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Mediating with an 800-Pound Gorilla: Medicare and ADR

Phyllis E. Bernard

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Mediating with an 800-Pound Gorilla: Medicare and ADR

Phyllis E. Bernard*

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I. Introduction

A. Whose Program Is It?

In 1965, President Lyndon Johnson's signature brought the Medicare program to life. Initially, this statutory creation did not receive an open-armed welcome from the majority medical establishment. For decades, the American Medical Association had fought against such legislation, condemning the very concept of government-financed health care insurance as "socialism."¹ In the ensuing years, Medicare evolved from being vilified as an unwanted interloper that disrupted the doctor-patient relationship, to being vilified for not paying enough for the privilege of interfering. Physicians, hospitals, and medical

1. The National Medical Association, representing the minority medical establishment, had for an equally long period argued that the government must intervene to assure that all Americans have access to health care services. See 55 J. NAT'L MED. ASS'N 464 (1963) (describing how this association of black physicians wanted the government to intervene to assure all Americans were able to access health care services). For a fuller discussion of the genesis of Medicare and its legislative intent to create a health care safety net for all Americans, see Phyllis E. Bernard, *Social Security and Medicare Adjudications at HHS: Two Approaches to Administrative Justice in an Ever-Expanding Bureaucracy*, 3 HEALTH MATRIX 339, 384-90 (Summer 1993), at <http://heinonline.org/HeinOnline/show.pl?handle=hein.journals/hmax3&d=345&size=4> (on file with the Washington and Lee Law Review).

schools may have begrudgingly embraced Medicare, but embrace it they did, nevertheless.

Medicare reimbursed capital expenses, including depreciation and other long-term financing costs, in ways that fueled the construction of ever-improving health care facilities.² Health care grew from a profession to an industry, complete with a publicly-traded, for-profit segment holding some of the hottest stocks on Wall Street.³ Medical schools came to rely upon millions in Medicare revenues from faculty practice plans along with more millions for the ephemeral, additional costs of graduate medical education.⁴

With the infusion of over 200 billion Medicare dollars annually, health care services now constitute one of the largest industries in the country. Medicare serves about forty million elderly and disabled persons annually and pays "nearly 1 million hospitals, physicians and other health care providers."⁵ In 2000, the Medicare program represented about 11% of the federal budget.⁶ According to colloquial labels for power relationships, Medicare surely qualifies as "the 800-pound gorilla" that sits "wherever it wants."

A skeptical observer might question the marginal role the beneficiary-patient plays in the perennial Medicare debates. Relative to those whose incomes derive from Medicare payments, the beneficiary-patient has only a

2. Some of the most exhaustive debates concerning costs and payment methodologies came with the 1983 transition to prospective payments. For a compilation and analysis of issues and proposals regarding Medicare's prospective payment system, see U.S. GEN. ACCOUNTING OFFICE, HRD-86-93, MEDICARE: ALTERNATIVES FOR PAYING HOSPITAL CAPITAL COSTS: REPORT TO THE CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, HOUSE OF REPRESENTATIVES (Aug. 1986).

3. The fertile soil nurturing the original growth of proprietary hospitals was Medicare payment policies paying the cost, plus a return on equity. See U.S. GEN. ACCOUNTING OFFICE, HRD-79-63, MEDICARE: EVALUATION OF A PROPOSAL TO INCREASE MEDICARE EQUITY RETURN PAYMENTS TO FOR-PROFIT HOSPITALS 34 (1979) (asserting that the for-profit hospital industry is considered a profitable and attractive investment).

4. This has been a long-standing issue for the Medicare program from the seventies through the nineties. See generally U.S. GEN. ACCOUNTING OFFICE, COMPTROLLER GENERAL OF THE U.S., HEW-#22-SSA, PROBLEMS PAYING FOR SERVICES OF SUPERVISORY AND TEACHING PHYSICIANS IN HOSPITALS UNDER MEDICARE, REPORT TO CONGRESS (Nov. 17, 1971); U.S. GEN. ACCOUNTING OFFICE, GAO-HEHS-94-33, MEDICARE: GRADUATE MEDICAL EDUCATION POLICY NEEDS TO BE REEXAMINED, REPORT TO CONGRESSIONAL REQUESTERS 10 (1994) (finding that in 1992, Medicare's payments to the 1,250 teaching hospitals in the country for graduate medical education amounted to \$5.2 billion).

5. This paragraph contains standard background information included in most U.S. General Accounting Office reports concerning aspects of the Medicare program. These particular statistics come from U.S. GEN. ACCOUNTING OFFICE, GAO-01-817, MEDICARE MANAGEMENT: CMS FACES CHALLENGES TO SUSTAIN PROGRESS AND ADDRESS WEAKNESSES, REPORT TO CONGRESSIONAL REQUESTERS 3 (2001).

6. *Id.*

muted voice. This outcome should not surprise us. It is the logical result of having relegated the recipient of services to the sidelines. In so doing, health care for seniors and the disabled has increasingly veered away from doctor-patient relationships of long duration and substantial trust, and towards high-intensity, invasive tertiary care that increases revenues to providers, but does not increase satisfaction to the patient.⁷

B. Using Mediation to Refocus Medicare on the Doctor-Patient Relationship

This Article proposes that we reorient Medicare. Medicare should refocus financing in ways designed to sustain a collaborative doctor-patient relationship, emphasizing primary care fitting the level of support the beneficiary and her family prefers. Such a reorientation would shift the direction of Medicare from provider-oriented to beneficiary-centered.⁸ The mechanism for effecting this change would be mediation aimed at developing a collaborative medical treatment plan. This plan would establish principles for

7. Assessments of consumer satisfaction or dissatisfaction are difficult to craft. For purposes of the present discussion we shall assume—in line with the positions the U.S. General Accounting Office (GAO) often takes and HHS sometimes takes—that quality programs to deal with beneficiary complaints need improvement. Consider, for example, the recent report by the HHS's Office of the Inspector General, Doc. No. OEI-01-00-00060, *THE MEDICARE BENEFICIARY COMPLAINT PROCESS: A RUSTY SAFETY VALVE* (Aug. 2001), available at <http://oig.hhs.gov/oei/reports/oei-01-00-00060.pdf> [hereinafter *OIG*]. This found the medical Peer Review Organizations (PROs) designated to bridge quality of care and consumer complaint response did not optimally handle either role. Some 13% of beneficiary complaints in a period from 1997 to 1999 involved problems with quality. *Id.* But, beneficiary complaints were treated "as a distinctly minor activity." *Id.* Instead, the PROs tended to be "more oriented toward the medical community than to the beneficiary community." *Id.* This left most beneficiaries with few identifiable means to present a complaint about quality of care, not payment for services. *Id.* *OIG* recommended the establishment of a complaint process outside of the PRO system that would include mediation. *Id.*

8. The call for such a reorientation is not entirely new. Professor Rand Rosenblatt identified the potentially corrosive effect of cost containment upon the doctor-patient relationship as early as the mid-1980s with regard to Medicaid. See Rand E. Rosenblatt, *Medicaid Primary Care Case Management, The Doctor-Patient Relationship, and the Politics of Privatization*, 36 *CASE W. RES. L. REV.* 915, 919–20 (1986) (asserting that "primary care case management" acts as a cost containment strategy that creates a financial incentive to deny adequate care to the poor). At that time, he promoted a "patient-centered ideal" as the "preeminent factor in the doctor-patient relationship and in the making of health policy." *Id.* at 939. He recognized the connection between "reimbursement and coverage decisions and the dynamics of the doctor-patient relationship." *Id.* Further, he offered ways to "operation-alize" the patient-centered ideal by having consumers directly represented in the provider's administrative structure. *Id.* at 938. Although this paper clearly embraces a patient-centered ideal, we shall analyze and seek to "operation-alize" this ideal as a person-to-person interaction.

anticipated hospitalizations and other tertiary care, establishing the balance of services (degree of intensity and invasiveness), and institutionalized versus non-institutionalized long-term care that comports with the patient's preferences. Mediation between the patient, the patient's relevant family member(s), and the medical team would facilitate efficient use of known Medicare (and other) resources.

A third-party neutral trained in the skills of restating and reframing to build consensus can: (1) reveal mistaken assumptions and unrealistic expectations; (2) identify shared values so that services meet underlying needs; and (3) address otherwise unarticulated and poorly managed anxieties. A nonstakeholder can bring confidence in the process itself specifically because this neutral person is not a member of the medical team, nor a designated patient representative (whom the medical team could view as an adversary). The use of trained neutral parties can assure fairness as a matter of system design, not relying primarily upon the right blend of temperaments to achieve optimal communication.

Does this matter? Dr. Jeffrey Kang, Centers for Medicare and Medicaid Services' (CMS) chief clinical officer, has been quoted as saying, "Most beneficiary complaints against Medicare providers aren't [sic] due to bad clinical care, but instead are the result of inadequate communication between the patient and the physician."⁹ Dr. Kang endorsed mediation to provide beneficiaries "a little more satisfaction" in the postdispute complaint process.¹⁰ This Article proposes offering both the patient and medical team much greater satisfaction by sequencing mediation at a predispute, preventative stage.

Such sequencing could address the complex human relations issues at the root of beneficiary complaints profiled by HHS's Office of Evaluations and Inspections in the Office of the Inspector General (OIG). For example, the study showed that initial confusion about the appropriate use of medications often emerged later as technical quality concerns questioning "clinical expertise and decisions."¹¹ Service quality concerns comprised approximately 14% of beneficiary complaints.¹² These complaints generally resulted from negative interactions between beneficiaries, their family caregiver, and medical or nursing staff.¹³ That difficult experience often stemmed from a health care

9. Ed Lovern, "Gotcha" Gives Way to Guidance; Quality Improvement Behind Plan to Change Medicare Review Groups' Image, MOD. HEALTHCARE, Dec. 17, 2001, at 20.

10. *Id.*

11. OIG, *supra* note 7, at 23. Such incidents comprised approximately 74% of beneficiary complaints reviewed. *Id.* at 24.

12. *Id.*

13. *See id.* (citing examples of beneficiary complaints that raise concerns regarding the

professional's narrow focus on efficiency. Complaints stated that health care providers inadvertently overlook "solicitude with patients" and "friendliness," both cited by OIG as major beneficiary concerns.¹⁴ Although some people might read the terms "solicitude" and "friendliness" as minor issues, the facts from which they arise represent core factors in the treatment dynamic.¹⁵

This Article also proposes that all the services Medicare provides pursuant to such a mediated plan would be paid without delay. This offers a substantial, tangible incentive for full participation by the beneficiary and by the practitioner. They both need incentives to undertake a process that HHS's OIG recognizes as "labor-intensive"¹⁶ and "a burden,"¹⁷ which operates under the perpetual cloud that "there is likely to be a perceived imbalance of power between the participants."¹⁸ OIG posited that these factors partially explain the low rates of participation in the five limited pilot mediation projects reviewed as of August 2001.¹⁹ In the OIG study, Peer Review Organizations (PROs) extended offers to mediate complaints fifty-eight times.²⁰ Only twenty-eight beneficiaries and only eleven providers mediated.²¹

Placing the mediation process at the predispute/pregrievance/precomplaint stage substantially reduces the need to sort through which types of complaints would be appropriate or inappropriate for mediation.²² Vastly improved communication may largely prevent disputes rising to the level of grievances or

quality of service delivered by medical and nursing staffs).

14. *Id.* at 23.

15. The report offers two tangible examples: (1) A surgical center transferred a beneficiary by wheelchair to a hospital six blocks away, dressed only in a hospital gown, with his family following behind. *Id.* at 24. This was perceived as seriously disrespectful of his dignity. *Id.* Not surprisingly, complications arose and the family cited the inappropriate conditions of the transfer as part of their complaint concerning the quality of technical services. *Id.*; (2) The wife of a beneficiary receiving services in a rehabilitation center did not receive regular updates from nursing staff about his health. *Id.* She had special concerns about his decrease in appetite. *Id.* This exacerbated her anxiety about the technical quality of care her husband received, especially when he was later discharged while still fighting an infection. *Id.* These became complaints about both service and technical quality. *Id.*

16. *Id.* at 10.

17. *See id.* ("Bringing together a beneficiary and provider or practitioner can present a burden to both parties, particularly a frail beneficiary.").

18. *Id.*

19. *Id.*

20. *Id.*

21. *Id.*

22. This is an unanswered question the OIG presented as it recommended larger-scale experimentations in mediation of beneficiary complaints. *See id.* (making the recommendation for larger-scale experimentation).

complaints. Placing the mediation at the formation stage in the doctor-patient relationship—before the beneficiary's health has deteriorated and before a dispute has raised the emotional stakes—lifts yet another serious burden from the beneficiary.²³ Finally, institutionalizing these mediated dialogues and making payment contingent upon the resulting treatment plan assures follow-up to protect the interests of beneficiaries, as the OIG requested.²⁴

The mediated treatment plan, once institutionalized, could substantially reduce the future volume of appeals for denials of claims and coverage. It can offer a mechanism to assure compliance with HHS's treatment guidelines, especially for chronic conditions.²⁵ It offers an appropriate, compassionate means to address access and end-of-life decisions.²⁶ This process, however, takes time and deserves compensation. Thus, the mediation time of the medical team should be separately paid as a billable service. By making such mediations standard procedure, the Medicare program could emerge as the salvation of the doctor-patient relationship it has been accused of destroying.

Alternative dispute resolution (ADR) and the medical establishment have a growing acquaintanceship. In the 1990s mediation became the policymakers' dispute resolution mechanism of choice for handling denials of services by managed care organizations.²⁷ Some experience has been gained, although not all of it has been encouraging.²⁸ Most importantly, one must ask whether any

23. This responds to the point OIG raised regarding the potential burden placed on a frail beneficiary to meet with a provider or practitioner. *See id.* (discussing burdens).

24. *See id.* (asking how mediation would serve as a beneficiary protection if there is no intervention or follow-up after the mediation).

25. *See, e.g.*, U.S. GEN. ACCOUNTING OFFICE, GAO-HEHS-97-48, MEDICARE: MOST BENEFICIARIES WITH DIABETES DO NOT RECEIVE RECOMMENDED MONITORING SERVICES, REPORT TO THE CHAIRMAN, SUBCOMMITTEE ON HEALTH AND ENVIRONMENT, COMMITTEE ON COMMERCE, HOUSE OF REPRESENTATIVES 20 (1997) (determining how well the health care system provides preventive services for patients with diabetes and finding that patients who receive the recommended levels of preventive services experience an enhanced quality of life); U.S. GEN. ACCOUNTING OFFICE, GAO 02-422, MEDICARE: BENEFICIARY USE OF CLINICAL PREVENTIVE SERVICES, REPORT TO THE CHAIRMAN, SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS, COMMITTEE ON ENERGY AND COMMERCE, HOUSE OF REPRESENTATIVES 6 (2002) (detailing the lack of coordination and underuse of basic preventative care).

26. *See generally* U.S. GEN. ACCOUNTING OFFICE, GAO/HEHS-98-8, MEDICARE HOME HEALTH: DIFFERENCES IN SERVICE USE BY HMO AND FEE-FOR-SERVICE PROVIDERS, REPORT TO THE CHAIRMAN, SPECIAL COMMITTEE ON AGING (1997).

27. The National Association of Insurance Commissioners (NAIC) took the lead in developing a template for ADR use in managed care settings. The federal government and the states have followed this template. An excellent review of these various methods for handling managed care complaints is presented in Jennifer E. Gladieux, *Medicare+Choice Appeal Procedures: Reconciling Due Process Rights and Cost Containment*, 25 AM. J.L. & MED. 61 (1999).

28. The American Bar Association Commission on Legal Problems of the Elderly

unrepresented patient can effectively mediate with the gatekeeper who seeks to deny the services the patient perceives as essential to life or to an acceptable quality of life. The medical institutions hold power that dwarfs the power of the vulnerable patient. How can mediation achieve balance and thus fairness in such negotiations? Taking it a step further, how can one structure an equitable mediation in which the patient confronts not only the medical establishment, but the federal government, in the form of the Medicare program?

C. Mediating the Dynamics of Power

This Article explores the issues of power, balance and collaboration in a specialized context. This proposal strategically places mediation at an earlier stage in the process than is typical. The proposed design would compel mediation before a serious dispute or claim has arisen. Mediation after conflict strains the power balance even further, accentuating the emotional stakes for the patient and the patient's family. Can the negotiating table ever be "even" under such circumstances? With this in mind, the proposal presented here suggests mediation in a preventative, pro-active role, rather than merely attempting damage control after the dispute is already forming into a matter for litigation.

Part II of this Article offers an overview of how ADR has been used in the Medicare program to date. More pointedly, it considers a framework for understanding the proper or improper usage of ADR processes in a publicly funded program. Part III presents a paradigm for understanding power relationships between the Medicare program, providers, practitioners, and beneficiaries. Conflicts involving the doctor-patient relationship should be resolved at a time and in a manner that neutralizes the power balancing issues arising in standard ADR processes. Part IV presents a working model of empowerment by using trained mediators to facilitate the development of

conducted an 18-month study of managed care organizations' internal dispute resolution practices. As reported in Naomi Karp & Erica Wood, *Health Plan Internal Consumer Dispute Resolution Practices: Highlights from a National Study*, 5 J. HEALTH CARE L. & POL. 283, 323 (2002), ADR methods can be a helpful complement to the standard adjudicatory appeals system. Karp and Wood quote the American Association of Health Plans as endorsing ADR because its "comparatively informal and non-adversarial techniques" contribute to "preserving partnerships between health plans and their members." *Id.* A leading expert on Medicare appeals processes expresses doubt, however, about the waiver of judicial remedies. Is such a waiver truly knowing? See Eleanor D. Kinney, *Resolving Consumer Grievances in a Managed Care Environment*, 6 HEALTH MATRIX 147, 163 (Winter 1996) (finding contractually imposed ADR procedures that take the place of court proceedings are especially suspect because they eliminate a range of judicial protections with which patients presumably are familiar).

comprehensive medical treatment plans in collaboration with the patient and the patient's family.

II. *Are Medicare and Mediation Compatible?*

A. *A Brief Overview of ADR in the Medicare Program*

1. *Justice on a Mass Scale*

Like most federal agencies designated as the primary interface between the public and the government, the Health Care Financing Administration (HCFA), now known as the Centers for Medicare and Medicaid Services (CMS), has sought to be efficient, fair, and user-friendly. These goals in theory are unquestionable. In practice, however, they prove not only elusive but often contradictory.

The annual volume of Medicare cases that HCFA/CMS faces requires that justice be processed through mass production quite unlike the image of litigated, individualized justice dispensed in the court room. If millions of beneficiaries, providers, and suppliers are to receive some sort of hearing concerning a dispute with the program, fairness requires attention to the mundane, unglamorous features of due process. The chosen system for resolving disputes over payments cannot attempt to replicate the formal APA trial-type proceeding. It would prove too slow, too varied in result, and too costly.²⁹

Medicare disputants need a response in a fairly short period of time, especially when the answer makes a fundamental difference in a beneficiary's course of treatment, or in the fiscal viability of a provider institution. Results must be consistent enough to assure the public that their government has not acted in an arbitrary and capricious manner. Actions must be sufficiently predictable that businesspeople can make realistic plans. And, the final prong of the *Mathews v. Eldridge*³⁰ due process test looms ever larger as the volume of cases also grows.³¹

29. Professor Jerry L. Mashaw's classic book on the Social Security Disability Program convincingly articulated this concept of justice on a mass scale, its elements, and its impact. See generally JERRY L. MASHAW, *BUREAUCRATIC JUSTICE: MANAGING SOCIAL SECURITY DISABILITY CLAIMS* (1983).

30. *Mathews v. Eldridge*, 424 U.S. 319 (1976).

31. See *id.* at 335 (ruling that the government's interest acts as one of three factors that must be considered for due process analysis, including the fiscal and administrative burdens the additional or substitute procedural requirements would entail).

Namely, administrative costs for maintaining an adjudicatory process must be affordable even when multiplied by an extraordinary volume of cases.³²

2. Streamlining and Humanizing Medicare Adjudications

Throughout the 1980s and into the 1990s the Administrative Conference of the United States (ACUS) addressed these considerations to develop thoughtful, neutral studies and recommendations designed to meet the goals of efficiency, fairness, and accessibility for the lay public. In 1986, ACUS determined that the Medicare appeals system was a "patchwork with differing administrative and judicial review requirements" that needed to be rationalized.³³ By the end of ACUS's funding period, several modifications were under study, including a proposal to bring ADR to the Part A adjudications the Provider Reimbursement Review Board (PRRB) handles.

ACUS first presented the proposal in 1992, and completed and published the report in 1995. The report suggested that the PRRB's adjudicatory functions be reduced or eliminated entirely, replaced by ADR, possibly through the HHS Departmental Appeals Board (DAB).³⁴ Those who utilized PRRB adjudicatory services—within the government and within the provider community—expressed remarkable willingness to undertake such a change.³⁵ In 1998, CMS determined that the time for

32. See Jennifer L. Wright, *Unconstitutional or Impossible: The Irreconcilable Gap Between Managed Care and Due Process in Medicaid and Medicare*, 17 J. CONTEMP. HEALTH L. & POL. 135 (Winter 2000) (arguing that "managed care, as currently constituted" fails the due process test). Specifically, Professor Wright argues that it is "inherently unconstitutional in the Medicaid and Medicare context" because "each medical treatment decision is conflated with a Medicaid/Medicare coverage decision, and these decisions are made by care providers and managed care organizations that are subject to systemic incentives to deny even covered care." *Id.* at 135.

33. ACUS Recommendation No. 86-5, § 305.86-5 Medicare Appeals, 51 Fed. Reg. 46,987 (December 30, 1986).

34. PHYLLIS E. BERNARD, ACUS, ADJUDICATING MEDICARE HOSPITAL PAYMENT DISPUTES: ISN'T THERE A BETTER WAY? A REPORT TO THE ADMINISTRATIVE CONFERENCE OF THE UNITED STATES (1995). The "director's cut" was published as an article in the *Administrative Law Review* in 1997. See Phyllis E. Bernard, *Empowering the Provider: A Better Way to Resolve Medicare Hospital Payment Disputes*, 49 ADMIN. L. REV. 269, 339-40 (1997) [hereinafter Bernard, *Empowering the Provider*] (presenting a model to reconfigure the PRRB's appeals process by including ADR procedures that have the HHS Departmental Appeals Board act as mediators to facilitate negotiated settlements).

35. Bernard, *Empowering the Provider*, *supra* note 34, at 339-40.

mediation of PRRB cases had arrived and implemented a pilot mediation project.³⁶ The in-house mediation program has been a major success, from the perspective of both providers and government representatives.³⁷

The advent of managed care emphasized negotiation, mediation, and arbitration as preferred methods for resolving disputes between the Medicare program, providers, and beneficiaries. Private sector, private payor managed care organizations had led the way with varied success.³⁸ Medicaid managed care demonstration projects at the state level experimented with ADR components. These experiments later informed the choices that CMS made.³⁹ On both the federal and state levels, legislators made ADR provisions boilerplate in almost every managed care statute and other health reform statutes over the past ten years.⁴⁰ We must reserve some doubt, however, about the basis for these public affirmations that ADR is appropriate in virtually all managed care settings. Does this stem from a desire to make appeals processes rapid, flexible, and truly user-friendly? Or is it tinged with a significant, unacknowledged desire simply to save administrative costs and shift responsibility?

36. See Kathleen Scully-Hayes, *Mediation and Medicare Part A Provider Appeals: A Useful Alternative*, 5 J. HEALTH CARE L. & POL. 356, 359 (2000) (describing the pilot mediation project).

37. See *id.* at 362 (noting that participant feedback was overwhelmingly positive with participants uniformly indicating their intention to use mediation in the future). One consultant went so far as to say that the "[b]oard sponsored alternative dispute resolution process is the best single idea that has been implemented, in terms of a party-neutral expedition of the PRRB appeal process since the first hearing held on April 1, 1975." *Id.* at 363.

38. See, e.g., Ann H. Nevers, *Consumer Managed Care Appeals: Are the Available Procedural Protections Fundamentally Fair?*, 33 J. HEALTH LAW 287 (2000) (reviewing adjudicatory and ADR procedures in private payor HMOs and MCOs).

39. Professor Sidney Watson presents an intriguing class analysis of Medicaid HMOs and other managed care plans, wherein she suggests "managed care, when done responsibly," offers ways to "reconstruct" welfare medicine by focusing on "a long-term relationship with primary care providers." Sidney D. Watson, *Commercialization of Medicaid*, 45 ST. LOUIS L.J. 53, 71, 77 (2001). The CMS final rule publishing enrollment, quality assurance, grievance rights and other procedures for Medicaid managed care entities offers insight into the complicated dialogues between practitioners, providers, state agencies and beneficiaries with CMS and identifies the positive and negative experiences to date. See generally Medicaid Program; Medicaid Managed Care, 67 Fed. Reg. 40,989 (June 14, 2002).

40. A comprehensive survey of grievance procedures throughout the nation is found in Joyce Krutick Craig, *Managed Care Grievance Procedures: The Dilemma and the Cure*, 21 J. NAT'L ASS'N ADMIN. L. JUDGES 336 (2001).

B. Mediating in Private About Public Matters

1. The Theoretical Framework

The issues for discussion here illustrate in a tangible way the theoretical concerns Professor Owen Fiss raises in his now-classic article *Against Settlement*.⁴¹ His critique of institutionalized ADR may sound caustic. "Consent is often coerced; . . . although dockets may be trimmed, justice may not be done. Like plea bargaining, settlement is a capitulation to the conditions of mass society and should be neither encouraged nor praised."⁴² But it has the ring of truth. For, unless the contending parties stand on roughly equal footing, coercion is built into the very structure of society and the legal system. What happens if both parties do not have access to the same resources?

Fiss explains that "disparities in resources between the parties can influence the settlement in three ways."⁴³ All three reflect the power dynamics of mediations between private parties and the Medicare program. In considering the situation of beneficiaries mediating with health care providers and with Medicare as payor, the influence of such disparities is amplified.

- "[T]he poorer party may be less able to amass and analyze the information needed to predict the outcome of the litigation; and thus be disadvantaged in the bargaining process."⁴⁴ No provider institution, individual provider, nor beneficiary has at their disposal the arsenal of data concerning Medicare treatment and payment practices and policies that CMS possesses. Furthermore, the federal government holds immediate and, increasingly, ultimate authority over the outcome by controlling not only the adjudicators, but all principles used for decision-making.⁴⁵

41. See Owen M. Fiss, Comment, *Against Settlement*, 93 YALE L.J. 1073, 1075 (1984) (stating that settlement should not be "institutionalized on a wholesale and indiscriminate basis").

42. *Id.*

43. *Id.* at 1076.

44. *Id.* (emphasis added).

45. This theoretical issue has taken practical shape in recent months concerning Medicare national coverage determinations. Last year CMS published a proposed rule that, *inter alia*, would require administrative law judges (ALJs) to be bound by local medical review policies, and to compel ALJs to comply with national coverage determinations (NCDs) that have been based on clinical and scientific evidence. See CMS, Medicare Program: Review of National Coverage Determination and Local Coverage Determinations, 67 Fed. Reg. 54,534, 54,538 (proposed Aug. 22, 2002) (proposing that NCDs be binding on ALJs and not allowing an ALJ to disregard, set aside, or otherwise review an NCD). The proposed rule would remove their

- "[The poorer party] may need the damages he seeks immediately and thus be induced to settle as a way of accelerating payment, even though he realizes he would get less now than he might if he awaited judgment."⁴⁶ In 1984 Fiss wrote "simply" about the fiscal exigencies pressuring a party who confronts on one side a growing hill of debts (such as medical expenses) already incurred because of the litigated incident, and on the other side, the loss of regular income, again because of the underlying dispute.⁴⁷ Today, in the context of Medicare fiscal disputes, both time pressures and time value for their resolution have magnified considerably. Here, by definition, most beneficiaries live on fixed incomes that have little margin for unanticipated, unpaid medical expenses. Even in situations that are not fee-for-service, both the managed care organization and the patient must know promptly whether Medicare will or will not cover a service, or risk impairment of the patient's health by failing to provide the service in a therapeutically efficacious time frame.
- "[T]he poorer party might be forced to settle because he does not have the resources to finance the litigation, to cover either his own projected expenses, such as his lawyer's time, or the expenses his opponent can impose through the manipulation of procedural mechanisms such as discovery."⁴⁸ Most patients lack the financial or emotional resources to support protracted litigation over health care services or payment denials. Furthermore, few advocates—attorney or non-attorney—can undertake such representation on terms affordable for the bulk of the elderly or disabled receiving Medicare benefits. Without a reasonably knowledgeable and dogged advocate, it is unlikely that most Medicare beneficiaries could successfully navigate the

discretion to conduct an independent review of the propriety of that determination on a case-by-case basis. See *id.* at 54,537, 54,547 (determining that it is not appropriate for an ALJ to rewrite coverage determinations). This has raised a storm of protest because federal judges have ruled in favor of the beneficiaries and their providers in more than half the cases where ALJs denied coverage. According to some reports in the popular press, the Bush administration intends to present legislation replacing ALJ review with mediation or arbitration, in line with a Connecticut demonstration project. See Robert Pear, *Bush Pushes Plan to Curb Appeals in Medicare Cases*, N.Y. TIMES, Mar. 16, 2003, at A1 (outlining legislation the Bush administration may steer Medicare reviews toward ADR).

46. Fiss, *supra* note 41, at 1076 (emphasis added).

47. *Id.*

48. *Id.* (emphasis added).

confusing world of health care appeals. Yet, such patient advocacy is rare.⁴⁹

How does society rebalance such imbalances of power? Through the courts. Fiss argues eloquently that: "Civil litigation is an institutional arrangement for using state power to bring a recalcitrant reality closer to our chosen ideals."⁵⁰ He sees adjudication "American-style" not as a "reflection of our combativeness," but rather as "a tribute to our . . . commitment"⁵¹ to equal justice even when the parties are not economically, socially, or politically equal.⁵²

In this paradigm of justice, although recognizing that true equality may be illusory, fairness requires adjudicatory processes so the playing field is tilted less abusively. Legal scholars from perspectives as diverse as Professor Richard Delgado⁵³ to Professor Judith Resnik⁵⁴ have challenged the institutionalization of ADR. Resnik has urged caution in the apparent rush to make ADR the default setting for adjudication.⁵⁵ That is to say, when the courts fail to fulfill their promise of justice—due to crowded dockets and high litigation costs—we should think carefully whether the system should divert

49. There is a call for change. As Professor Maxwell Mehlman argued, the patient needs a true, uncompromised patient advocate who can "prevent the patient from being injured by the denial of necessary services" as much as securing "redress after the injury has occurred." Maxwell J. Mehlman, *Medical Advocates: A Call for a New Profession*, 1 WID. L. SYMP. J. 299, 320 (1996). See also Bethany J. Spielman, *Managed Care Regulation and the Physician-Advocate*, 47 DRAKE L. REV. 713, 719 (1999) (comparing Mehlman's expanded role of patient advocate with the traditionally conceived role of the physician as patient advocate).

50. Fiss, *supra* note 41, at 1089.

51. *Id.* at 1090.

52. Indeed, as Professor Marilyn Denny cautions, the informal, internal dispute resolution processes of managed care plans could create the "illusion of fair dealing" while diverting the beneficiary (especially those who are poor or otherwise disadvantaged) into processes in which "their rights are violated in the name of efficient justice." Marilyn Denny, *Managed Care: Increasing Inequality & Individualism*, 3 QUINNIPIAC HEALTH L.J. 59, 83 (1999/2000).

53. See Richard Delgado et al., *Fairness and Formality: Minimizing the Risk of Prejudice in Alternative Dispute Resolution*, 6 WIS. L. REV. 1359-1404 (1985) (arguing that ADR procedures may foster racial and ethnic prejudice and should be reserved for disputes in which parties of comparable status and power confront each other).

54. See generally Judith Resnik, *Many Doors? Closing Doors? Alternative Dispute Resolution and Adjudication*, 10 OHIO ST. J. ON DISP. RESOL. 211 (1995) (arguing that ADR may in fact narrow the forms of dispute resolution available to litigants instead of increasing such options).

55. See *id.* at 262 (suggesting that injecting ADR into the adversarial process will undermine the attributes that prompted praise for ADR).

parties to ADR.⁵⁶ This would assure some access to justice, but it may be suboptimal.

On the other hand, Resnik notes that some parties might prefer ADR over adjudication.⁵⁷ For them, ADR would not constitute a mere "default" setting. Rather, they may prefer the informality of ADR as a way to promote candid communication and improved problem-solving. The very absence of procedural and evidentiary rules found in the court room could equate to more, not less, justice.⁵⁸ Still, a wide disparity of resources between the parties (as Fiss described) would undermine fairness. And clearly, there is no greater disparity of resources than in a dispute between a private person and the federal government.

When this Article turns to the issue of mediating with the federal government, yet another foundational premise of ADR must be re-examined. Private resolutions for disputes between private parties may suit a society that privileges individualism and autonomy.⁵⁹ However, the past generation of administrative law reforms has struggled to bring transparency to government. The watch word has been openness in government, not privacy or secrecy.⁶⁰

56. *Id.*

57. *See id.* at 243–52 (exploring the arguments supporting ADR over adjudication).

58. *Id.* at 252.

59. Consider how settlement may serve the needs of individuals by preserving their privacy and ability to negotiate resolutions that save them from personal embarrassment. The same settlement, however, may work against the larger interests of the organizations, corporations, or social groups of which those parties are members. *See Fiss, supra* note 41, at 1078 (providing examples that show the conflict of interest between the individual interest of the person given authority to settle on behalf of an organization and that organization's larger interest).

60. This debate comes into sharpest focus around the question of confidentiality in government ADR. *See Mark M. Grunewald, Freedom of Information Act and Confidentiality Under the Administrative Dispute Resolution Act*, 9 ADMIN. L.J. AM. U. 985, 986 (1996) (examining the confidentiality and conflict between the Administrative Dispute Resolution Act of 1990 (ADRA) and the Freedom of Information Act (FOIA) and recommending legislation that will give full effect to the confidentiality standards of the ADRA). This article predated the thorny litigation commenced when, in an investigation of the possible misuse of public funds, the Office of the Inspector General for the U.S. Department of Agriculture sought access to mediation records in a Texas farmer-lender mediation program sponsored by the agency. *See In re Grand Jury Subpoena*, 148 F.3d 487, 492–93 (5th Cir. 1998) (holding that although the mediation statute required mediation sessions to be confidential, this did not necessarily mean "privileged," and therefore the statute did not clearly manifest Congress's intent to prevent such mediation sessions from being submitted to a grand jury). Since then, the senior ADR counsels for cabinet agencies have developed guidelines attempting to balance the general expectation of privacy in mediation with the need for public accountability. *See Subcommittee of Federal ADR Steering Committee, Confidentiality in Federal Alternative Dispute Resolution Programs*, 65 Fed. Reg. 83,085, 83,086 (Dec. 29, 2000) (containing detailed guidance on the nature and limits of confidentiality in Federal ADR programs).

Thus, the very concept of privately mediated settlements fits uneasily with the implementation of public policy and the payment of public funds.

The Administrative Dispute Resolution Act of 1990 (ADRA)⁶¹ attempted to strike a workable balance. Congress based its enactment of this statute on a finding that ADR was "faster, less expensive and less contentious" than adjudication,⁶² and should be encouraged.⁶³ Congress expressed its hope that agencies would use ADR processes to develop more "creative, efficient and sensible outcomes"⁶⁴ than would result from federal court litigation. Nevertheless, Congress recognized that administrative justice sometimes demands more formality, accountability, and openness.⁶⁵ Agencies were expected to develop guidelines for identifying those situations that would benefit from the standard processes of litigation as compared to ADR.⁶⁶ HHS has led the way in implementing ADR. The past ten years have welcomed a series of innovations that cut a path through the dense, troublesome issues outlined here.

2. Medicare's Growing Experience with ADR

a. Building In-House Capacity

HHS proceeded incrementally, acting through the Departmental Appeals Board (DAB).⁶⁷ Throughout the 1980s, the DAB earned a strong reputation for integrity and competence in handling a wide range of adjudications, especially

61. Administrative Dispute Resolution Act of 1990, Pub. L. No. 101-552, 104 Stat. 2736 (codified as amended at 5 U.S.C. §§ 571-583 (2000)).

62. See Administrative Dispute Resolution Act of 1990, Pub. L. No. 101-552 § 2(3), 104 Stat. 2736 (2000) (requiring agency employees presiding at hearings to inform the parties of available ADR forums).

63. See *id.* §§ 2(1)-(8), 104 Stat. at 2736 (noting the advantages of ADR over traditional litigation and Congress's wish to encourage ADR processes); see also 5 U.S.C. §§ 556(1)(7), 573(c) (mandating that the President appoint an interagency commission to encourage the use of ADR).

64. Administrative Dispute Resolution Act of 1990, Pub. L. No. 101-552 § 2(4), 104 Stat. 2736 (2000); 5 U.S.C. § 571 (2000).

65. 5 U.S.C. § 572(b) (2000) (listing contra-indicators, which are factors that should preclude ADR).

66. Administrative Dispute Resolution Act of 1990, Pub. L. 101-552, § 3, 104 Stat. 2736 (2000).

67. See Procedures of the Departmental Grant Appeals Board, 45 C.F.R. § 16 (2002) ("This part is designed to provide a fair, impartial, quick and flexible process for appeal from written final decisions.").

disputes over grants and medical research.⁶⁸ The real and perceived independence of the DAB, albeit located within the Office of the Secretary, served a vital role in assuring the fairness of ADR.⁶⁹ Namely, the public utilizing ADR services—and, arguably, the legislators overseeing agency activities—needed reassurance that settlements achieved behind closed doors deserve the same level of respect accorded judgments rendered in a public hearing room.⁷⁰

In August 1992, Secretary Louis Sullivan appointed John Settle of the DAB as Dispute Resolution Specialist for all of HHS, pursuant to the Executive Order No. 12,778 on Civil Justice, the Administrative Dispute Resolution Act, and the Negotiated Rulemaking Act.⁷¹ All major components of HHS designated senior officials to serve as liaisons to the Dispute Resolution Specialist.⁷² In October 1992, HHS published an interim policy on ADR within the Department which sought to rationalize current and proposed pilot projects on ADR, while not stifling innovations.⁷³ The interim policy explained that this gigantic agency, with 118,000 employees located nationwide, has "many differing functions . . . [and] wide variation in opportunities and experience in ADR."⁷⁴ The interim policy expressly embraced flexibility, which would allow "a practical adaptation of mechanisms to program needs."⁷⁵

Earlier in 1992, the Department had put in place an Early Complaint Resolution Process to resolve employment disputes among its own staff.⁷⁶ HHS began a "series of initiatives" to evaluate the effectiveness of ADR in the labor-management arena.⁷⁷ These initiatives included mediation and negotiation of grievances, unfair labor practices, and labor-management

68. See 45 C.F.R. § 16.18 (2002). A positive description of DAB's ADR work is contained in Daniel Marcus & Jeffrey M. Senger, *ADR and the Federal Government: Not Such Strange Bedfellows After All*, 66 Mo. L. REV. 709, 720-21 (2001).

69. See Bernard, *Empowering the Provider*, *supra* note 34, at 342 (noting the perception of the DAB as an independent arbiter of disputes even though it is part of HHS).

70. See *id.* at 289-95 (discussing in more detail concerns about HCFA control over PRRB decision-making); *id.* at 341-43 (discussing in more detail DAB's potential role as an independent arbiter in PRRB disputes because of its public legitimacy).

71. Use of Alternative Dispute Resolution, 57 Fed. Reg. 48,616 (Oct. 27, 1992) (notice of interim policy).

72. *Id.*

73. See *id.* (describing the goals of the interim ADR policy and stressing the "results oriented approach" HHS was seeking).

74. *Id.*

75. *Id.*

76. *Id.* at 48,616-17.

77. See *id.* at 48,617 (observing that HHS had an experimental labor ADR program in place and was preparing to examine it "using cooperative techniques").

relations.⁷⁸ Additional in-house ADR applications included using the "Total Quality Management" program within the Department to expand internal ADR initiatives, and the development of an internal ombudsman position for Social Security Administration personnel.⁷⁹

b. Mediation and Medical Services

Some observers have posited that negotiation and mediation should fit readily into the language of health care professionals because the transactions of daily work involve so much give-and-take.⁸⁰ Whether the issue is developing medical treatment plans,⁸¹ communicating those directives to all patient care staff,⁸² or negotiating rates of payment with payors,⁸³ ADR methods steer health care operations.⁸⁴ If this thesis is correct, then it helps illuminate the relatively rapid expansion of mediation at HHS. From the 1992 listing of a "potential pilot project in the exploratory stage, to use ADR in disputes before the Provider Reimbursement Review Board in the Health Care Financing Administration,"⁸⁵ to implementation, took only six years.⁸⁶

Another series of notices came during this period, erecting a regulatory framework for rapid resolution of disputes among patients, providers, physicians, and managed care organizations over denials or terminations of treatment.⁸⁷ These procedural changes sought to ameliorate the overwhelming

78. *See id.* (discussing a number of ongoing and proposed ADR efforts within HHS).

79. *Id.*

80. *See generally* LEONARD J. MARCUS ET AL., *RENEGOTIATING HEALTH CARE: RESOLVING CONFLICT TO BUILD COLLABORATION* (1995).

81. *See id.* at 207 (placing the nurse at the center of this process, where negotiating is seen as "their primary means of surviving on the job").

82. The authors urge that information exchange among a variety of health care professionals rests at the heart of the medical enterprise and that the outcome of care depends upon the quality of those communications. *See id.* at 48 (noting that patient care is a collaborative effort that requires effective communication channels).

83. *See id.* at 196–197 (discussing the role of senior managers in conducting negotiations with insurance companies over payment contracts).

84. Marcus's work offers the perspective of a composite health care administrator: "Health reform demands that everyone in the system adjust to a new set of realities. If this change process is to work, that adjustment must be part of an informed and collaborative process." *Id.* at 191.

85. Use of Alternative Dispute Resolution, 57 Fed. Reg. 48,616, 48,617 (Oct. 27, 1992) (notice of interim policy).

86. *See* Scully-Hayes, *supra* note 36, at 359–60 (noting that the Office of Hearings began its pilot mediation project in 1998 with forty-eight cases).

87. *See* Establishment of an Expedited Review Process for Medicare Beneficiaries

and unfair pressures of time-sensitive decision-making outlined in the previous section of this Article.⁸⁸ The cited issues of power dynamics, unequal resources, and the exigencies of time pressures coalesced in 1993 in the form of a federal class action, *Grijalva v. Shalala*.⁸⁹

In *Grijalva*, Medicare beneficiaries enrolled in risk-based managed care organizations sued to assure that their rights be heard concerning quality of care complaints, medical treatment decisions, and adequacy of information.⁹⁰ Four years later, Congress enacted the Balanced Budget Act of 1997,⁹¹ which included in Section 4001 a new Subpart C of the Medicare Program known as the "Medicare+Choice Program" (M+C) embracing managed care plans.⁹² This new statutory mandate required M+C organizations to provide "meaningful procedures for hearing and resolving grievances between the organization . . . and enrollees"⁹³

In December 2000, the United States District Court for the District of Arizona approved the settlement agreement negotiated to resolve *Grijalva* and to implement the mandates of the Balanced Budget Act.⁹⁴ As the Department described in the preamble to its final rule: "A key element of the agreement was that CMS would propose to establish an independent review entity [IRE] to conduct fast-track reviews of appeals of decisions to terminate services."⁹⁵

Enrolled in Health Maintenance Organizations, Competitive Medical Plans, and Health Care Prepayment Plans, 62 Fed. Reg. 23,368 (Apr. 30, 1997) (final rule with comment period) (to be codified at 42 C.F.R.) (publishing the appeal and grievance rights for Medicare beneficiaries enrolled in various medical plans). HCFA and CMS used the NAIC model grievance act as a guide, but did not expressly set forth the ADR procedures established after *Grijalva v. Shalala*, 946 F. Supp. 747 (D. Ariz. 1996). Changes to the grievance procedures based on program experience and feedback from M+C organizations were published as a proposed rule at Modifications to Managed Care Rules, 67 Fed. Reg. 65,672, 65,685 (Oct. 25, 2002) (to be codified at 42 C.F.R. pts. 409, 417 and 422).

88. See *supra* Part II.A.1 (outlining time pressures).

89. *Grijalva v. Shalala*, 946 F. Supp. 747 (D. Ariz. 1996).

90. See *id.* at 749 (observing that the class action plaintiffs sued to force HHS "to implement and enforce effective notice, hearing, and appeals procedures for HMO service denials").

91. Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251 (codified as amended in scattered sections of U.S.C.).

92. *Id.* at § 4001, 111 Stat. at 276 (codified as amended at 42 U.S.C. § 1395w-21 to § 1395w-28 (2000)).

93. 42 U.S.C. § 1395w-22(f) (2000).

94. Improvements to the Medicare+Choice Appeal and Grievance Procedure, 8 Fed. Reg. 16,652 (Apr. 4, 2003) (final rule with comment period) (to be codified at 42 C.F.R. pts. 422 and 489).

95. "Under the proposed process, M+C enrollees would receive detailed written notices concerning their service terminations and their appeal rights at least four days before a service

Beneficiaries having a grievance—any other complaint about service—would have a different track.⁹⁶ Grievances would go through ADR, with an emphasis on negotiation, conciliation, and mediation.⁹⁷

Beneficiary advocacy groups primarily had demanded that CMS assure safeguards would protect neutrality in the ADR intervention.⁹⁸ Therefore, CMS designated a neutral party for disputes concerning termination of services by an MCO.⁹⁹ In this Article's proposal, the use of a trained third-party neutral mitigates deeply embedded concerns about perceived conflicts of interest and severe imbalances of power.

This Article now looks more deeply into the dynamics of ADR within Medicare services. Specifically, whether the patient can find justice in forced collaboration with the provider institution, physician, and Medicare program—all of which still hold vastly superior power.

III. Deconstructing the 800-Pound Gorilla

A. A Suitable Metaphor?

The 800-pound gorilla is a metaphor for a severe imbalance of power. This iconic reference in contemporary society connotes a struggle: either a potential adversarial relationship or one that has already manifested. Does the metaphor truly fit mediation between the patient and provider concerning Medicare services? Perhaps another contemporary insight deserves consideration: Is there something broken that actually needs fixing? It seems difficult to obtain a clear, unequivocal picture of beneficiary (namely, the voting taxpayer) perceptions of Medicare. Are they satisfied with the services received? Dissatisfied? In what proportions? To what degree? In which service venues? And satisfied or dissatisfied compared to what alternatives?

termination." *Id.* at 16,652–16,653. The designated IRE for CMS is the Center for Health Care Conflict Resolution.

96. *See id.* (explaining that "[a]ll other disputes are subject to the grievance requirements under section 1862(f) of the Act").

97. *See* Improvements to the Medicare+Choice Appeal and Grievance Procedure, 66 Fed. Reg. 7,593, 7,594 (Jan. 24, 2001) (notice of proposed rulemaking) (noting that grievance procedures outside of fast-track review would be subject to standard procedures, including ADR).

98. *See id.* (explaining that the federal class action was brought to preserve the rights of enrollees when challenges to changes in their coverage were filed).

99. *See id.* (noting that the IRE "would be independent of any managed care organization, or company affiliated within a managed care organization").

Impressions range widely. CMS tracked the volume of cases in its appeals processes and concluded that Medicare customer satisfaction in managed care ranked on par with that of private payor MCOs.¹⁰⁰ Some critics may not consider this a ringing endorsement. Both the popular and scholarly press are filled with assessments that consumers are dissatisfied with private payor MCOs as well.¹⁰¹ Still, it could be that just as doomsday reports of Medicare's fiscal woes could be overblown,¹⁰² so might apprehensions concerning the impact of managed care on the doctor-patient relationship.

Part III of this Article approaches the use of ADR in Medicare managed care as a proposed remedy to a specific systemic dysfunction. Deconstructing

100. CMS estimates that with approximately 11.8 million Medicare beneficiaries being discharged from hospitals each year, approximately 1.8 million are M+C enrollees. Of these, CMS further estimates that only 0.1% to 0.2% (1,800 to 3,600) cases will be disputed. As CMS reported in its recent rule publication, approximately 75% of MCOs reversed their initially adverse determinations after appeal. CMS derived this figure from a General Accounting Office 1999 Report to the Special Committee on Aging, "Greater Oversight Needed to Protect Beneficiaries' Rights." Improvements to the Medicare+Choice Appeal and Grievance Procedures, 68 Fed. Reg. 16,652, 16,664 (Apr. 4, 2003) (final rule with comment period) (to be codified at 42 C.F.R. pts. 422 and 489).

Professor Eleanor Kinney reviewed federal reports on Medicare grievance and appeals procedures and found that there may be underreporting of "consumer concerns about coverage denials, given that few coverage denials actually proceed to appealed lawsuits or even reconsiderations." Eleanor D. Kinney, *Tapping and Resolving Consumer Concerns About Health Care*, 26 AM. J.L. & MED. 335, 346 (2000).

101. There is clearly also some dissatisfaction with Medicare HMOs for reasons that could be addressed in part through the proposal presented in this paper. High voluntary disenrollment rates from HMOs need to be taken seriously. As presented by the GAO, "[a] 1992 study reported that 48 percent of disenrollees from Medicare HMOs cited dissatisfaction as their reason for leaving, [and] 23 percent cited a misunderstanding of HMO services or procedures . . ." U.S. GEN. ACCOUNTING OFFICE, GAO/HEHS 98-142, MEDICARE: MANY HMOs EXPERIENCE HIGH RATES OF BENEFICIARY DISENROLLMENT, REPORT TO THE SPECIAL COMMITTEE ON AGING, U.S. SENATE 3-4 (1998). Of the 194 HMOs with Medicare risk contracts in 1996-1997, covering at least 250 members for seven months, forty-one plans, or one-fifth, had disenrollment rates of 20% or more. One Florida plan's rate was 71% of its annual membership. *Id.* at 4.

Special concern exists over the quality, appropriateness and consumer satisfaction with long-term care services. See generally U.S. GEN. ACCOUNTING OFFICE, GAO/HEHS-95-109 LONG-TERM CARE: CURRENT ISSUES AND FUTURE DIRECTIONS, REPORT TO THE CHAIRMAN, SPECIAL COMMITTEE ON AGING, U.S. SENATE (1998) (providing an overview of the debate from various perspectives, including HHS). See also U.S. GEN. ACCOUNTING OFFICE, GAO/T-HEHS-94-140, LONG-TERM CARE: DEMOGRAPHY, DOLLARS, AND DISSATISFACTION DRIVE REFORM (1994) (finding that despite billions of dollars spent, and despite high costs "disabled persons are increasingly dissatisfied with available services and their ability to obtain them").

102. See Theodore R. Marmor & Gary J. McKissick, *Medicare's Future: Fact, Fiction and Folly*, 26 AM. J.L. & MED. 225, 246 (2000) (noting that forecasts of the financial state of Medicare are "all too often fear-mongering . . . [that] distorts one's understanding of Medicare's current problems . . .").

the power relationships inherent in mediations among a patient, the patient's family, the medical care team, and the Medicare program as payor is not meant, in and of itself, to imply that there has been bad practice in handling such matters. Rather, this analysis merely searches for principles to shape ideas about future best practices. As such, this Part is presented in the spirit and tradition of continual quality improvement, attempting to further program efforts to make Medicare appropriately innovative and responsive.

B. The Standard Paradigms of Power

1. Power Balance and Mediation

Most people would look at the Medicare program—with its vast powers of financial and legal coercion—and see overwhelming power over a provider of services and over a beneficiary of services. In the view of most program participants, what Medicare wants, Medicare gets. Providers comply with the Medicare decisions, if only because of the enforcement power of the federal government, the Office of the Inspector General, and the FBI. This includes the power to impose criminal sanctions. If only for ease of administration, services for other patients, which are covered by other payors, often are structured to be compatible with Medicare's requirements.

Under these circumstances, how can one assert that there is a balance of power sufficient to recommend mediation between the payor and provider concerning a dispute in payment or coverage? Mediation can work when the providers are sophisticated, institutional entities with legal representation present at the negotiations, principles of law are not central to resolving the dispute, perceptions of facts are more important than the law, and personal credibility and trustworthiness are essential to the use of a flexible approach in resolving the dispute. With these factors in place, mediation of Part A disputes has proved successful at the Provider Reimbursement Review Board.¹⁰³ But can it work when the mediation involves the beneficiary?

Mediation is ideal for the "people problems" that present themselves disguised as "legal problems." Thus, it can work well or is appropriate when:

103. A discussion of potential changes to the Medicare review process, developed in focus groups of providers and provider representatives and in consultations with government stakeholders, is found in Bernard, *Empowering the Provider*, *supra* note 34, at 334–42. See the favorable review of the pilot project by a health law attorney representing providers in Thomas H. Brock, *PRRB Mediation Pilot Program Expedites Payment Dispute Resolution*, HEALTHCARE FIN. MGMT. Mar. 1, 1999 at 52.

- The parties are not in a gross imbalance of power, such that any agreement could not be considered the product of freely exercised will.¹⁰⁴
- There is a prior, existing, or continuing relationship between the parties; or, if there is no prior or likely future relationship, the parties desire a good reputation in the community.¹⁰⁵
- There are few legal issues at stake and no precedent that needs to be enunciated.¹⁰⁶
- All persons necessary to effect and hold to a successful resolution are present at the table.¹⁰⁷

104. A classic such situation was presented in *Olam v. Congress Mortgage Co.*, 68 F. Supp. 2d 1110 (N.D. Cal. 1999), in which an older woman of infirm health, operating under great emotional stress, entered into a mediated agreement with a mortgage company that worked seriously to her disadvantage. *Id.* at 1114. Because mediations occur in private, parties are usually without a written record of the proceedings. Moreover, because disadvantaged parties by definition will not likely have the resources to pursue a vigorous appeal of a coerced agreement, proportionally few cases have reached the courts. Some scholars, following the lead of Professor Fiss, have examined the issue, including Andre R. Imbrogno, *Using ADR to Address Issues of Public Concern: Can ADR Become an Instrument for Social Oppression?*, 14 OHIO ST. J. ON DISP. RESOL. 855 (1999). Within that article, Imbrogno discusses domestic violence as an example of "issues of general societal concern, involving historically disadvantaged groups, that courts should be reluctant to channel into ADR." *Id.* at 878.

105. The relationship of the parties—indeed, that there is a relationship—embodies the intangible but essential element of trust without which mediation cannot work. One contributor to a symposium on whether environmental ADR is working in America cited this as an area needing serious attention: "ADR not only depends on trust but is itself probably a contributor to increasing or decreasing trust." J. Clarence Davies, *Environmental ADR and Public Participation*, 34 VAL. U.L. REV. 389, 400 (2000). Congress has articulated a concern for building trust through ADR. To create a more user (taxpayer) friendly system with a greater "likelihood of achieving consensual resolution of disputes." Alternative Dispute Resolution Act of 1990, Pub. L. No. 101-552, § 2(2), 104 Stat. 2736 (2000).

106. If the law is essential to justice in a case, then ADR is probably not appropriate. This accords with ADRA, 5 U.S.C. § 572(b)(1)–(3), (5) (2000) (expressing a policy of adapting formal procedures when precedent on procedural transparency is highly valued). Consider the analysis in Richard C. Reuben, *Public Justice: Toward a State Action Theory of Alternative Dispute Resolution*, 85 CAL. L. REV. 577 (1997), noting that the "law does not provide a basis for substantive review of [ADR] results." *Id.* at 639.

107. *G. Heileman Brewing Co. v. Joseph Oat Corp.*, 871 F.2d 648 (7th Cir. 1989) is probably the best-known case on the issue of compelling attendance by stakeholders with settlement authority. In a mediation styled to include the clients in active, problem-solving roles, personal attendance may merit a court order. On the other hand, where mediation is conducted as a settlement conference between the attorneys, the personal input by the clients matters less. See Leonard L. Riskin, *The Represented Client in a Settlement Conference: The Lessons of G. Heileman Brewing Co. v. Joseph Oat Corp.*, 69 WASH. U. L.Q. 1059, 1115 (1991) (noting the importance of encouraging party participation in mediation meant to "facilitate and

- All participants have available to them whatever is required to make informed choices.¹⁰⁸
- The mediation participants are ready and able to speak for themselves, even if they must be assisted by persons the participants have designated in advance.¹⁰⁹
- A pragmatic resolution will be acceptable, even if it does not follow the technicalities of the law.¹¹⁰
- The parties will voluntarily comply with the resolution.¹¹¹

When Medicare mediations are framed in this light, one questions the basic premise entirely. Is mediation of such issues appropriate at all when the parties are not sophisticated institutional providers of care, but instead are unsophisticated, typically unrepresented lay persons confronted by a denial of care, reduction in treatment, refusal of coverage, or an experience of disrespect or discord in the provision of medical care?

2. Power Imbalance and Medical Treatment

Some researchers studying the dynamics of conflicts concerning medical practice have described the psychological context of these conflicts in ways that

educate"). Separately, ADRA recommends against ADR in government cases significantly affecting the rights and interests of persons or organizations who are not parties to the proceeding. 5 U.S.C. § 572(b)(4) (2000).

108. See *supra* Part II.B.1 (discussing information available to the parties).

109. ADRA charges agencies with the responsibility to identify cases "so complex or specialized" that parties need attorney representation or assistance. Alternative Dispute Resolution Act of 1990, Pub. L. No. 101-552, § 9(a)(2), 104 Stat. 2746, 2747 (2000). It also generally allows for party assistance in ADR, although not requiring those person to be lawyers. *Id.* at § 9, 104 Stat. at 2747.

110. This is the corollary of 5 U.S.C. § 572(b)(3) (2000) (instructing agencies to forego ADR where "maintaining established policies is of special importance . . .").

111. Otherwise, the agency's continuing jurisdiction would be required under ADRA, 5 U.S.C. § 572(b)(6) (2000) (noting that ADR is inappropriate if the agency would have to monitor the implementation of the agreement). The case would therefore not be appropriate for ADR. Courts have taken a variety of stances concerning the enforceability of a mediated agreement when a party attempts to repudiate it. Although voluntariness and self-determination theoretically play a vital role in mediation, courts do not always honor their exercise. An excellent case review on this topic is found in James J. Alfani & Catherine G. McCabe, *Mediating in the Shadow of the Courts: A Survey of the Emerging Case Law*, 54 ARK. L. REV. 171, 195-205 (2001) (discussing the practical reasons why courts have refused to enforce mediated agreements).

we should consider with regard to coverage issues.¹¹² Although the system may see this as a payor-payee or provider-beneficiary matter, for the individual caught in the midst of it all, this is about a doctor-patient relationship that has gone sour.¹¹³ It is about trust that either has been broken or had not been forged from the beginning.¹¹⁴

To understand the dynamics of the conflicts mediation seeks to resolve or prevent, we must return to the generating circumstances. We must understand the interrelationships of the stakeholders to understand the possibilities for settlement beginning with the mind-set of the patient-beneficiary.

Clearly, when a person is ill enough to go to a doctor, he is experiencing some level of physical discomfort. This physical issue also has psychological and emotional dimensions, even if it is not what society would categorize as a psychosomatic disorder. As one registered nurse and conflict resolution specialist astutely described,¹¹⁵ the patient typically enters the relationship with a diminished self-image.¹¹⁶ This is accompanied by a feeling that he is losing control over his life,¹¹⁷ which may be a reality. Hence, the patient experiences

112. See Chris Currie, *Mediation and Medical Practice Disputes*, 15 *MEDIATION Q.* 215, 217 (1998) (describing the mental state of a patient when seeking medical care).

113. See *id.* (noting that a patient approaches a doctor with preconceived notions of trust that can be destroyed if the doctor gives improper or incomplete care).

114. Trust has been even harder to form and maintain under managed care systems. See Eugene C. Grochowski, *Ethical Issues in Managed Care: Can the Traditional Physician-Patient Relationship Be Preserved in the Era of Managed Care, or Should it Be Replaced by a Group Ethic?*, 32 *U. MICH. J.L. REFORM.* 619, 636 (1999) (arguing vigorously that the physician has an affirmative "duty to create an atmosphere that will foster a trusting relationship"). Dr. Grochowski offers an example of how trust affects services, explaining that trust "is therapeutic (perhaps through a placebo effect)" and it relieves "anxiety." *Id.* A forty-year old man whose brother died of a myocardial infarction visits his physician, demanding an expensive cardiac stress test. *Id.* However, "what he really wants is to be reassured that he is healthy." *Id.* After a series of less costly examinations, tests, laboratory procedures, and acid-inhibiting medication, the physician determines that the man shows no troubling symptoms, despite his family history. *Id.* Grochowski goes on to conclude:

If the physician and patient have a trusting relationship, then the patient will likely accept the reassurance from his physician and drop his request for an exercise stress test. However, if the patient perceives that the physician is a gatekeeper who achieves a secondary financial gain through not recommending the expensive exercise stress test, the patient may not be convinced that the exercise stress test is unnecessary.

Id. at 636-37.

115. Currie, *supra* note 112, at 217.

116. *Id.*

117. See *id.* (describing the perception a patient maintains of his personal mental state when seeking a physician).

"considerable anxiety and insecurity."¹¹⁸ These stresses may reveal themselves in a heightened desperation to believe the "myth that Western medicine is infallible,"¹¹⁹ such that anything short of a complete cure violates trust.¹²⁰ Lack of a perfect outcome therefore equals betrayal.

The physician also experiences the therapeutic relationship at a psychological and emotional level.¹²¹ When confronted with the complaint, grievance, or general displeasure of a patient, his attitude evidences defensiveness.¹²² The patient's disapproval threatens the physician's self-image as a healer.¹²³ The sense that his work has not been appreciated feeds an underlying anger, which may or may not be expressed.¹²⁴ Undeniably, the doctor becomes increasingly tense.¹²⁵ There is much resentment over the "significant amounts of time taken from their practice to respond to what they believe are frivolous claims."¹²⁶ And, finally, there is frustration and bewilderment, as he sincerely believes he has met his promises to his patients.¹²⁷

It would be appropriate to extend the psychological and emotional context of the physician to include the psychological and emotional context of the provider organization. Although some do not believe that organizations have a psyche or emotions, the expansion should include the MCO's representatives.

C. Toward a Paradigm of Empowerment More Than Power Balance

1. Power Goals Require Power Balance

When the goal of the mediation is to win, power begins, sustains, and ends the analysis. What does winning entail? In regard to Medicare services, a

118. *Id.*

119. *Id.*

120. *See id.* (noting that a patient perceives a lack of a total cure to be a violation of the doctor's duty).

121. *See id.* (observing that a physician enters a relationship with a patient with pre-existing attitudes and beliefs).

122. *See id.* (arguing that a patient's complaint can cause the doctor to suffer tension).

123. *See id.* (relating the physician's self-perceived role as an authority on medical issues).

124. *See id.* (describing the sense of annoyance physicians feel when faced with patient complaints).

125. *See id.* (analyzing the physician's animosity to patient claims).

126. *Id.*

127. *See id.* (observing that a physician generally posits that a patient was given the most effective cure possible).

"win" for a patient might mean achieving authorization for, and payment of, services which had been denied. Or the physician might have "won" when the IRE or CMS has confirmed her medical judgment. Even ostensibly fiscal disputes carry an emotional content. For example, a determination in favor of coverage relieves beneficiaries of financial burdens that have been weighing on them and their credit history. A favorable monetary outcome, therefore, improves the overall situation for the patient, the provider, and the physician. Yet all participants probably have nonmonetary issues that cannot be addressed through the processes of administrative or civil litigation.

In disputes better described as "people problems" as opposed to "legal problems," the proper goals of mediation shift. The need to win recedes and is replaced by a need to understand. When this occurs, a facilitative model of mediation, designed to make communication between participants clearer and more meaningful, can restore relationships to support the therapeutic mission.

Power matters most in cases in which the objective is for one party simply to compel the other party to do its will, or in which a party effects its will by exerting whatever nonviolent force is available. Under such circumstances, the critiques launched by ADR theorists are justified. The ADR theorists have cast serious doubt upon the widespread practice of mandatory referral to mediation for civil cases that suffer from severe imbalances of power. Examples of such imbalances include:

- the unrepresented tenant with only a marginal education and no other housing options versus the landlord, and¹²⁸

128. This is the prototypical case from small claims courts nationwide, in which "parties unwittingly forfeit their legal protections and acquiesce to the demands of the powerful." Joel Kurtzberg & Jamie Henikoff, *Freeing the Parties from the Law: Designing an Interest and Rights Focused Model of Landlord/Tenant Mediation*, 1997 J. DISP. RESOL. 53, 54 (1997). The authors, although critiquing this position, note that the traditional view argues that tenants "leave a mediation feeling satisfied . . . only because they are unaware of what they have conceded." *Id.* The director of clinical programs at New England School of Law has closely examined the housing courts, small claims courts, and bankruptcy matters handled through mediation in Boston. Russell Engler, *And Justice For All—Including the Unrepresented Poor: Revisiting the Roles of the Judges, Mediators and Clerks*, 67 FORDHAM L. REV. 1987 (1999). He urges "a fundamental re-examination . . . of the roles of judges, mediators, and clerks in cases involving unrepresented litigants." *Id.* at 1988. He contends that our rules barring assistance by mediators or clerks stem from a false assumption that people willingly choose to appear in court without counsel. *See id.* (noting that the unrepresented plaintiff is considered an aberration. As a result, he argues that some degree of guidance or legal advice is essential to ensure a represented or otherwise legally sophisticated party does not take "unfair advantage over the unrepresented party." *Id.* at 2033.

- the divorcing, unrepresented, formerly stay-at-home-wife and mother versus the savvy businessman-husband and father.¹²⁹

But these critiques turn on a delicate axis that often goes unexamined. Were these cases in which the only meaningful outcome was monetary? Or, were these cases with relational factors that mattered equally, or even more than money? Were there mechanisms in place to channel the primarily monetary issues to a more adjudicatory setting for an impartial third party to review and decide while face-to-face mediation dealt with the relational (people) problems? Did the party with substantially less power have access and time to obtain the information needed to make knowing and voluntary decisions? Particularly, did the party with less power have an advocate to assist in clarifying communications, protecting against coercive tactics, and lending emotional support? The mediation diversions theorists criticize do not deal appropriately with these issues of system design. What is proposed in Part IV of this Article properly considers these concerns.

2. Relational Goals Require Empowerment

During the past twenty years, lawyers have come to recognize the potential value of restoring harmony to relationships. The very words sound antithetical to the role of the barrister-litigator; indeed they might be. On the other hand, settlements reached in negotiation or mediation resolve most legal work in America, including civil litigation. Presumably "hard-nosed" corporations, insurers, and their legal counsel have grown to appreciate the dollar value of listening and tendering an apology.¹³⁰ In the health care industry, studies have shown that an overwhelming majority of medical malpractice claimants file suit

129. This case is a composite of the central paradigm attacked as inappropriate for mediation in several pioneering works. See Trina Grillo, *The Mediation Alternative: Process Dangers for Women*, 100 YALE L.J. 1545 (1991) (arguing that mediation does not embrace a woman's relational position and life experiences); Penelope E. Bryan, *Killing Us Softly: Divorce Mediation and the Politics of Power*, 40 BUFF. L. REV. 441 (1992) (discussing mediation's tendency to place women in inferior bargaining positions, thereby disempowering them). The answer may be found in Penelope E. Bryan, *Reclaiming Professionalism: The Lawyer's Role in Divorce Mediation*, 28 FAM. L.Q. 177 (1994) (arguing that lawyers should participate actively in negotiated settlement conferences or mediation on behalf of their clients in order to rebalance power and protect their client's interests in ways the mediator ethically cannot); Craig A. McEwen et al., *Bring in the Lawyers: Challenging the Dominant Approaches to Ensuring Fairness in Divorce Mediation*, 79 MINN. L. REV. 1317 (1995) (same).

130. A broader discussion of this insight is found in John Lande, *Failing Faith in Litigation? A Survey of Business Lawyers' and Executives' Opinions*, 3 HARV. NEGOT. L. REV. 1 (1998) (discussing survey results indicating that executives and in-house counsel are looking more favorably on ADR as compared to litigation).

not for a monetary remedy but instead as leverage to obtain a relational remedy.¹³¹ They want respect, an explanation for what happened, an apology, and an assurance it will not happen again to someone else.¹³²

Chris Currie offered a useful description of the relational goals a patient seeks when he files a complaint or grievance against his managed care organization or physician.¹³³ The patient wants:

- answers to questions he feels the physician or provider institution, or both, have not been willing to answer honestly;
- recognition from the physician or provider institution, or both, that his condition is serious and his condition has long-term, life-changing consequences;
- to vent his anger over a poor doctor-patient or MCO-enrollee relationship in which he felt ignored, neglected, or mistreated; and
- to hold the physician or the MCO, or both, accountable in order to prevent the same situation from recurring with another patient.¹³⁴

The goals described above embody what a transformative approach to mediation describes as "empowerment."¹³⁵ As defined by Robert Baruch Bush and Joseph D. Folger, the founders of this approach to conflict resolution, empowerment with regard to goals occurs "when a party reaches a clearer realization, compared to before, of what matters to her and why, together with a realization that it's important and deserves consideration."¹³⁶ The transformative model frames party power in personal terms, as a matter of personal (not necessarily material) power.¹³⁷ This can manifest in the ability of

131. As a medical reviewer summarized: "[P]oor physician communication is the most important factor influencing a patient to file a lawsuit against his physician." Zeev E. Neuwirth, *Physician Empathy—Should We Care?*, 350 *THE LANCET* 606, 606 (1997).

132. See Currie, *supra* note 112, at 217–18 (discussing the result a patient hopes to attain through mediation); see also Scott Forehand, *Helping the Medicine Go Down: How a Spoonful of Mediation Can Alleviate the Problems of Medical Malpractice Litigation*, 14 *OHIO ST. J. ON DISP. RESOL.* 907, 922–25 (1999) (documenting two empirical studies that indicate that mediation can be an effective forum for resolution of medical disputes).

133. See Currie, *supra* note 112, at 217–18 (noting the four personal elements a patient seeks in a solution to a medical claim).

134. See *id.* (describing the needs of parties).

135. ROBERT A. BARUCH BUSH & JOSEPH D. FOLGER, *THE PROMISE OF MEDIATION: RESPONDING TO CONFLICT THROUGH EMPOWERMENT AND RECOGNITION* 87 (1994) (describing, among other things, elements necessary for empowerment of participants in ADR).

136. *Id.* at 96.

137. See *id.* at 87 (describing empowerment as a personal conception related to an

parties "to clarify their views—to know what they want and do not want, to stand up for those views, [and] what resources they have to address the situation"¹³⁸ Given this subjective, self-referencing understanding of power, Bush and Folger posit that no one is wholly without power.¹³⁹ Everyone has the potential to acknowledge and exercise his or her own personal power in a mediation.¹⁴⁰ Indeed, this becomes one of the most important aspects of a mediation.¹⁴¹

A transformative mediation "succeeds" when there is empowerment.¹⁴² This occurs when "a party experiences a greater sense of self-worth, security, self-determination, and autonomy."¹⁴³ Clearly, the transformative model overlays well with the concept of mediation to heal a troubled doctor-patient relationship. However, one must ask whether these goals are sufficient when the patient or beneficiary confronts institutional power.

3. *Sharing Power Between the Physician and Patient*

It is important that any system for ADR present opportunities for party empowerment. But it is equally important that the parties be fully informed and make knowledgeable choices in the exercise of their autonomy. The physician can serve as the single most valuable information resource for the patient. The challenge is designing reliable, replicable methods to facilitate that sharing of information and power in a nonthreatening way that is sensitive to emotional cues. Some physicians, most notably Dr. Howard Brody, have engaged in courageous self-examination useful to our analysis.

We begin here not with Brody's initial, foundational premises (which form the basis of Part IV), but with his discussion of the patient's sense of powerlessness that often accompanies illness.¹⁴⁴ Brody sees this as a critical element in the therapeutic relationship to which the physician must respond.¹⁴⁵

individual's emotional development).

138. *Id.* at 198.

139. "[E]mpowerment is an objective that can be achieved in *all* cases" *Id.* at 94.

140. "If a party has taken the opportunity to collect herself, examine options, deliberate, and decide on a course of action, empowerment has occurred, regardless of the outcome." *Id.* at 87.

141. *See id.* (noting that empowerment should be a goal in mediation regardless of the outcome of the process).

142. *See id.* at 89 (discussing the features of successful ADR within the empowerment process).

143. *Id.*

144. *See* HOWARD BRODY, *THE HEALER'S POWER* 64 n.11 (1992) (noting that a physician

The first step the healer can take toward empowering the patient is to share knowledge.¹⁴⁶ The physician has a near-monopoly over medical skills and knowledge that can be used unilaterally (in an abuse of power) or bilaterally (in a sharing of power).¹⁴⁷ The patient may express preferences concerning how much he cares to know, thus limiting the scope of information revealed.¹⁴⁸ Brody suggests that the general rule, however, should be to err on the side of more rather than less education about the "nature of the disease and the treatment."¹⁴⁹

An expanded scope of information-sharing includes discussing specific psychological aspects of the illness. Sharing power includes identifying those issues with the patient, and then collaborating on the management and treatment plan, just as would happen with technical aspects of healing.

One of the continuing psychological dynamics will be the patient's sense of loss of control. Whether as a placebo effect or not, Brody perceives the patient's personal power as essential for treatment.¹⁵⁰ Thus, from time to time, the physician (or medical team) will need to remind the patient "explicitly" that the patient still possesses power, which could be realized by accessing additional social or human resources.¹⁵¹

Finally, because society has invested the physician with greater social power compared to the patient, especially in a controlled, managed care setting, additional, explicit reassurances may be necessary. The patient needs to know that the physician is using all these social powers and skills solely to secure "a positive therapeutic outcome" for the patient.¹⁵²

often forgets that a patient retains some power while seriously ill).

145. *See id.* at 64–65 (observing how power in the physician-patient relationship can be used ethically).

146. *See id.* at 65 ("The physician should try whenever practicable to share her Aesculapian power by informing the patient . . . about the nature of the disease and the treatment.").

147. Brody endorses shared power as a way to make the patient less vulnerable than when the physician "has a power monopoly." When power is shared, the physician is "less tempted to abuse his power." Secondly, the patient is more likely to "call [the physician] to account" and the physician is more likely to reflect on how he uses power before invoking it. *Id.* at 61.

148. *See id.* at 65 (observing that a physician should respect a patient's desire to know or not to know information about a disease).

149. *Id.*

150. *Id.*

151. *Id.*

152. *Id.* One must note, however, that a physician's actual power in a MCO typically falls far short of the fee-for-service setting, and perhaps short of the patient's perception of the physician's power. The OIG found many physicians reported concerns with Medicare HMOs, including dissatisfaction with the HMO referral process (42% of physicians in the study) and

Although it may be self-evident to the healer, it is not always so to the patient, especially in a managed care environment which has attenuated the doctor-patient link.¹⁵³ Indeed, if facilitated discussions between physician and patient achieve only this—a common recognition that both seek the same objectives—it may be sufficient. However, such credibility can likely only be achieved through the use of a highly trained third-party neutral person, with no perceived conflicts of interest.

D. The Empowerment Paradigm: Timing May Be Everything

The paradigm of empowerment described in this Part has the potential to deal adequately and fairly with relational and communication conflicts in medical treatment. Its real potential for quality improvement becomes evident when applying this approach before a specific grievance or complaint has manifested. The foundation of genuine power-sharing as Brody describes it is that the physician and patient would be in full accord concerning the patient's "life plan," "definition of the presenting problem," and what constitutes "excellence and quality in the practice of medicine."¹⁵⁴ The overarching goal, particularly in primary care, is for the physician-patient relationship to be "a primary therapeutic tool." This impressive goal could be realized through the mediation model discussed in Part IV.

restriction of clinical independence (62%), leading them to believe fee-for-service is better for access to specialists (72%) and for new treatments (69%). Physicians in this study also disliked how their internal HMO complaints were handled (40%). Interestingly, 29% thought referral restrictions for Medicare patients were worse than for all HMOs in general. U.S. DEPT. OF HEALTH AND HUMAN SERVICES, OFFICE OF THE INSPECTOR GENERAL, OEI-02-97-00070, PHYSICIAN PERSPECTIVES OF MEDICARE HMOs, at ii (1998).

153. This can be characterized, in part, as a fee-for-service versus managed care matter. Companion articles in the *Journal of the American Medical Association*, cited by Grochowski, present arguments that patients with the freedom to choose will actively seek out a physician whom they trust, and select their provider on the basis of trustworthiness. See Alan L. Hillman, *Mediators of Patient Trust*, 280 JAMA 1703, 1704 (1998) (presenting arguments that patients with the freedom to choose the method of physician payment will actively seek out a physician whom they trust, and select their provider on the basis of trustworthiness); Audrey C. Kao et al., *The Relationship Between Method of Physician Payment and Patient Trust*, 280 JAMA 1708, 1710 (1998) (same); see also Grochowski, *supra* note 114, at 629, 636 n.49 (citing the Hillman and Kao articles and concurring that such communication as part of the physician's duty to respect the patient's autonomy). "[V]eracity, confidentiality, and informed consent" lead to the logical outgrowth: "that patients should be treated as partners and that physicians and patients ought to share medical decision-making." *Id.* at 629.

154. BRODY, *supra* note 144, at 64.

IV. *The Mediated Medical Treatment Plan as a Model for Empowerment*

A. *Reconciling a False Dilemma*

Most Medicare beneficiaries can recall a time when they had a private physician who had treated them for at least a decade, probably longer. The physician knew the patient as more than a set of physiological disorders and quirks. Their knowledge of each other extended beyond the skewed, artificial setting of the examining room to a network of frequent social interactions in the larger community. In the days before case management, when health care was a profession not an industry, the doctor's visit centered on personal discussions about the patient's life plan, the patient's definition of the presenting problem, and how the physician could work with the patient to improve the latter in line with the former.

The above description fits a nostalgic world often unfamiliar to managed care settings.¹⁵⁵ Increasingly, the doctor-patient relationship is episodic. To the extent a patient finds continuity of care, that care vests in a multiperson medical team whom the patient has probably never met except on an "as needed" or "need to know" basis. There may or may not be a coherent plan for treatment. If one exists, the plan has a short horizon, going from crisis episode to crisis episode.¹⁵⁶ The plan is developed without substantial, direct input by the patient and the patient's key family members. The medical team may not have communicated the overall plan to the patient and the patient's family. If such communications did occur, because of the timing—a crisis or hospitalization—and the high stress of the medical event, the patient's comprehension probably suffered.

The result? Frustration of good will on all sides, communications which fail to connect, exacerbated insecurities, and, ultimately, the stage is set for a complaint, grievance or appeal when the patient's medical condition changes yet again. Managed care need not present a false dilemma of either having a

155. The American Medical Association's Council on Ethical and Judicial Affairs has recommended that physicians should "reorient themselves 'toward the importance of having effective discussions with patients about their preferences,'" so that the planning of end-of-life decisions is "much more tightly woven into the fabric of the physician-patient relationship than it has been previously." Kathy L. Cerminara, *Eliciting Patient Preferences in Today's Health Care System*, 4 PSYCH. PUB. POL. L. 688, 689-90 (Sept. 1998).

156. See Grochowski, *supra* note 114, at 621-22 (finding decisions about treatment coverage, and cost are made at the hospital bedside ("bedside rationing"), in a way "not compatible with patient centered duties").

well-rounded doctor-patient relationship or having available an array of sophisticated medical technology at affordable rates. They can go together.

1. The Donald W. Reynolds Department of Geriatric Medicine Model

The Donald W. Reynolds Department of Geriatric Medicine at the University of Oklahoma College of Medicine in Oklahoma City has demonstrated one way to join the two concepts. This innovative department brings together internists, family practitioners, nurse practitioners, nurses, clinical social workers, doctors of pharmacy, nutritionists, and psychologists to offer a full spectrum of patient services. For the frail elderly, physical and occupational therapists join the interdisciplinary team. The program focuses on wellness, emphasizing in its training of medical students and residents that old age is not a disease.¹⁵⁷ This basic assumption of patient competency and personal power undergirds and reinforces the guiding principle that the doctor-patient relationship should be, itself, "a primary therapeutic tool," as Brody described.

The initial patient visit consists not only of a full medical assessment, but also a self-assessment designed to convey the patient's life plan. How comfortably is the patient meeting the activities of daily living? Is it optimal? What would improvement look like from the patient's point of view? The department's comprehensive geriatric assessment seeks to understand the patient's perspective and also the views of the patient's family caregiver.

Often, a patient will have a family member or close friend who accompanies them on medical visits. This could be a spouse, adult child, or neighbor. Regardless of the relationship to the patient, this caregiver serves informally as the patient's assistant in decision-making. They may also play the behind-the-scenes role of assuring compliance with treatment decisions, such as obtaining prescriptions, taking medication on time, and interfacing with social service organizations. If the patient's level of competency has diminished, this

157. The University of Oklahoma's program is one of only five geriatrics departments in allopathic medical schools in the nation. Under the leadership of Dr. Marie A. Bernard, this department pioneered the teaching of geriatrics for all medical students with an emphasis on community-based elders. By partnering medical students with healthy, non-hospitalized elder "mentors," doctors-in-training learn by experience to understand the special abilities and challenges of this patient population. Data demonstrate that the program has had a major, positive impact on attitudes of medical students toward geriatric patients, compared to those whose only clinical experience with the elderly has been the acute, often catastrophic events necessitating hospitalization. See generally Marie A. Bernard et al., *An Evaluation of a Low-Intensity Intervention to Introduce Medical Students to Healthy Older People*, 51 J. AMER. GERIATRICS SOC. 419 (2003).

caregiver becomes his de facto advocate and representative, even without formal guardianship or medical power of attorney.

The department assigns an interdisciplinary team to each patient. This team develops a treatment plan that goes beyond technical medical services to address social and mental health needs. In close consultation with the patient and his caregiver, the department develops guidelines to handle anticipated emergency or other acute care requiring hospitalization. Wishes concerning long-term care options and personal preferences for financial and physical autonomy all contribute to the cycle of discussions.

2. *The Mediated Treatment Plan*

The Reynolds Department of Geriatric Medicine approach offers an excellent, already established and proven model to build upon. The suggested modification is to add trained comediators to the meetings between the patient, the patient's caregiver, and the interdisciplinary team as the treatment plan is reviewed and finalized. What purpose would mediators serve?

Even in a predispute setting, the participants may need expert facilitation to assure effective communication. Each stakeholder at the table brings an important and different viewpoint. The professional cultures from which they proceed differ, although they may overlap in synergistic ways. This is the strength of the multidisciplinary methodology, coupled with participation by the patient and the patient's family. This also presents a potentially serious barrier to successful communication. Add to this a much-needed diversity in demographics (age, ethnicity, gender, religious tradition, geographic region, class) and the odds increase that parties will talk past each other, never realizing they have not had a meeting of the minds.¹⁵⁸

In the comprehensive geriatric assessment (CGA), the patient completes a "values history." Among other things, this elucidates the patient's preferences concerning end-of-life options, antibiotics, transfusions, dialysis, respirators, feeding tubes, and other "potentially harmful diagnostic and therapeutic

158. The reader should note that the suggestions presented here do not stem from demonstrated, systemic problems to date. Rather, the proposed modifications attempt to take an approach that has already worked well and, in the spirit of continual quality improvement, make it even better. For purposes of this proposal, "better" means applying ADR at a time and in a manner likely to empower the patient and cement a positive relationship with the physician/medical team; rather than limiting the use of ADR to postgrievance or postcomplaint mediation where power imbalances argue against fairness and where ADR is unlikely to advance a therapeutic relationship.

interventions."¹⁵⁹ It is an important step forward in preserving patient dignity. Still, for most people, values discussions rank among the most hazardous. The values themselves may have gone unexamined for a long time. Confronting them, especially in the presence of and in participation with others, can feel threatening. The unsettling nature of "values talk"¹⁶⁰ implicates all participants, both the patient and health care professionals.¹⁶¹

When studying the process of group communication, authors have observed that sometimes civility, collegiality, and a general desire to please can result in less empowerment rather than more.¹⁶² The person who tends toward

159. AMERICAN GERIATRICS SOCIETY, COMPREHENSIVE GERIATRIC ASSESSMENT POSITION STATEMENT, at <http://www.americangeriatrics.org/products/positionpapers/cga.shtml> (last updated Jan. 1, 1993, currently under revision). The interdisciplinary approach routinely used by the Donald W. Reynolds Department of Geriatric Medicine implements the CGA endorsed by the American Geriatric Society as being "critical in providing appropriate health care." *Id.* The Position Statement notes that although the CGA is routine for older patients in long-term care facilities in Great Britain, its use in America is limited to some academic centers and Veterans Administration hospitals. *Id.*

160. See AMITAI ETZIONI, THE NEW GOLDEN RULE: COMMUNITY AND MORALITY IN A DEMOCRATIC SOCIETY 102–06 (1996) (adopting the term "values talk" in analyzing the process of moral dialogues).

161. See Nancy Neveloff Dubler, *Mediating Disputes in Managed Care: Resolving Conflicts over Covered Services*, 5 J. HEALTH CARE. L. & POL'Y 479, 479 n.*, 486–87 (2002) (offering a number of illustrative examples from the national study "Strengthening the Patient-Provider Relationship in a Changing Health Care Environment," funded by the Robert Wood Johnson Foundation). One study describes a conflict between the hospital neurologist, the primary care physician the MCO assigned, and the patient's family concerning delayed treatment following what arguably was a stroke. Could the patient be provided care in a residential rehabilitation facility, or could she be provided care in her home? As Nancy Dubler describes:

The level of calumny and conflict was high. The plan physician accused the neurologist of shilling for the financial interests of the hospital and its financially linked rehabilitation facility and of misunderstanding the range of safe and effective home services. The hospital physician accused the plan of balancing its books by short-changing its patients and denying them necessary services. According to the neurologist, he told the plan physician, in front of the family, that "she should be ashamed of herself."

This conflict was loud and disruptive. . . . There were manifest parties (the physician) and latent parties (the administration of the hospital and the plan) parties. Yet in the end, it was these latent parties that assisted in finding a resolution. The visible players gathered around the hospital bed, providing a ready forum, but were "dug into" their positions with little sense of how to move the discussion and engage in useful information exchange. Clashing personalities did not necessarily elucidate the perspectives and interests of patient, family, hospital and community plan [MCO]. The voice of the patient was somewhat lost in the din.

Id. at 486–87.

162. See, e.g., DEBORAH TANNEN, YOU JUST DON'T UNDERSTAND: WOMEN AND MEN IN

introversion, or who simply processes and speaks at a slower pace than others may find their contributions stifled. Doubts or concerns may go unspoken in an effort to "not be a troublemaker," only to flare up months later.¹⁶³

Skilled facilitators serve the function of keeping things civil and free of bitter conflict by, paradoxically, giving people a voice to express dissent and to engage, if needed, in productive conflict. Please note that the word "conflict" is used here in its generic denotation, referring to the expression of diverse viewpoints.¹⁶⁴ This clash of ideas is not the same as an entrenched struggle of wills. It is democracy in action; it is a lively discussion between equals, in which everyone at the table is empowered.

Mediators adhering to a Code of Professional Conduct, such as that of the Oklahoma Supreme Court for its court-connected program (known as Early Settlement),¹⁶⁵ would moderate the pace of discussions to assure the patient has

CONVERSATION 224–27 (2001) (discussing the linguistic ambiguity of communications between men and women). For example, consider how society often views indirectness differently. In a man, this linguistic strategy typically would be characterized as "politeness" in a man. The same communication style in a woman would connote instead that she is merely "powerless." *Id.* at 224–27. Tannen finds this two-edged interpretation applies equally well in analyzing dialogues among persons from different ethnic backgrounds. For example, the minority person's own preferences might be signaled by asking a question about the *other* person's desires, rather than stating directly and unequivocally (in standard European-American fashion) what they wish to have happen. *Id.* at 226–27.

163. See PHYLLIS BECK KRITIK, *NEGOTIATING AT AN UNEVEN TABLE: A PRACTICAL APPROACH TO WORKING WITH DIFFERENCE AND DIVERSITY* 35 (1994) (describing the importance of equality in negotiation settings). One aspect of the "uneven table" is described as:

[S]eating people who have historically never been there, and then expecting them to successfully negotiate on their own behalf despite the sizable gap in skills, experience, and cultural training between such new participants and those who have been there for some time. In addition, in this situation, the fact that the mores, customs, and values of the group who have been there for some time will prevail is ignored, and the new participant is expected to adapt rather than change these mores, custom, and values. Indeed the new player is considered a "problem" if this adaptation does not occur.

Id. This description, developed by a health care practitioner with substantial conflict resolution experience, offers an excellent description of the slanted dialogues which the Reynolds Department of Geriatric Medicine endeavors to avoid, by welcoming the addition of mediators to assure an even table without fail.

164. The primary definition of "conflict" in WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY (1981) reads: a "clash, competition, or mutual interference of opposing or incompatible forces or qualities (as ideas, interests, wills)."

165. Code of Professional Conduct for Mediators, Okla. Stat. Ann. Tit. 12, ch. 37, app. A at 485 (West 1993). The Code of Conduct states:

Mediation is an informal process for resolving a dispute with the assistance of a mediator [defined in A.1 as: "an impartial third party certified according to the provisions of the [Oklahoma Dispute Resolution Act] who enters a dispute with the consent of the parties, to aid and assist them in reaching a mutually satisfactory

at hand the knowledge required to make an informed choice about the matters under review. This could require a recess or reconvening the mediation to obtain additional information. The critical point would be to assure all participants reached voluntary, knowledgeable consensus before the treatment plan was finalized. The Early Settlement model trains mediators to look for verbal and nonverbal cues that suggest emotional problems that need further exploration. Using specific communication techniques, they seek out underlying concerns and aspirations to assure full understanding and voluntariness in decision-making.

Informed consent in a managed care environment has come under scrutiny lately. Some observers ask, dubiously, whether there can be informed consent as the standard developed in traditional fee-for-service medicine, when the MCO undoubtedly discourages informing enrollees about higher-cost options.¹⁶⁶ This concern may have merit.

However, it seems more likely that Medicare enrollees are not clamoring for more expensive, more intensive tertiary care. Rather, they seek a better quality of interaction with the human beings who provide hands-on care.¹⁶⁷ They want someone to listen respectfully to their concerns. If treatments are necessary, they want to limit any time spent in an acute care setting. They seek ways to retain their own home and their dignity for the maximum time.

These are likely the patients' underlying interests, whether articulated fully or not. Mediators trained under a facilitative model, such as the Oklahoma Supreme Court's Early Settlement Program, endeavor to bring these interests to the surface. They frame and reframe discussions around these all-important principles. Invasive, high-intensity procedures may seem to be the symbol of

settlement to the issues in dispute"] Those who act as mediators must be dedicated to the principle that all disputants have a right to negotiate and attempt to determine the outcomes of their own conflicts.

Id.

The Code of Conduct requires the mediator to suspend or terminate the mediation: (1) "when it appears that continuation would harm or prejudice any party"; (2) "when it appears that a party is unable or unwilling to make an effort to meaningfully participate in the mediation process;" or (3) "when it appears that mediation is not productive, and the parties are unwilling to continue." *Id.* at 486. Early Settlement mediators are trained according to a standardized protocol. If one party insists upon using the process to intimidate the other party, the mediator is instructed to call the session to a halt and to refuse to proceed. *See* ADRS Basic Training Manual, §§ 9-40, 9-41 (defining "impasse").

166. *See, e.g.,* Wright, *supra* note 32, at 138 ("Under managed care, the coverage/treatment decision is made, in the first instance, by individual doctors and managed care organizations who are subject to direct financial incentives to deny care.").

167. *See supra* Part I.B (describing the patients' desire to develop more meaningful relationships with caregivers).

Western medicine at its best and therefore this represents the measure of high quality care. On the other hand, a patient whose most deeply held values are autonomy and dignity might not be willing to agree to large amounts of tertiary care.¹⁶⁸

Trade-offs may be unavoidable. Knowing this in advance, and working through it collaboratively, can avoid the destructive confrontations between families and providers that can occur in a medical crisis. Using a trained third-party neutral to facilitate these predispute discussions may be "essential to ensuring integrity in decision-making" as consumer advocates urged in reference to HMO complaint processes.¹⁶⁹

B. Merging Idealism and Pragmatism

1. Toward a Synergy of Public Resources

To the jaded, the concept of sharing power to enhance the efficacy of medical treatment may seem hopelessly idealistic. On the other hand, the U.S. Department of Health and Human Services—not known as a "soft touch"—has opened the door to experimentation along these lines.¹⁷⁰

In Oklahoma, discussions are underway to explore how mediators from the Early Settlement program might facilitate the development of medical treatment plans within the Reynolds Department of Geriatric Medicine.

168. See C. Patterson & C. Rosenthal, *Living a Little More Dangerously*, 350 THE LANCET 1164, 1164 (Oct. 18, 1997) ("Risks perceived by individuals often differ substantially from the perceptions of 'experts.'"). Such decision-making presents a complex, subtle interplay of personal and societal values. The goal sought is genuine, knowledgeable and fully developed informed consent. The theoretical principles are self-determination and shared power. The operational question is risk assessment from the patient's point of view. One geriatrics department framed it succinctly: "How do old people view risk? Would most wish to enjoy life more, or perhaps for fewer years?" *Id.* These writers note: "Risks perceived by individuals often differ substantially from the perceptions of 'experts.'" *Id.*

169. U.S. GEN. ACCOUNTING OFFICE, GAO-T-HEHS-98, HMO COMPLAINTS AND APPEALS: PLANS' SYSTEMS HAVE MOST KEY ELEMENTS, BUT CONSUMER CONCERNS REMAIN 4 (1998).

170. For example, three CMS solicitations of proposals in 2002 could fit within the model suggested here: (1) Solicitation for Proposals for the Demonstration Project for Disease Management for Severely Chronically Ill Medicare Beneficiaries with Congestive Heart Failure, Diabetes, and Coronary Heart Disease, 67 Fed. Reg. 8,267 (Feb. 22, 2002); (2) Solicitation for Proposals for Medicare Preferred Provider Organization (PPO) Demonstrations in the Medicare+Choice Program, 67 Fed. Reg. 18,209 (Apr. 15, 2002); and (3) Solicitation for Proposals for the Physician Group Practice Demonstration, 67 Fed. Reg. 61,116 (Sept. 27, 2002). CMS has published an interim final rule with comment period updating authorization for "Programs of All-Inclusive Care for the Elderly (PACE)," 67 Fed. Reg. 61,496 (Oct. 1, 2002) which could also embrace an approach such as that suggested here.

Several years ago, under a Hewlett Foundation grant, the Oklahoma Supreme Court trained a cadre of Early Settlement mediators in the advanced skills required for adult guardianship cases.¹⁷¹ These mediators may form the initial corps trained specifically to facilitate these discussions.

The style will likely parallel the Individuals with Disabilities Education Act (IDEA)¹⁷² mediations used to resolve disputes among parents, teachers, counselors, therapists, and school administrators concerning disabled children mainstreamed into public education. The Oklahoma Supreme Court maintains a roster of Early Settlement mediators specially trained for IDEA mediations under contract with the State Department of Education. Although the style may track that of IDEA, the system design would differ. Improvements described in Part IV.B.2 could ameliorate some suboptimal aspects of IDEA mediations: timing, mandatory nature of referrals, delegation of authority, and compensation for personnel time.

In IDEA cases a multidisciplinary team develops an individualized education plan (IEP)¹⁷³ which is a comprehensive assessment of the child's full range of abilities and disabilities, used to guide educational activities for the student. The IEP attempts to bridge the child's worlds at home and at school to achieve coherence and cooperation among the adults who are vital to the child's well-being. Although the IEP is far from immutable, the exercise of creating an IEP has the capacity to focus

171. Sue Darst Tate, Director, Alternative Dispute Resolution System, Administrative Office of the Courts, developed this project that brought together a cross-section of public and private input to identify critical components of a successful model. Early Settlement adult guardianship mediators are, like all others in the court-connected program, volunteers selected, trained, and supervised to assure compliance with the Supreme Court's ethics code for mediators. Adult guardianship mediators had already been certified at the basic level (twenty hours of classroom instruction plus supervised postclassroom observations conducting small claims court mediations) and had been certified in divorce and child custody mediation under the Court's model (forty hours of classroom instruction plus supervised postclassroom observation conducting actual mediations). They received a special twenty-hour training in adult guardianship issues and advanced facilitation skills applicable to the family, medical, social, and disability issues raised in adult guardianship matters. By definition, adult guardianship cases presuppose a scenario of doubtful patient competency. Most mediated medical treatment plans would presuppose sufficient competency to support informed self-determination. Although the skills and training of the adult guardianship mediator may be more extensive than needed for most mediated medical treatment plans, it would be valuable to have this level of expertise "in reserve." Qualifying as a Mediator, Okla. Stat. Ann. Tit. 12, ch. 37, App. Rule 11 at 482.

172. 20 U.S.C. §§ 1400-19 (2000).

173. *Id.* § 1414.

the team away from turf issues and towards the best interests of the student. A productive, nonadversarial experience in such problem-solving builds a positive foundation for future interactions between parents and the school.¹⁷⁴

Typically, a successfully negotiated IEP can establish a baseline of trust capable of sustaining good faith efforts through the inevitable changes and crises that develop over time. When the initial IEP development does not manage to create a productive baseline, or when other issues have destabilized the IEP, the parent can request an IDEA mediation to facilitate problem-solving with the team.¹⁷⁵ Success of such mediations varies, due at least in part to the style of mediation used, and the perceived neutrality of the mediation process.¹⁷⁶

Compliance by schools and school districts often hinges on whether the key administrators recognize that the large investment of time by staff in a mediation is far less than the resources that would be invested in a due process hearing. Otherwise, there can be concerns about the burden placed upon the teachers, counselors, therapists and school administrators whose time in mediation is not compensated. Under such conditions, mediation itself can be resented.

The mediated medical treatment plan under discussion incorporates knowledge gleaned from IDEA, adult guardianship, family, and other mediations to craft a mediation model accessible and empowering to beneficiaries, nonadversarial and supportive towards providers, and efficient and cost-effective to the Medicare program.

174. Mediation of IDEA disputes "appeared to encourage parents, guardians, and school officials to openly discuss their underlying concerns and interests, potentially laying the groundwork for greater mutual understanding and more effective and constructive relationships." Grace E. D'Alo, *Accountability in Special Education Mediation: Many a Slip 'Twixt Vision and Practice?*, 8 HARV. NEGOT. L. REV. 20, 203 (2003).

175. See 20 U.S.C. § 1415(e)(1) (2000) (describing the availability and requirements of mediation procedures); 34 C.F.R. Sec. 300.506 (same). For a discussion of the successes and continuing challenges in the substantive issues (defining disability, funding, and case-by-case enforcement versus legislation), see Terry Jean Seligmann, *An IDEA Schools Can Use: Lessons from Special Education Legislation*, 29 FORDHAM URB. L.J. 759 (Dec. 2001).

176. Professor D'Alo's study of IDEA in Pennsylvania notes that a transformative approach—as discussed in this paper—may achieve far greater success in bringing IDEA's vision in line with its practice, to further the goals of collaborative problem-solving and relationship-building. See D'Alo, *supra* note 174, at 205. The new model developed by the Pennsylvania working group closely follows that used by the Oklahoma Supreme Court for nearly ten years, including the Early Settlement mediator skills evaluation. *Id.* at 223–38.

2. *Morality Follows Money*

It is unquestioned that comprehensive geriatric assessments and treatment plans developed pursuant to such assessments represent the right therapeutic approach.¹⁷⁷ Nevertheless, it remains a practice in only a minority of hospitals and medical schools.

If it is undoubtedly the right thing to do as a matter of medical practice and ethics, then why is it so rare? In a word: money.¹⁷⁸ Under current payment structures, the time of the interdisciplinary team conducting the comprehensive assessment and modifying the plan according to the needs of the patient and caregiver largely goes unpaid. Although the physician's time is recognized, that of others may not be factored in. Time spent in consultation with the patient and caregiver as an integral part of developing and finalizing the plan typically must go unrecognized.¹⁷⁹ Programs that have adopted this approach and have implemented it in full have relied upon outside grant funds to cover these costs. Once such funding ends, the comprehensive model also likely ends.

Medicare could advance its agenda of streamlining and humanizing appeals by investing finances at the front end. Assuring compensation for all providers of services in the comprehensive medical assessment (applicable to both the elderly and to the disabled), coupled with compensation for time spent mediating the medical treatment plan, would guarantee full implementation. Once the plan has been finalized in writing and reviewed generally for coverage, all services rendered pursuant to the plan should be deemed covered

177. See, e.g., U.S. GEN. ACCOUNTING OFFICE, HEHS-95-109, LONG-TERM CARE: CURRENT ISSUES AND FUTURE DIRECTIONS 5-6 (1995) (stating that a person's long-term care needs cannot be determined from his or her medical diagnosis and explaining other ways to determine a person's ability to function independently); see also U.S. GEN. ACCOUNTING OFFICE, GAO/T-PEMD-94-20, LONG-TERM CARE: THE NEED FOR GERIATRIC ASSESSMENT IN PUBLICLY FUNDED HOME AND COMMUNITY-BASED PROGRAMS (1994) (assessing what geriatric evaluation is, how it is used, and the extent to which it is available in public programs).

178. See Cerminara, *supra* note 155, at 693 (explaining in reference to implementation of the AMA's recommendations on end-of-life planning, "today's physicians know their individual patients much less well than the traditional, prototypical family physician," and that "it is crucial that the patient's caregivers know the patient's preferences, values, and beliefs in order to make intelligent decisions" about the "gap" not covered in the standard check-off boxes of advance directive forms). "Setting aside enough time to get to know a patient is difficult enough because of the limited amount of time a physician can devote to each patient in the larger patient pool." *Id.*

179. See, e.g., *id.* at 791 (suggesting with regard to end-of-life planning decisions that these "should be the subject of open, honest, and meaningful conversation," and recommending that the physician's time be compensated "on a fee-for-service basis rather than as part of regular patient care covered by capitated payments").

and paid promptly. These changes in billing could create a powerful and lasting incentive for providers to make the necessary commitment of resources.

What would the Medicare program receive in return for its investment? The program should see greater rationalization of services, major reductions in disputes over coverage or denial of services, greatly reduced incentives to practice costly, often inefficient "defensive medicine" to stave off malpractice suits, and improved tools to implement continual quality improvement.¹⁸⁰ Moreover, the Medicare program could forge the mechanism whereby the doctor-patient relationship returns to its proper place as the primary therapeutic tool.

180. As encouraged by U.S. GEN. ACCOUNTING OFFICE, GAO/HEHS-96-20, *MEDICARE: FEDERAL EFFORTS TO ENHANCE PATIENT QUALITY OF CARE* 26–27 (1996), and as part of the larger government-wide orientation toward collaboration to achieve continual quality improvement, as seen in U.S. GEN. ACCOUNTING OFFICE, GAO-03-454, *PROGRAM EVALUATION: AN EVALUATIVE CULTURE AND COLLABORATIVE PARTNERSHIPS HELP BUILD AGENCY CAPACITY* 16–17 (2003) (concerning aspects of total quality management) and 20–23 (regarding state-federal and public-private partnerships to access specific expertise).

