1625 (Oct. 26, 2000); see also *Texas Seeks Supreme Court Appeal of Decision Striking HMO Review Law*, 6 Health Plan & Provider Rep. (BNA) 1358 (Nov. 8, 2000) (describing Texas briefs as detailing split in circuits).

213. *Moran v. Rush Prudential HMO, Inc.*, 121 S. Ct. 1400 (2001); see *Illinois HMO*, supra note 212, at 1625; see also *HMO Seeks High Court Review of Illinois External-Appeal Statute*, 7 Health Plan & Provider Rep. (BNA) 54 (Jan. 10, 2001); *Supreme Court Seeks Federal Position on Preemption of State HMO-Review Laws*, 10 Health L. Rep. (BNA) 71 (Jan. 11, 2001).

IV. A BROAD-BASED, CONTEXTUALIZED APPROACH WILL BE MORE BENEFICIAL THAN AD HOC INCORPORATION OF ADR MEASURES

Despite what has transpired in health care dispute resolution, conflicts and tension remain. ADR suggestions that have been implemented represent well-meaning attempts to resolve such conflicts and tensions, at least when they erupt into disputes. Many of the attempts implemented thus far, however, have involved mandated adjudicatory ADR measures, which create as many issues, tensions and sources of confusion as they manage to resolve. It would behoove the health care industry to take this beginning at least one step further and work on managing patient conflict at many points rather than resolving disputes after they arise.

In elaborating on this suggestion, this Article will discuss the differences between conflict and disputes and will outline a proposal, focusing on how that proposal can help patients achieve a sense of procedural justice in resolving health care disputes.²¹⁴ Finally, it will examine the goals of corporate members of the health care industry and demonstrate why those goals also would be served by incorporation of the outlined proposal.²¹⁵

A. A Conflict Management Proposal

This Article has distinguished between the more generalized concept of conflict and the narrower, more concrete, term “dispute.”²¹⁶ It is necessary at this point to elaborate on that distinction before discussing the virtues of conflict management as compared to dispute resolution.

Institutions of all types experience conflict on a daily basis. Conflict is “the process of expressing dissatisfaction, disagreement, or unmet expectations with any organizational interchange.”²¹⁷ When conflict remains unresolved, it may escalate into a dispute, or a tangible and concrete expression of that unresolved conflict centered around one or

214. See *infra* notes 216-29 and accompanying text.

215. See *infra* notes 230-48 and accompanying text.

216. See, e.g., *supra* note 15 (delineating the difference).

217. COSTANTINO & MERCHANT, *supra* note 15, at 5.

more issues and positions.²¹⁸ Conflict is a natural, inevitable condition, occurring daily,²¹⁹ especially in times of change.²²⁰

Health care corporate executives and policymakers need to recognize that conflict is ubiquitous in part because of the way health care is delivered and financed through increasingly large corporate organizations. There is no reason to believe that health care is less plagued by conflict than other organizations. In fact, there are good reasons to assume it may experience more than its share of conflict, given the transition from fee-for-service provision of care to managed care; the increasing size of the corporate entities involved in the provision of care, and the previously mentioned regulatory concerns riddling the industry.²²¹

The degree to which conflict is either harmful or beneficial is in part determined by an organization's response to it. Generally, organizations respond to conflict either by "fight" or by "flight."²²² An organization can fight by belittling disputants rather than identifying the cause of conflict, or it can launch a full-scale battle to support its position regardless of merit.²²³ Alternatively, an organization engaging in flight may engage in denial, avoidance or accommodation to avoid dealing with and resolving conflict.²²⁴ To improve organizations' efforts in dealing with conflict in new ways, some theorists have suggested that organizations develop systems for exposing and resolving dissatisfaction.²²⁵ Rather than compartmentalizing dispute resolution functions into one or a few departments, theorists propose that organizations should cut across departmental lines, opening conflict management efforts to interaction between and among various actors in various areas of the organization.²²⁶

218. *Id.* For example, Costantino and Merchant suggest that conflict exists when parties disagree and that conflict has escalated into a dispute when one party decides to file suit against the other. *Id.* "The conflict is the process and state of dissatisfaction; the dispute is the product of the unresolved conflict." *Id.*

219. *Id.* at xvi; see also LEONARD J. MARCUS ET AL., *RENEGOTIATING HEALTH CARE: RESOLVING CONFLICT TO BUILD COLLABORATION*, x (1995) (viewing conflict resolution as "a regular function of . . . work").

220. William L. Ury, *Foreward* to COSTANTINO & MERCHANT, *supra* note 15, at ix.

221. MARCUS ET AL., *supra* note 219, at XXIX (suggesting that rather than seeing conflict as failure, it must be seen as an "inevitable part of our work and relationships in health care").

222. COSTANTINO & MERCHANT, *supra* note 15, at 8.

223. *Id.* at 8.

224. *Id.* at 8-9.

225. *Id.* at 22.

226. *Id.* at 23-26.

In such theories, conflict is seen as “inevitable and natural.”²²⁷ Rather than considering conflict as a problem to be solved, it represents an opportunity to improve.²²⁸ Rather than dealing on an ad hoc basis with individual disputes as they arise, conflict managers collaborate with those involved on larger, systemic tensions revealed through disputes. They attempt to work with various interest groups to resolve the tension and, ideally, head off disputes.²²⁹

1. Varied and Contextual Approaches to Suit Each Situation

In accordance with such recommendations, rather than incorporating one type of ADR method,²³⁰ health care industry executives and policymakers should adopt a more broad-based and more multi-faceted approach to the conflict prevalent in the industry. Just as medical conditions, reaction to treatments, care plans, and patient perceptions are all individual, no one type of ADR can fit all health care settings. Solutions instead must be varied and contextual.

In particular, health care organizations should institute programs cutting across internal departmental divisions.²³¹ A good model may resemble ombudsman programs,²³² which centralize authority for conflict management efforts in a high-level office of relative independence²³³ with authority to conduct far-ranging investigations

227. *Id.* at 56.

228. *Id.*

229. *Id.* at 56-57.

230. *Id.* at 33 (referring to ADR as a middle step between “fight or flight” and conflict management systems).

231. *Id.* at 22-23 (suggesting that one mistake that has been made thus far with dispute resolution efforts in organizations has been to compartmentalize them into their own departments). The result, of course, is that conflict which could result in dispute is a matter to be referred to “[choose a department].” (This may be Customer Service, or it may be Legal, for example.) Others in the organization do not feel a need to assist in resolving the problem, and indeed, they may be prevented from so assisting by turf wars or other interdepartmental territorial concerns. *Cf. id.* at 26, 62.

232. I refrain, however, from labeling my proposal an “ombudsman program” as such, because of concerns expressed by ombudsmen that the term is being diluted and the role is eroding due to its use in various settings without consideration of “‘established models and core values.’” *Ombudsmen Define Themselves*, *supra* note 99. Nevertheless, as one corporate ombudsman has stated, the shift from dispute resolution to conflict management is one which seems to bring with it a need for ombudsman involvement. *See Rowe & Gottehrer*, *supra* note 101, at n.2 (remarks of Mary Rowe).

233. One might wonder whether any employee or officer within a health care organization can be independent enough to truly assist fairly in conflict management efforts. It is easy to imagine, for example, that an employee or officer would feel pressure always to resolve conflict in a way that benefited his or her employer. Part of the position envisioned, however, like the positions of internal ombudsmen or institutionally employed mediators, involves enforcing norms, not merely reaching “good” results for the employer. Moreover, as will be seen in this section, achieving

and, sometimes, to recommend various solutions to conflict. Under this model, ideally, the patient encountering difficulty in dealing with a health care entity will reach a key conflict management figure early in the process.²³⁴ This initial contact person (or members of an initial contact staff) could discuss matters with patients, determine patients' goals and help determine the proper action to move toward resolution.²³⁵ Such initial contact people would be ideally suited to note and pass on, in the organizational hierarchy, the need for further educational efforts.²³⁶

In some instances, the provision of information, or the involvement of a person from a particular department, could alleviate a patient's feelings of dissatisfaction. When providing information or involving other departments cannot resolve conflict, however, the initial contact person can recommend the type of ADR that could best serve a patient's needs, assuming ADR would serve those needs.²³⁷

patient satisfaction is in the interests of the health care entity employing such a conflict management official. *See infra* notes 241-42 and accompanying text.

234. Skills that would tend to be important in this position would include active listening, nonconfrontational questioning, and keen observation of the focus of the caller in presenting his or her problem. Social workers, ombudsmen, nurses, psychiatrists, psychologists and members of the clergy, among others, may be likely candidates to fill such positions. New positions with specialized training may be required to fill in existing gaps in personnel. *See* David Mechanic, *Managed Care and the Imperative for a New Professional Ethic*, 19 HEALTH AFF., Sept.-Oct. 2000, at 100, 109.

The National Association of Insurance Commissioners has suggested that state insurance departments develop complaint analyst positions similar to the type of positions described here for establishment by corporate members of the health care industry. *See* National Association of Insurance Commissioners (NAIC), *Consumer Complaints White Paper 22* (June 2000) (on file with author) [hereinafter *Consumer Complaints White Paper*].

235. Frank Sander and Stephen Goldberg similarly have recommended to attorneys that they consider clients' needs and goals in determining whether to proceed to court or to some form of ADR, as well as in determining how to decide among various methods of ADR. Frank E. A. Sander & Stephen B. Goldberg, *Fitting the Forum to the Fuss: A User-Friendly Guide to Selecting an ADR Procedure*, 10 NEGOTIATION J. 49, 50 (1994).

236. The National Association of Insurance Commissioners, for example, has noted a need for additional outreach and educational programs among insurance companies. *See Consumer Complaints White Paper, supra* note 234, at 10.

237. Some disputes may require going to court, which should not be discouraged if necessary. Resolution of important matters of public interest, for example, at least arguably should not be relegated to a private, non-precedential dispute resolution process. *See, e.g.*, Owen M. Fiss, *Against Settlement*, 93 YALE L.J. 1073 (1984).

Additionally, the initial contact person must remain aware that there exist serious concerns in some settings with perpetuation and magnification of traditional power relationships or other injustices that could arise in various ADR settings. *See, e.g.*, Richard Delgado et al., *Fairness and Formality: Minimizing the Risk of Prejudice in Alternative Dispute Resolution*, 1985 WIS. L. REV. 1359; Trina Grillo, *The Mediation Alternative: Process Dangers for Women*, 100 YALE L.J. 1545 (1991).

Experience on the Florida Managed Care Ombudsman Committee suggests, for example, that patients experiencing conflict with their health care provider or payor seek to voice their conflict regardless of whether they have a legally cognizable dispute. Many patient frustrations with the health care system stem from misunderstanding and misinformation rather than from actual denials of rights.²³⁸ Take, for example, three cases crossing this author's desk as a volunteer with the Committee in one three-week period. None of the three patients calling for assistance presented problems more complex than difficulty with navigating the system.

In one case, the caller was the mother of a small boy who had broken his finger. His emergency care was handled promptly and without fuss, but the caller encountered difficulty when she attempted, at the direction of the emergency room physician, to obtain a referral to an orthopedic surgeon for her son. Her primary care physician agreed with the need for the referral, but the caller had been bounced back and forth three times between the primary care physician's office and the specialist's office. The primary care physician's office told her she had to secure an appointment before the referral form could be completed. However, the specialist's office told her she could not secure an appointment until the receptionist there had received a response to an email requesting an appointment time. The health care system was not at fault, rather, the physicians' offices failed to treat their patients with respect and understanding.

Perhaps in this situation the system could be improved by requiring a different order of form completion, such as permitting completion of a referral form without a specific physician appointment. Or perhaps the health plan could better police its doctors and tell the physicians that it expects more professional service from office staff working with health plan patients. The caller's main complaint was the manner in which she had been treated: by the time she contacted the Ombudsman Committee, her son had been treated. She merely wanted to ensure that this did not happen to others.

Such matters are the types that mediation might address to good effect, if the experience of the Massachusetts Board of Medicine²³⁹ is

238. David Mechanic has written that one of the sources of perceived injustice and unfairness in the health care setting is the practice of managed care organizations' "depend[ing] more on marketing slogans than on explaining carefully the terms of the contract, the trade-offs required, and the basis of the types of limitations they will impose." Mechanic, *supra* note 234, at 104.

239. See *supra* notes 63-67 and accompanying text (discussing Massachusetts Board pilot project called Voluntary Mediation Program that allows patients to register complaints regarding physicians).

any indication. Seen as a mediation matter, the mother who sought to improve practices for future patients seeking referrals actually presented an opportunity for her managed care entity to improve the way it serves patients. A consensual, problem-solving, negotiating session—perhaps with a mediator—could help both sides feel as if progress was made on that score, much as similar sessions appeared to resolve matters at the Massachusetts medical licensing board.²⁴⁰ In contrast, a person seeking coverage of a prescription, thus presenting a claim of entitlement under an interpretation of contract language, may be best served by an adjudicatory system of dispute resolution.

In a similar vein, the other two calls both involved patients who simply did not know that they could achieve care on their own with one simple telephone call each. In both of these cases, the patients had been prescribed medications by their primary care physicians. In one case, coverage of a woman's prescription was refused, and one phone call to the health plan quickly clarified that the patient only needed to telephone her physician and request that the office fax documentation of her medical condition to her managed care organization. In more than ninety percent of cases involving prescriptions of this medication for this patient's condition, the plan said, the plan approved coverage of this medication once the physician provided documentation.

In the other case, a managed care organization agreed to pay for one prescription prescribed for a patient by his primary care physician, but refused to pay for refills even though the primary care physician prescribed refills. Again, all the patient had to do to achieve coverage was call the physician and ask the physician's office to fax additional documentation to the managed care organization.

It may be in these types of cases that the availability of a learned intermediary²⁴¹ could help resolve the conflict patients feel. Such an individual could help patients understand procedures for appeal and policies governing managed care organizations' decisions. Certainly, health care and health care coverage information are complex enough that it would benefit patients to receive such assistance.

In these latter two cases, the patients would have been spared a great deal of frustration if they simply had been better informed. In the first case, the caller unfortunately went through a great deal of frustration, but she sought to change the system to ensure that others did not have to

240. *Id.*

241. See MARC RODWIN, PROMOTING ACCOUNTABLE MANAGED HEALTH CARE: THE POTENTIAL ROLE FOR CONSUMER VOICE 12, 27 (Oct. 2000), available at <http://www.indiana.edu/~speaweb/perspectives/vol15/html>.

go through such frustrations. The managed care companies in these three cases were not violating anyone's rights; in all cases, the patient received the requested care in the end. The patients, however, needed assistance in negotiating the system, and they only realized they needed such assistance after a dispute arose.

2. Consideration of Types of Patients When Determining Appropriate Approach

Taking this eclectic range of patients' complaints into account, it is important also to think about the characteristics of the patient in question when determining which type of ADR would fit each patient's needs. This idea parallels some of the work of John Conley and William O'Barr. Conley and O'Barr have identified a distinction between rights-oriented litigants and litigants they term relationship-oriented, who "come to the legal system seeking redress for a wide range of personal and social wrongs."²⁴² In a small claims court context, Conley and O'Barr examined the way lay litigants approached the legal system and the goals they sought to achieve through it, as revealed through the language they used in pursuing their claims and interacting with the courts.²⁴³ Their study revealed two sorts of litigants: (1) relational ones, who sought to incorporate into their claims notions of social need and entitlement as well as details about social relationships; and (2) rule-oriented ones, who viewed the law as a set of rules applying to factual situations irrespective of social status or situation.²⁴⁴ Unsurprisingly, rule-oriented litigants generally experienced less discord as they moved through the legal system; relational litigants were routinely frustrated.²⁴⁵ Relational litigants wished the court would attend to their feelings as well as their actual claims, but they were unlikely to achieve this goal unless their judge was also relational in orientation.²⁴⁶

Analogously, patients who describe their concerns by focusing on rights and rules may feel quite comfortable and feel a sense of procedural justice and participation in an adjudicatory setting such as arbitration or external review. Those who want to discuss their entire relationship with a health care entity, and who seek to incorporate in

242. JOHN M. CONLEY & WILLIAM M. O'BARR, RULES VERSUS RELATIONSHIPS: THE ETHNOGRAPHY OF LEGAL DISCOURSE ix (1990).

243. *Id.* at ix-xiv.

244. *Id.* at 58-59.

245. *Id.* at 175.

246. *Id.* at 141, 174-75.

their complaints both cognizable claims and relational concerns, however, may be better served by mediation. In mediation they will have an opportunity to exercise more control over process and to express concerns that may play no role and may not be addressed in an adjudicatory setting.

More specifically, the callers to the Managed Care Ombudsman Committee who did not understand the need for documentation of a doctor's prescription would have felt more fairly treated if someone had simply explained, in an understandable, non-confrontational way, why the managed care company was requesting documentation. In all likelihood, had that step been taken, the discomfort of those patients would not have escalated into disputes over the coverage of those prescriptions.²⁴⁷

3. The End Result: Conflict Management From Inception Through Multiple End Points

The conflict management approach suggested herein thus involves a more understanding, more accepting and more nuanced attitude on the part of entities managing care when patients signal their dissatisfaction. Such an approach would constitute a more "therapeutic"²⁴⁸ method of dealing with those patients, each of whose conflict may or may not rise to the level of a dispute. While exact details of implementation would vary depending on the particular way each managed care organization chose to incorporate such change into its structure, broad tasks can be enumerated here for the organizations wishing to do so.

First, entities managing care should provide conflict management training to all those on the front line of receiving complaints from patients. When patients or their family members call to express frustration, a person with some level of training in conflict management would be best-positioned to recognize the caller's angst and treat him or her as a person rather than simply as the source of another complaint. Providing such training to front-line customer service personnel would enable them to better recognize and respond constructively when a patient's complaint actually derives from confusion or feelings of being

247. Medical care providers also need to help. They should not, for example, express to patients their impatience with utilization review efforts by a managed care company.

248. A field of law identified as "therapeutic jurisprudence" suggests that law should be evaluated in terms of the therapeutic or anti-therapeutic effect on those it governs. *See generally* DAVID B. WEXLER & BRUCE J. WINICK, *LAW IN A THERAPEUTIC KEY* (1996) (examining the application of therapeutic jurisprudential concepts in various legal settings). The approach suggested in this Article, in the same vein, might be seen as a recommendation for "therapeutic conflict management."

overwhelmed. The improved assistance such personnel could provide as a result would foster a feeling among callers that they have received procedural justice from their contact with that managed care entity.

Second, managed care organizations should establish ombuds-type offices to serve as the central point to which complaints not resolved by more understanding front-line personnel could be referred. The staffs of such offices can determine whether each referral is a simple matter of lack of information or understanding or is a dispute requiring resolution through established procedures. Thereafter, paying attention to the type of complaint at issue and the type of person voicing it, the staff of such an office can determine whether the complaint is the type best addressed through the provision of information, mediation, a more adjudicatory method of dispute resolution, or some other, more creative, solution. Such offices would operate somewhat like the "multi-door courthouse" system suggested by some commentators as a model for future development of the judicial system.²⁴⁹ It likely would be optimal in the health care setting, however, for a member of the staff of such an office additionally to serve as a conflict case manager, each remaining a constant presence for the complainant throughout the procedures that follow until resolution.²⁵⁰

It would behoove managed care entities adopting this suggestion to proactively identify certain events that likely will always cause great fear, conceptual paralysis and confusion among patients and patients' families. Some might be medical events; it might be, for example, that any patient who is diagnosed as having a serious illness such as cancer should automatically be assumed to be experiencing conflict. Provision of an extra level of information to that patient and his or her family automatically might be appropriate, and managed care entities thus might avoid later conflict over issues such as whether the entity will cover a form of cancer treatment that in reality has little chance of success.²⁵¹ Other events almost certain to cause fear and confusion might be clearly coverage-related; a managed care entity likely can assume its patients and their families will experience conflict if the entity is denying coverage of treatment involving some significant amount of money. The entity, for example, could review its past records to examine the dollar values of various treatments for which it had refused coverage and to determine the instances in which patients

249. See, e.g., Ray & Clare, *supra* note 18.

250. Like case managers involved in coordinating care, these conflict case managers would help each complainant as he or she proceeds through what may be several rather confusing steps.

251. I owe special thanks to Bill Sage for suggesting this idea.

had litigated or pursued requests for coverage nearly to litigation. Thereafter, based on the results of those reviews, it would be a relatively simple matter to determine a dollar value above which patients almost always hotly contested coverage denials. In light of this information, the managed care entity could automatically refer to the ombuds-type office described all complainants who expressed dissatisfaction with denials of coverage involving treatment totaling that dollar value or more.

In incorporating such suggestions, managed care entities should ensure that their efforts are appropriately funded, staffed and supported. In cases in which conflict arises through a lack of information or understanding, for example, the inclination may be to use the ombuds-type office to provide such information or to achieve such understanding. That may work well, or it may result in expectations that the staff of the ombuds-type office learn too much about too many varied, specialized areas. In the latter instances, the staff of the ombuds-type office should be supported in referring issues to learned intermediaries separately situated within the corporate structure. Similarly, in cases in which conflict appears, to the staff of the ombuds-type office, to be best addressed through mediation, the inclination may be to require that staff to act as the mediators. Again, this may work in some situations, but such a procedure would require that all staff in the ombuds-type office be trained as mediators; when all are not, the complainant would be better served if the staff were to refer him or her to trained mediators not located within that office. Continuity would be assured to complainants if the staff of the ombuds-type office adopted the case-management approach just discussed in order to follow matters through from initial complaint to eventual resolution.

Taking this conflict management, rather than a dispute resolution, approach to patients' problems in the health care industry could help introduce some flexibility into a fairly rigid system of dispute resolution.²⁵² Currently, patients "merely" experiencing dissonance or

252. Another source of flexibility should be some sort of temporal contextualization of dispute resolution when conflict management fails. The current fashion has been to propose specific time periods, usually in terms of hours or days, during which certain types of decisions must be made, on a sliding scale ranging from expedited to normal procedure. There is a comfortable certainty to such numbers; having such bright lines makes it easy to determine if participants in the process are complying with the law's requirements. But, given that patients' goals vary, and that varying types of ADR may satisfy patients' needs in various types of cases, definitive deadlines may be too rigid. Rather than a bright-line, time-based rule, perhaps the standard should be patient satisfaction with timeliness in attempting to reach resolution of various matters. Lawmakers may wish to, and should, retain bright-line rules as clear indications of the outer margins of acceptability, but the goal should be to resolve matters expeditiously, within a time frame that

discomfort because they do not understand the bureaucratic process often have nowhere to turn to receive information to ease their feelings of conflict and tension. Patients who have no cognizable legal claims but who seek to improve the procedures they experienced, such as the mother who wanted to improve referral procedures, have no reliable way to do that. Additionally, persons with cognizable legal claims have available as options only pre-defined dispute resolution procedures which may or may not satisfy their sense of procedural justice.

B. Why the Health Care Industry Should Care

The foregoing discussion is adequate from a patient advocate's point of view. There appear to exist good reasons to support the health care industry's adoption of broad-based conflict management techniques, incorporating a contextualized approach to resolving disputes in addition to managing conflict to avoid eruptions of dispute. The industry should adopt such measures to make patients feel included in the system.

Members of the health care industry, however, may not easily be persuaded to employ such a system. After all, implementing such a broad, multi-faceted proposal likely will be expensive and time-consuming. It will require an organization-wide change of conflict culture,²⁵³ and it will force industry executives to step back, focus on and reconstruct the big picture rather than adopting cookie-cutter ADR procedures into an existing picture. Once established, moreover, a conflict management system of the sort described in this article carries with it operating costs. It must be adequately funded; volunteer labor will not suffice.²⁵⁴ Additionally, those working within this conflict

serves the patient's needs for assurance and tension reduction, rather than to ensure coming in within the number of hours or days specified for decision-making.

253. See COSTANTINO & MERCHANT, *supra* note 15, at 7-11.

254. Cf. Society of Professionals in Dispute Resolution ADR in the Workplace Track I Committee, *Guidelines for the Design of Integrated Conflict Management Systems Within Organizations*, at <http://www.spidr.org/article/icmsD.html> (last modified Nov. 10, 2000) (addressing conflict resolution in the workplace and urging in section 3.5.11 that "[s]ufficient financial and human resources must be allocated to the system"). The author knows from personal experience that a volunteer committee such as Florida's does not work well. It is too easy for volunteers to allow their jobs and other commitments to prevent them from following up on patient inquiries and problems. See FLA. SENATE COMM. ON HEALTH, AGING AND LONG-TERM CARE, *supra* note 41, at 5 (attributing the ineffectiveness of Florida's Managed Care Ombudsman Program in part to lack of funding). Underfunding is common among state-level health care ombudsman programs. See *Federal Grants for Ombudsman Programs Would Help Consumers*, 7 Health Plan & Provider Rep. (BNA) 435 (April 4, 2001); Issuance Program for Health Insurance Consumers, S. 651, 107th Cong. (2001).

management system must have sufficient authority and independence to carry through on the promise of the system as conceived.²⁵⁵

One might wonder why, then, any corporate entity in the health care industry would invest in such an undertaking. The answer is simply that members of the health care industry should invest in such efforts because doing so will help them achieve their goals. Adoption of a conflict management approach in health care would help health care entities operate more efficiently and profitably while earning more of the trust that is currently missing from their relationships with those they serve.

Much has been written about the diminishing levels of trust characterizing the health care industry since the advent of large-scale efforts at managing care. Trust between patients and health care providers is negatively affected by suspicions that health care providers are elevating financial considerations over patient care concerns.²⁵⁶ Trust between patients and health care entities (meaning managed care or insurance entities) similarly has suffered from the industry's profit-oriented, adversarial approaches to cutting health care costs.²⁵⁷

This lack of trust can only be harmful to the health care industry. First, a health care entity losing the trust of those patients with whom it has relationships is likely to lose subscribers and thus money, for patients likely will seek to exercise their rights to exit any health care arrangement with which they are dissatisfied (i.e., that they no longer trust).²⁵⁸ Second, great numbers of complaints, and general lack of trust, cannot help but hurt an entity's reputation, which means that the public will lose confidence in it.²⁵⁹ In that event, employers who purchase health care coverage for their employees very well may decide

255. Otherwise, establishment of such a system could create a sense of "false consciousness." See LIND & TYLER, *supra* note 3, at 4 (defining "false consciousness").

256. See, e.g., *Pegram v. Herdrich*, 530 U.S. 211 (2000); MARC A. RODWIN, *MEDICINE, MONEY AND MORALS: PHYSICIAN'S CONFLICTS OF INTEREST* (1993); Mark O. Hiepler & Brian C. Dunn, *Irreconcilable Differences: Why the Doctor-Patient Relationship is Disintegrating at the Hands of Health Maintenance Organizations and Wall Street*, 25 PEPP. L. REV. 597 (1998).

257. See, e.g., *Pegram*, 530 U.S. at 211; Marc A. Rodwin, *Exit and Voice in American Health Care*, 32 U. MICH. J. L. REFORM 1041 (1999); cf. David Mechanic & Marsha Rosenthal, *Responses of HMO Medical Directors to Trust Building in Managed Care*, 77 MILBANK Q. 283 (1999), available at <http://www.milbank.org/quarterly/7703feat.html> (discussing managed care organizations introducing practices to enhance public credibility and encourage individuals to put more trust in physicians).

258. See RODWIN, *supra* note 256, at 1053-57 (noting that some patients are not able to exit, for they have only one option).

259. See Mechanic & Rosenthal, *supra* note 257, at 284 (noting that reputation is "a critical dimension of public confidence in larger institutions, including [managed care organizations]").

to stop working with the entity with a poor reputation, thus institutionally deciding to exit, rather than leaving exit decisions to individuals.

Internally undertaken actions to this effect, moreover, are more likely to increase trust than are externally imposed ADR procedures.²⁶⁰ Imposition of ADR measures by an outside entity (such as the government) implies social distrust of the managed care entity, leading to patient distrust of that entity.²⁶¹ By adopting conflict management measures on its own initiative, the managed care entity will foster a sense among its patients both that the entity is trustworthy and that they will generally receive procedural justice in dealing with it.²⁶²

Ultimately, there exists in this conflict management proposal a real opportunity to improve the operation of the health care industry. Health care entities could improve their procedures by listening carefully to the sources of conflict patients describe. The eventual result could be an increase in business through increased patient satisfaction. Improving patient education in response to tensions created by lack of information or by mis-information can only help the organization to run more smoothly in the future. Rather than presenting examples of failure, to be resisted, patients reporting conflict and tension actually present organizations with opportunities to improve the situation and avert future disputes.

V. CONCLUSION

It thus makes good business sense for health care organizations to invest now in conflict management, offering contextualized ADR possibilities rather than cookie-cutter mandates to patients expressing complaints. Rather than reacting only to cognizable disputes and imposing one-size-fits-all attempts at resolution short of a courtroom, the health care industry should begin to work positively with the conflict and tensions present in the health care system. Doing so will increase patients' senses of satisfaction with the system and the way it treats them. It will also benefit health care entities, for they will gain in trust and reputation, leading to a better financial position.

260. See Mark A. Hall, *Trust, Law and Medicine: Towards a Therapeutic Jurisprudence of Health Care Delivery* 44 (unpublished manuscript, on file with author).

261. *Id.*

262. Cf. LIND & TYLER, *supra* note 3, at 78 (noting "the judgments of process fairness were consistently the major factor involved in generalizations from personal experience to system-level views").