Relational Malpractice

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I. INTRODUCTION

Legal scholarship in recent decades has devoted considerable attention to the "malpractice crisis." Surprisingly, however, the vast majority of this literature has overlooked a fundamental aspect of the problem: the deterioration of the doctor-patient relationship. So far, mainstream legal writing on malpractice has tended to frame the situation as either an insurance crisis or a litigation crisis.[1] The insurance crisis claim focuses on the rise in professional insurance premiums as a result of exceptionally high awards;[2] while the problem of litigation allegedly stems from the ills of the court system—its high costs, unpredictability, and the distorted incentives it provides.[3] Others have acknowledged that the current malpractice regime has negatively affected the doctor-patient relationship, as evidenced by the adoption of apology laws, disclosure-conversation laws, and by the institution of Alternative Dispute Resolution (ADR) programs.[4] Nevertheless, these initiatives have narrowly framed the scope of the problem by implying that the doctor-patient relationship is threatened

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[1] *See, e.g.*, TOM BAKER, THE MEDICAL MALPRACTICE MYTH (2005); PAUL C. WEILER, MEDICAL MALPRACTICE ON TRIAL 1–16 (1991); David A. Hyman, *Medical Malpractice and the Tort System: What Do We Know and What (if Anything) Should We Do About It?*, 80 TEX. L. REV. 1639 (2002). In the last decade a third approach has emerged, emphasizing safety and error prevention. This approach, which emerged from within the medical setting, has permeated the writings on medical errors that focus on public policy and institutional response. However, it has yet to infiltrate mainstream legal scholarship. For a discussion of this third approach, see *infra* Part III.A.

[2] BAKER, *supra* note 1, at 45–67; WEILER, *supra* note 1, at 1–5.

[3] BAKER, *supra* note 1, at 22–44; WEILER, *supra* note 1, at 54–56; *see also infra* notes 36–43 and accompanying text.

[4] *See* discussion *infra* Part II.D.

only in the aftermath of a medical error.[5] Such an approach misses the broader impact malpractice has had on the entire spectrum of doctor-patient relations, spanning from the first encounter through the end of treatment, whether an error has taken place or not.

In this Article, we propose that the malpractice crisis is an overall relationship crisis that inevitably impacts the quality of healthcare services. The framing of the problem in terms of relationships paves the way for a paradigm shift in the medico-legal analysis of malpractice law, calling for the displacement of the current fault-based tort regime with a relationship centered no-fault scheme. Designing a no-fault alternative with relationships in mind would allow for a deep transformation to take place, one that addresses all realms of the problem, encompassing issues related to costs, compensations, deterrence, and the overall quality of healthcare.

A relational understanding of the malpractice predicament underscores the fact that contemporary doctor-patient interactions often resemble a battle zone: many physicians view "every patient as a potential malpractice lawsuit,"[6] while patients complain that their physicians are driven by financial incentives,[7] treat them brusquely, and fail to provide honest and full information.[8] We contend that these dynamics have colored the entire doctor-patient relationship, extending well beyond those discrete instances in which a medical error has occurred.[9] We tie the deterioration in the doctor-patient relationship to a combination of forces that have increased patients' voice and control, turning them from passive and submissive patients to knowledgeable consumers and sophisticated rights-bearers em-

[5] *See infra* note 133 and accompanying text.

[6] Michelle M. Mello et al., *Caring for Patients in a Malpractice Crisis: Physician Satisfaction and Quality of Care*, 23 HEALTH AFF. 42, 49 (2004).

[7] S*ee* Jonathan Todres, *Toward Healing and Restoration for All: Reframing Medical Malpractice Reform*, 39 CONN. L. REV. 667, 689 (2006). According to research findings cited by Todres, "82% of respondents believed that medical care had become a big business and that the industry put profits ahead of patients." *Id.* (quoting Philip G. Peters, Jr., *The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium*, 57 WASH. & LEE L. REV. 163, 197 (2000) (internal quotation marks omitted)).

[8] Indeed, in the aftermath of a medical error, the failure of the healthcare team to provide information on the occurrence often triggers patients to pursue litigation with the hope that such litigation will drive healthcare providers to transmit such information. *See infra* notes 126–30 and accompanying text. Todres has described these dynamics as fostering "an 'us vs. them' environment that pits doctors against patients and the community." Todres, *supra* note 7, at 691.

[9] Orna Rabinovich-Einy, *Escaping the Shadow of Malpractice Law*, 74 LAW & CONTEMP. PROBS. 241, 266–74 (2011).

powered by law.[10] These developments have permeated the entire web of relations in the healthcare arena, but most notably the doctor-patient relationship—the major relational axis in this context.

The medical literature has acknowledged the importance of the doctor-patient relationship as a fundamental component in the provision of healthcare services in general, and in the malpractice context specifically, recognizing the links among relationships, errors, and quality.[11] Specifically, medical scholarship has underscored the significance of a collaborative doctor-patient relationship premised on mutual, open, and cooperative discourse.[12] Such a mode of interaction has been linked with enhanced physician ability to draw relevant medical information from patients, greater motivation by patients to seek and adhere to treatment, and increased patient satisfaction.[13] Despite these findings, the dominant model of doctor-patient relations has been a defensive, hierarchical, and closed mode of communication.[14]

While physician communication patterns have typically been tied to longstanding professional and organizational cultures, we emphasize the role the law has played in cutting off communication channels between providers and patients. Current research on the doctor-patient relationship proves that the existing malpractice regime does not allow a collaborative relationship to evolve.[15] On the contrary, it harms the doctor-patient relationship by providing disincentives for open, free-flowing communication by breeding distrust, conflict, and

[10] *See* discussion *infra* Part II.B.

[11] *See, e.g.*, M. Robin DiMatteo, *The Physician-Patient Relationship: Effects on the Quality of Healthcare*, 37 CLINICAL OBSTETRICS & GYNECOLOGY 149, 152 (1994); Bernard B. Virshup et al., *Strategic Risk Management: Reducing Malpractice Claims Through More Effective Patient-Doctor Communication*, 14 AM. J. MED. QUALITY 153 (1999). The publication of two reports contributed dramatically to this new understanding. *See* INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (Linda T. Kohn et al., eds., 2001); MASS. COAL. FOR THE PREVENTION OF MED. ERRORS, WHEN THINGS GO WRONG: RESPONDING TO ADVERSE EVENTS: A CONSENSUS STATEMENT OF THE HARVARD HOSPITALS (2006); *see also* discussion *infra* Part II.C.

[12] *See, e.g.*, DEBRA L. ROTER & JUDITH A. HALL, DOCTORS TALKING WITH PATIENTS / PATIENTS TALKING WITH DOCTORS 3–22 (2nd ed. 2006); Ezekiel J. Emanuel & Nancy Neveloff Dubler, *Preserving the Physician-Patient Relationship in the Era of Managed Care*, 273 JAMA 323, 323–29 (1995). For further elaboration on the notion of collaborative doctor-patient relationship, see *infra* note 64 and accompanying text.

[13] *See infra* Part II.C.

[14] *See, e.g.*, Rabinovich-Einy, *supra* note 9, at 243.

[15] *See, e.g.*, Dale C. Hetzler et al., *Curing Conflict: A Prescription for ADR in Healthcare*, 11 DISP. RESOL. MAG. 5, 6 (2004).

defensiveness.[16] Specifically, these studies have disclosed the manner in which tort law has shaped doctor-patient communication in the aftermath of an error. Doctors are driven to cut off communication following an adverse event, failing to supply patients and family members with basic information and emotional support.[17] Paradoxically, this has actually motivated patients to sue their doctors; research findings show that patients' decisions to sue are connected to their interactions with their healthcare providers rather than the pursuit of monetary compensation.[18] We build on these findings and reveal the deeper, elusive impact malpractice law has had on the doctor-patient relationship, extending well beyond the moment of error and resulting in an overall relationship crisis.[19] This crisis has indirectly hampered doctor-patient communication along the entire continuum of care and has reduced the quality of healthcare services.

This Article advances the view that the law governing medical errors should strengthen the doctor-patient relationship by engendering open, mutual, and honest communication. The implications of such an approach are twofold. First, it would entail examining the impact of legal arrangements on both the doctor-patient relationship as well as the surrounding web of relations.[20] Second, a legal regime concerned with relationships would promote a collaborative doctor-patient relationship.[21] We argue that this transformation can only be achieved by displacing the current malpractice regime and adopting a no-fault based solution.[22] No-fault compensation schemes are administrative mechanisms that substitute the tort system with an alternative framework for the compensation of injured patients.[23] Such a

[16] Carol B. Liebman & Chris Stern Hyman, *A Mediation Skills Model to Manage Disclosure of Errors and Adverse Events to Patients*, 23 HEALTH AFF. 22, 23–24 (2004).

[17] *See* Hetzler et al., *supra* note 15, at 5–6; Liebman & Hyman, *supra* note 16, at 28.

[18] Extensive research supports this point. *See, e.g.*, Christine W. Duclos et al., *Patient Perspectives of Patient-Provider Communication After Adverse Events*, 17 INT'L J. FOR QUALITY IN HEALTHCARE 479, 483 (2005); Wendy Levinson et al., *Physician-Patient Communication: The Relationship with Malpractice Claims Among Primary Care Physicians and Surgeons*, 277 JAMA 553 (1997); Kathleen M. Mazor et al., *Communicating with Patients About Medical Errors: A Review of the Literature*, 164 ARCHIVES INTERNAL MED. 1690, 1694 (2004); Virshup et al., *supra* note 11, at 156. For further reading, see *infra* note 65 and accompanying text.

[19] *See infra* Part II.A.

[20] *See* discussion *infra* Part III.C.

[21] *See* discussion *infra* Part III.C.

[22] *See* discussion *infra* Part III.

[23] Clark C. Havighurst & Laurence R. Tancredi, *"Medical Adversity Insurance": A No-Fault Approach to Medical Malpractice and Quality Assurance*, 51 MILBANK MEM'L FUND Q. 125, 126, 128–32 (1973); Jeffrey O'Connell, *No-Fault Insurance for Injuries Arising*

mechanism is not premised on individual fault, but rather on a statutory definition of medical errors that deserve compensation.[24]

The no-fault alternative is not a novel concept, but former proposals have sought to advance different goals. Earlier proposals focused on just compensation based on the larger pool of claimants and a better screening process for actual negligence by providers.[25] Over time, a different justification has emerged focusing on error prevention and patient safety through systemic learning about the sources of errors.[26] Under this systemic approach, uncovering repetitive sources of medical mishaps became a central concern. Removing individual blame would further facilitate this goal.[27] Previous no-fault reform proposals, however, have not addressed the broader connec-

from Medical Treatment: A Proposal for Elective Coverage, 24 EMORY L.J. 21, 34–42 (1975); Paul C. Weiler, *The Case for No-Fault Medical Liability*, 52 MD. L. REV. 908, 944–47 (1993); *see also infra* notes 141–46 and accompanying text.

[24] The literature on medical errors has distinguished between *medical errors* and *adverse events* with an inner distinction between preventable and unpreventable adverse events. An *adverse event* is defined as "[a]n injury that was caused by medical management rather than the patient's underlying disease . . . . An adverse event may or may not result from an error." MASS. COAL. FOR THE PREVENTION OF MED. ERRORS, *supra* note 11, at 4. *Medical errors* are defined as "[t]he failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Medical errors include serious errors, minor errors, and near misses . . . . A medical error may or may not cause harm." *Id.* A *preventable adverse event* refers to "[a]n injury (or complication) that results from an error or systems failure." *Id.* An *unpreventable adverse event* is defined as "[a]n injury or complication that was not due to an error or systems failure and is not always preventable at the current state of scientific knowledge." *Id.* at 5.

The tort system compensates claimants only for those medical errors that meet the legal requirements for negligence. No-fault initiatives have expanded the scope of events that are covered depending on the specific definition of the triggering event for compensation. *See infra* text accompanying notes 142–44. In this Article, we use the terms "medical error" and "adverse event" in accordance with the above definitions, but as we demonstrate in Part III.C. *infra*, our approach makes such distinction less acute than previous cases. We advocate for the adoption of a comprehensive system that provides redress, not necessarily monetary, for a broad range of adverse events.

[25] Troyen A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I*, 324 NEW ENG. J. MED. 370, 374–75 (1991).

[26] David M. Studdert & Troyen A. Brennan, *No-Fault Compensation for Medical Injuries*, 286 JAMA 217, 217–19 (2001). The new justification was grounded in a broader change—moving towards identifying the root cause of medical errors. Following the publication of *To Err is Human: Building a Safer Health System*, the malpractice problem was seen as tied to the issue of healthcare quality. *See generally* INST. OF MED., *supra* note 11. Such approach laid the foundation for a shift from individual blame for errors to systemic sources of errors. *See also infra* notes 182–86 and accompanying text.

[27] Studdert & Brennan, *supra* note 26, at 217.

tion between medical errors and the doctor-patient relationship. Consequently, the proposed solutions were not designed with relationships in mind and therefore did not present an avenue for change in this realm.

Our approach brings to the fore a new justification supporting the shift to no-fault—the transformation of doctor-patient relations.[28] This alternative assigns weight to the empirical evidence of the connection between doctor-patient relationships and the quality of healthcare provided. The goals of such reform would be to cultivate collaborative relations, to expand the pool of disputes handled systematically, and to establish broad criteria for learning about relationships.[29] This would allow for a more open and rigorous inquiry into the causes of medical errors, and would result in lower conflict levels, which often serve as a diversion for healthcare providers and result in reduced patient trust.

The significance of the new justification stems from the following: (1) it highlights the fact that the harm created by the current malpractice regime extends beyond the occurrence of medical mistakes, infiltrating a broad range of physician-patient interactions; (2) it provides a more comprehensive explanation for the ways a no-fault alternative can enhance prevention of medical errors; and (3) it more effectively addresses some of the critiques of the no-fault alternative in the realms of cost and deterrence.

Part I of this Article portrays the current state of doctor-patient relations as a battle zone and underscores some of the historical sources that have contributed to the combative nature of the interaction between healthcare professionals and patients. We explain the significance of effective doctor-patient communication, which emerges from a collaborative doctor-patient relationship and has been tied to enhanced quality of medical care. We show that targeted efforts to transform such interactions have had a limited effect, because they were introduced in the shadow of the existing malpractice regime. Part II presents the no-fault alternative, highlighting the novelty of the relational justification presented in this Article for choosing this particular regime. We emphasize the need to do away with the malpractice system for the improvement of doctor-patient relations. We conclude that a no-fault system for compensating victims of medical errors would be not only a better avenue for redress-

[28] *See infra* Part III.B.

[29] *See* discussion *infra* Part III.C.

ing patient injuries and preventing future mistakes but also for bringing about a deep change in doctor-patient interactions.

II. THE DOCTOR-PATIENT RELATIONSHIP IN THE SHADOW OF MALPRACTICE

A. Doctor-Patient Interactions as a Battle Zone

Medical malpractice has been one of the most significant phenomena in the healthcare arena, shaping such factors as insurance for practitioners and enterprises, professional standards and training, and the scope and nature of medical care given in particular instances.[30] While early medical malpractice claims appeared around 1840 in the United States,[31] malpractice litigation as we know it today was shaped by developments that took place in the mid-twentieth century and has since become a widespread phenomenon.[32] Malpractice litigation in the United States is becoming increasingly prevalent,[33] with many more potential claims settling before a lawsuit has even been filed.[34] Although malpractice claims are more common in particular areas of practice,[35] the reality of large-scale medical malpractice claims has colored doctor-patient relations across all fields.

Over time, the legal rules governing malpractice have expanded, creating a complex framework that is unpredictable, cumbersome, and costly. Specifically, to establish a claim for medical malpractice, the patient must prove that the injury was caused by a negligent act by satisfying the basic tort elements of duty, breach, causation, and harm. Satisfying these requirements can be difficult, especially given the ongoing evolution of medical knowledge and standards of practice,[36] the knowledge gap between healthcare providers and patients,[37]

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[30] Todres, *supra* note 7, at 669, 679–93.

[31] James C. Mohr, *American Medical Malpractice Litigation in Historical Perspective*, 283 JAMA 1731, 1731–32 (2000).

[32] *See* discussion *infra* Part II.B.

[33] Weiler, *supra* note 23, at 912 (showing that within three decades, claims have risen "from approximately one claim per 100 doctors a year in the late 1950s to more than ten claims per 100 doctors in the early 1990s").

[34] Tom Delbanco & Sigall K. Bell, *Guilty, Afraid, and Alone—Struggling with Medical Error*, 357 NEW ENG. J. MED. 1682, 1682–83 (2007).

[35] *See, e.g.*, Gerald B. Hickson et al., *Development of an Early Identification and Response Model of Malpractice Prevention*, 60 LAW & CONTEMP. PROBS. 7, 7 (1997) (obstetric medicine).

[36] *See* David. R. Riemer, *Follow the Money: The Impact of Consumer Choice and Economic Incentives on Conflict Resolution in Health Care*, 29 HAMLINE J. PUB. L. & POL'Y 423, 423–24 (2008) ("[Medicine] is inherently imprecise. Uncertainty, probability, and risk permeate many, if not most, of the decisions that doctors make.").

and the delays and costs associated with the backlogged court system.[38] Consequently, litigation results are often described as arbitrary because, while justified claims are often not pursued, frivolous suits may result in substantial awards.[39] On the one hand, researchers have estimated that approximately ten percent of potential claimants do not bring a malpractice claim precisely because of these difficulties.[40] These findings suggest that the high awards often granted in extreme cases obfuscate the fact that many injured parties remain undercompensated.[41] On the other hand, the system enables those with financial and emotional stamina to pursue borderline claims,[42] and has thus drawn criticism for generating arbitrary and unpredictable outcomes.[43] The reach of medical malpractice has not been limited to the courtroom, as evidenced by the emergence of "defensive medicine"[44] and a "brain drain" in certain high-risk fields.[45] The result is a complex picture in which courts provide distorted incentives for healthcare providers, patients, and the healthcare system at large.[46]

Another source of discontent has been the emotional toll malpractice has had on patients and doctors alike, even in situations in which litigation is merited. From the injured patient's perspective, a trial typically lasts several years during which time the claimants are preoccupied with the lawsuit and find it difficult to heal and move on

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[37] Marlynn Wei, *Doctors, Apologies, and the Law: An Analysis and Critique of Apology Laws*, 40 J. HEALTH L. 107, 153 (2007); Weiler, *supra* note 23, at 926. This general knowledge gap is further aggravated by the prevailing physician-communication patterns. Oftentimes patients do not understand much of what they are being told by their physicians, who tend to use professional jargon, leave little room for questions, and hold very different beliefs than patients about what constitutes adequate disclosure. *See* DiMatteo, *supra* note 11.

[38] Todres, *supra* note 7, at 681, 686.

[39] *Id.* at 679–82; Weiler, *supra* note 23, at 912–14.

[40] Brennan et al., *supra* note 25, at 371–72.

[41] Todres, *supra* note 7, at 679–80, 682; Weiler, *supra* note 23, at 918–19.

[42] *See* Todres, *supra* note 7, at 681.

[43] *See* Paul J. Barringer et al., *Administrative Compensation of Medical Injuries: A Hardy Perennial Blooms Again*, 33 J. HEALTH POL. POL'Y & L. 725, 740 (2008) (stating that in response to the Harvard Medical Practice Study on malpractice claims, "the lawyers asserted that the study demonstrated that far too many instances of malpractice went uncompensated; physicians argued that it highlighted the litigation system's arbitrary nature and inability to distinguish negligent from non-negligent injuries"). Physicians, who predictably have very little trust in the system, typically believe that the outcome of litigation has more to do with the extent of the injury than with the existence of negligence. *See* Todres, *supra* note 7, at 684.

[44] *See* Todres, *supra* note 7, at 684–85.

[45] *See infra* note 139 and accompanying text.

[46] *See* Hyman, *supra* note 1, at 1645; Weiler, *supra* note 23, at 912–19.

with their lives. Physicians, on the other side, are deeply concerned with the harmful impact such litigation can have on their reputations and professional status, as well as with the financial implications of rising insurance premiums.[47] In addition, they are often consumed by feelings of guilt, isolation,[48] and even depression.[49]

In this Article, we argue that the fear of malpractice liability is far-reaching and extends beyond instances actually involving mistakes, contaminating the entire sphere of doctor-patient relations and infiltrating such interaction from the outset.[50] Fear of malpractice liability is a barrier to communication between the medical team and the patient (and the patient's family members) in the aftermath of a medical mistake. Patients and their families seek an apology and information on the circumstances that gave rise to the mistake and its consequences while doctors often disclose as little information as possible,[51] refrain from communicating with patients and their families altogether, and are hesitant to apologize.[52] As a result, patients and family members may sue precisely because the silence and evasion by the healthcare team has generated feelings of resentment and

[47] Charity Scott, *Therapeutic Approaches to ADR in Health Care Settings*, 21 GA. ST. U. L. REV. 797, 798 (2005). *See generally* Samuel R. Gross & Kent D. Syverud, *Getting to No: A Study of Settlement Negotiations and the Selection of Cases for Trial*, 90 MICH. L. REV. 319, 364–67 (1991) (discussing the impact of reputational stakes in settlement patterns of malpractice cases).

[48] Delbanco & Bell, *supra* note 34, at 1682.

[49] *See infra* note 58 and accompanying text.

[50] *See infra* Parts III.B–III.D.

[51] *See* Liebman & Hyman, *supra* note 16, at 24; Todres, *supra* note 7, at 685.

[52] *See* Jay L. Hoecker, *Guess Who Is Not Coming to Dinner: Where Are the Physicians at the Healthcare Mediation Table?*, 29 HAMLINE J. PUB. L. & POL'Y 249, 258–59(2008); Jonathan R. Cohen, *Advising Clients to Apologize*, 72 S. CAL. L. REV. 1009, 1061–65 (1999). This reality has been somewhat softened by the adoption of "Apology Laws" aimed at encouraging physicians to provide patients and their families with information on medical errors by excluding the admission at trial of any statements of sympathy made by physicians during such disclosure. *See, e.g.*, CAL. EVID. CODE § 1160 (Deering 2012); COLO. REV. STAT. § 13-25-135 (2011); DEL. CODE ANN. tit. 10, § 4318 (2011); MASS. GEN. LAWS ch. 233, § 23D (2011). Critics have claimed, however, that apology laws have been unsuccessful in overcoming other barriers that discourage physicians from disclosure of errors. *See* Wei, *supra* note 37. In addition, some states have adopted "mandatory disclosure laws," which have, in effect, forced providers to conduct conversations with patients and families in the aftermath of "serious events." Liebman & Hyman, *supra* note 16, at 23. Here, as in the apology context, it is insufficient to allow for (or even mandate) such conversations to take place. For these talks to be fruitful and responsive to patient needs, they need to be conducted in accordance with patient expectations regarding provider demeanor and information provision in the course of the conversation. *See id.* at 23–24.

distrust, and they hope it will help them obtain more information about the circumstances of the relevant adverse event.[53]

Tensions related to communication patterns also stem from the reality of medical service delivery in many hospital departments. Long shifts in often under-staffed and under-budgeted departments have made it difficult for physicians to treat patients in accordance with their expectations of communication in a timely and attentive manner.[54] When patients seek medical care, in particular urgent care, in addition to their physical pain, they (and their family members) are often placed under extreme emotional pressure—subjected to fear and anxiety in the face of complex, bureaucratic surroundings.[55]

Factors, such as high rates of dissatisfaction with the practice of medicine,[56] physicians ceasing to practice,[57] and physician's developing clinical signs of depression (both those who have been sued and those who have not been sued for malpractice),[58] indicate the breadth of the impact that the malpractice crisis is having on doctor-patient interactions. In one study, seventy-five percent of specialists agreed with the statement: "Because of concerns about malpractice liability, I view every patient as a potential malpractice lawsuit."[59] The authors of the study deduced that, in this environment, "[a]n atmosphere of high liability risk and costs may affect the physician-patient relationship, precluding mutual trust and hampering communication (relationships)."[60]

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[53] *See* Delbanco & Bell, *supra* note 34, at 1683; *see also infra* note 65 and accompanying text.

[54] *See* Rabinovich-Einy, *supra* note 9, at 263–64.

[55] *See* Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 471(2002).

[56] *See* Mello et al., *supra* note 6, at 45.

[57] Allan Kachalia et al., *Physician Responses to the Malpractice Crisis: From Defense to Offense*, 33 J.L. MED. & ETHICS 416, 416 (2005); Mello et al., *supra* note 6, at 44.

[58] *See* Sara C. Charles et al., *Sued and Nonsued Physicians' Self-Reported Reactions to Malpractice Litigation*, 142 AM. J. PSYCHIATRY 437, 440 (1985) ("A surprising finding was that the groups [of sued and non-sued physicians] reported a similar degree of the cluster of symptoms that might be associated with major depressive disorder . . . . [I]t is possible that the nonsued respondents in general had a greater vulnerability to stress, especially that related to potential litigation."). In another article, malpractice litigation is found to generate feelings of uneasiness, vulnerability, frustration, and anger. Wei, *supra* note 37, at 139–40. This impact is related to the allegation of malpractice, not to the outcome of the litigation, and therefore being cleared of the allegations may do little to alleviate these feelings. *Id.*

[59] Mello et al., *supra* note 6, at 48–49.

[60] *Id.* at 44.

Indeed, research has found that physicians tend to adopt a defensive mode of communication—one that is hierarchical, distant, and confrontational or is based on avoidance and withdrawal.[61] With such a mode of communication, there is little engagement, limited listening, and reduced understanding. The consequences of poor communication between physicians and patients can be grave. Obviously, communication driven by distrust on both sides is bound to engender frequent conflicts, ranging from small-scale conflicts that stem from long patient waits to serious malpractice allegations. In such a setting, incentives and needs pull in opposite directions: physicians will seek to communicate as little as possible to minimize risk, while patients and family members will push for as much information as possible to allow them to feel safe in their doctors' care.[62] Patients are bound to feel that they are being treated in a curt and disrespectful manner. Therefore, the long waits with little proactive attention and few updates can be expected to generate angry responses. Such a loud environment, in turn, is hardly conducive to high-quality healthcare services.

The harm produced by frequent clashes in the corridor can be expected to expand beyond discomfort by affecting concentration and morale, potentially impacting clinical decision-making. But the connection between communication and malpractice runs deeper than mere "background noise"; high-quality medical care depends on effective communication between physicians and patients, as well as within the care team. As we demonstrate below, the ability to communicate effectively with patients and establish trust is key for physicians to solicit all necessary information on patient history and current symptoms, as well as to ensure that patients adhere to the prescribed treatment.[63] The need for a collaborative mode of communication with patients is at odds with physicians' protective inclination to minimize contact in case that the encounter should evolve into a dispute involving a malpractice allegation.[64] Paradoxically,

[61] Rabinovich-Einy, *supra* note 9, at 267.

[62] This phenomenon has received wide attention in the context of doctor-patient communication in the aftermath of a medical error. *See generally* Thomas Gallagher et al., *Choosing Your Words Carefully: How Physicians Would Disclose Harmful Medical Errors to Patients*, 166 ARCHIVES INTERNAL MED. 1585 (2006). But it has also been found to infiltrate such communications throughout treatment, even before an error has occurred. *See generally* Rabinovich-Einy, *supra* note 9.

[63] *See* discussion *infra* Part II.C.

[64] The term collaborative communication draws on a powerful typology developed by ROTER & HALL, *supra* note 12, at 24–34. Roter and Hall distinguished between paternalistic, consumerist, default, and mutual prototypes of the doctor-

physicians' desire to minimize risk translates into a closed mode of communication and actually increases the likelihood of their making a mistake, as well as that of being sued.[65] Fear of liability, resulting from the current malpractice system, extends beyond the individual level and infiltrates the doctor-patient interactions on a structural level. This is evident in physicians' reluctance to disclose information relating to errors and near misses, which harms individual patients and also hinders their ability to learn from past errors and prevent future ones through open discussion.[66] Effective doctor-patient communication is therefore important not only for enhancing the well-being of both doctors and patients[67] but also, as we maintain, for improving the quality of medical services.[68]

patient relationship. *Id.* Under the "consumerist" model, patients are described as having gained ultimate control over medical decision-making. *Id.* at 28. The "default" model is another consequence of the weakening of the medical profession together with the growing legal recognition of patient rights and autonomy. *See id.* at 33–34. Both the consumerist and default models represent extreme consequences of the shift in the power dynamics between doctors and patients. A more productive mode of interaction can be found in what has been termed a "mutual" model of doctor-patient interaction under which patient involvement in decision-making processes has been viewed as cardinal to medical care while acknowledging medical professional expertise and authority. *Id.* at 32. The mutual model, on the other hand, opens the door to a different kind of interaction between physicians and patients, one that is premised on collaboration. *Id.*; *see also* DiMatteo, *supra* note 11, at 149 (advocating for what he terms "collaborative informed choice"); Emanuel & Dubler, *supra* note 12, at 324 (pointing out that the lack of collaborative physician-patient communication, arising from financial incentives, has undermined the efforts for ensuring a positive physician-patient relationship).

[65] Many articles tie patients' motivation to sue to their physicians' communication patterns over disclosure of errors. Specifically, major driving forces for suing physicians are the desire for information about the circumstances under which the error occurred, the physician's demeanor, and the patient's desire for an apology. *See, e.g.*, Duclos et al., *supra* note18, at 483; Hickson et al., *supra* note 35, at 8; Levinson et al., *supra* note 18; Mazor et al., *supra* note18, at 1694; Virshup et al., *supra* note 11; *see also* DiMatteo, *supra* note 11, at 151 ("Effective communication can reduce the risk of malpractice litigation significantly by enhancing the physician's capacity to determine the patient's expectations for treatment outcomes, thereby reducing misunderstanding between physician and patient."). In addition, when medical decisions are a product of collaborative communication, patients are less likely to blame their physicians for the outcome. DiMatteo, *supra* note 11, at 157.

[66] *See* Todres, *supra* note 7, at 690–91. This reluctance also extends to errors made by others, promoting "a culture of protecting other doctors' actions." *Id.* at 691.

[67] Miriam Divinsky, *Stories for Life: Introduction to Narrative Medicine*, 53 CANADIAN FAM. PHYSICIAN 203, 203 (2007) (stating that better communication could provide "a remedy for the burnout, exhaustion and disillusionment many . . . physicians are feeling").

[68] *See* Mello et al., *supra* note 6, at 43 (tying the "culture of mistrust" that develops under a malpractice regime to the quality of care delivered); Todres, *supra* note 7, at 687 ("The current malpractice liability system deters open dialogue and information

Before we turn to the benefits associated with improved doctor-patient communication patterns, we elaborate on some of the historic developments that have shaped the doctor-patient relationship in the malpractice context in recent decades. This reveals the centrality of communication in conflicts between doctors and patients as well as its potential as a source for prevention and resolution of malpractice-related conflicts.

B. The Sources of Current Tensions in Doctor-Patient Relations

The history of doctor-patient relations in recent decades sheds some light on the contentious nature of these interactions in the malpractice context. Over the years, physician-patient relations have changed, with patients gaining increased power vis-à-vis doctors and the medical establishment, while physicians have lost some of their authority and have had to accept a heightened degree of scrutiny by their patients. These changes can be attributed to several factors, among them—legal recognition of individual patient rights[69] and the rise of consumer rights (i.e., rights *in* healthcare as opposed to the right *to* healthcare)[70]—developments that have both been strengthened by the healthcare industry's own commercial interests.[71]

In terms of patient rights, a deep change took place in the 1970s, when a series of court decisions did away with traditional paternalism in doctor-patient relations and made way for a new approach. This approach enshrined a patient's right to make informed medical decisions and to view and correct their medical records.[72] It

exchange to the detriment of patient care as well as the emotional well-being of both patients and healthcare providers."); *infra* Part II.C.

[69] The patients' rights movement and the rise of a moral paradigm in healthcare law promoted the insertion of values such as autonomy, liberty, privacy, consent, voice, and human dignity into all areas of health law, including malpractice, bioethics, informed consent, and informational privacy. *See* GEORGE J. ANNAS, THE RIGHTS OF PATIENTS (3d ed. 2004); JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT (1984); Einer Elhauge, *Allocating Health Care Morally*, 82 CALIF. L. REV. 1449 (1994); Hall, *supra* note 55, at 464; Meir Katz, *Towards a New Moral Paradigm in Health Care Delivery: Accounting for Individuals*, 36 AM. J.L. & MED. 78, 108–09 (2010).

[70] For this distinction, see George J. Annas, *A National Bill of Patients' Rights*, 338 NEW ENG. J. MED. 695, 696 (1998).

[71] Commercial interests have gained dominance since the 1970s with the introduction of the economic prism to the field of healthcare and the rise of the market paradigm in healthcare law. *See* M. Gregg Bloche, *The Invention of Health Law*, 91 CALIF. L. REV. 247 (2003); Einer R. Elhauge, *Can Health Law Become a Coherent Field of Law?*, 41 WAKE FOREST L. REV. 365 (2006).

[72] Annas, *supra* note 70, at 695–96; Marc A. Rodwin, *Patient Accountability and Quality of Care: Lessons from Medical Consumerism and the Patient' Rights, Women's Health and Disability Rights Movements*, 20 AM. J.L. & MED. 147, 152–53 (1994).

also delineated the healthcare team's duty to obtain patients' informed consent for medical procedures, to keep full medical records, and to maintain the confidentiality of such records.[73] The concept of patient-informed consent, and related rights, such as the right to refuse treatment, were further developed by the courts and in academia in the 1980s.[74]

While patients have gained increased power, the medical profession has experienced an all-time low on the personal, professional, and organizational levels;[75] a drain in medical staff in particular fields of medicine;[76] and extreme financial crises at public and community hospitals.[77] Availability of medical information has made patients more informed,[78] while developments in technology have made it more difficult for doctors to know all that they are expected to know.[79] The close of the twentieth century and the beginning of the twenty-first have been accompanied by extensive writing on the decline of the "professions." In a well-known article, Herbert Kritzer describes the decline of the medical and legal professions.[80] Kritzer claims that this decline is due to a combination of factors—foremost, the rise of digital media and the wide availability of information formerly monopolized by the professions, coupled with increased specialization and compartmentalization of the work into routine, simple, and repetitive tasks, some of which can now be handled quite effectively by low-skilled workers at much lower costs.[81]

These developments have challenged doctors' authority over patients and have transformed the doctor-patient relationship quite dramatically. While in the past, patients acceded to their doctor's advice, the general family doctor has now given way to a series of spe-

[73] Annas, *supra* note 70, at 695–96; Rowin, *supra* note 72, at 152–53.

[74] *See* Rodwin, *supra* note 73, at 152–53.

[75] Marion Crain, *The Transformation of the Professional Workforce*, 79 CHI.-KENT L. REV. 543, 564–71 (2004); Herbert Kritzer, *The Professions Are Dead, Long Live the Professions: Legal Practice in a Post-Professional World*, 33 LAW & SOC'Y REV. 713, 729–30 (1999); George Ritzer & David Walczak, *Rationalization and the Deprofessionalization of Physicians*, 67 SOC. FORCES 1 (1988).

[76] Florence Yee, *Mandatory Mediation: The Extra Dose Needed to Cure the Medical Malpractice Crisis,* 7 CARDOZO J. CONFLICT RESOL. 393, 400 (2006).

[77] *See* John D. Blum, *Beyond the Bylaws: Hospital-Physician Relationships, Economics and Conflicting Agendas*, 53 BUFF. L. REV. 459, 463 (2005).

[78] P. Greg Gulick, *E-Health and the Future of Medicine: The Economic, Legal, Regulatory, Cultural, and Organizational Obstacles Facing Telemedicine and Cybermedicine Programs*, 12 ALB. L.J. SCI. & TECH. 351, 373 (2002).

[79] Riemer, *supra* note 36, at 425.

[80] Kritzer, *supra* note 75.

[81] *Id.*

cialists whose authority patients and their families often question. This is due to the abundance of information that is freely available online, competing experts' opinions, and constantly evolving technologies that challenge existing conceptions.[82] Over the years, criticism has expanded beyond the treatment of individuals to treatment of specified groups, exposing biases in the profession. Targeted groups include women and people with disabilities, and these biases highlight the limits of expert opinion.[83] These changes have allowed patients to contest the course of treatment recommended by the healthcare team more frequently, which generated arguments in the course of treatment, as well as malpractice accusations and claims in its aftermath.

Patients have gained increased power not only vis-à-vis their caregivers, but also with regard to the medical establishment. Increasingly, hospitals are being driven by competition and commercial considerations,[84] seeking, on the one hand, to draw more patients (at least to certain departments and for specific procedures) while, on the other, to reduce expenditures primarily by cutting hospitalization costs.[85] These changes have put departments like emergency rooms under severe pressure, but have also given patients—or at least *some* patients suffering from *certain* illnesses—more power.[86] Since consumers make choices and such choices are often based on their satisfaction with treatment, patients' voices and concerns have become more prominent.[87] In other cases, however, dissatisfaction and conflicts have remained widespread.

Through the years, litigation over malpractice-related claims has soared,[88] as have other conflicts over such matters as coverage for

[82] *Id.* at 725–31. These developments are typical of the Israeli healthcare arena as well. *See* Ran Belitzer, *The Revolution of Information and the Impact on Doctor Patient Relationships*, 143 HAREFUAH 749 (2004).

[83] *See* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 388–89 (1982); Rodwin, *supra* note 73, at 157–66.

[84] As a result of a combination of factors that have taken place since the 1970s, U.S. hospitals were transformed from "community service entities" to "healthcare delivery businesses." Blum, *supra* note 77, at 463.

[85] *Id.*

[86] Rodwin, *supra* note 73, at 155–57.

[87] Louise G. Trubek, *New Governance and Soft Law in Health Care Reform*, 3 IND. HEALTH L. REV. 139, 157–58 (2006). *But see* Rodwin, *supra* note 73, at 154–55 (describing the difficulties in making such decisions in light of information asymmetries as well as some of the ways these problems have been addressed).

[88] Barringer et al., *supra* note 43, at 727; Weiler, *supra* note 23, at 912.

medical services and complaints about doctor demeanor.[89] With the rise in complaints and conflicts, many physicians have come to view patients with suspicion, fearing that professional encounters could deteriorate into legal debacles in the future.[90] Similarly, patients have consistently complained about physicians' distant and cold demeanor and their reluctance to provide satisfactory explanations in a direct and comprehensible fashion.[91] While doctors have always been infamous for their brusque manner, the role played by fear of liability in sustaining such communication culture has received insufficient attention. As the historic overview suggests, it may very well be that the tort-based malpractice regime has sustained doctors' traditional mode of communication in the face of social pressures for change.

As we can see, the picture of doctor-patient relations that emerges from the above overview is a complex one. On the one hand, the changes that have occurred in the last few decades can be seen as positive developments enshrining patient rights and contributing to the equalization of access to important information. On the other hand, these very developments and the ensuing change of balance in doctor-patient relations have also given rise to distrust, conflict, and defensive conduct on the part of healthcare practitioners. In the following section, we show that the impact of problematic communication patterns can extend beyond the emotional realm, shaping the very quality of medical services provided.

C. The Significance of Doctor-Patient Communication

Medical research and professional training have recognized the significance of open and effective communication between doctors and patients.[92] Various empirical studies conducted in the medical arena have substantiated the connection between such factors as relationship, communication, trust, and improved medical results. These findings show that a collaborative mode of communication could improve the quality of medical treatment in the following ways.

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[89] Indeed, in recent years many hospitals and medical groups have instituted an ombudsman or patient affairs office to handle such complaints. *See* Hickson et al., *supra* note 35, at 12.

[90] *See* sources cited *supra* notes 59–60.

[91] *See, e.g.*, Sherri Davis-Barron, *Cold Hard Death, Cold Hard Doctors*, 146 CAN. MED. ASS'N J. 560 (1992).

[92] *See* DiMatteo, *supra* note 11, at 154 ("The most effective relationships between physicians and patients are those in which power and control of health care decisions are shared. In practice, this sharing requires open, honest and forthright conversation between physician and patient.").

First, it is widely accepted that the quality of care depends on the provider's ability to obtain all relevant information regarding the patient's condition.[93] While physician-training places an emphasis on the acquisition of interviewing skills, experience on the ground demonstrates that the effectiveness of these techniques varies widely, hampered by an authoritarian professional culture and the reality of time, pressure, and exhaustion. Indeed, research has shown that patients tend to disclose different information on their condition to the various providers they encounter while being treated.[94] This state of affairs is further exacerbated by cognitive biases, which drive physicians to assume what is relevant and what is not prior to asking questions, and to further interpret the answers they receive as strengthening their preexisting assumptions on the patient's state.[95] Studies have shown that open-ended questions allow the physician to draw a richer, sometimes surprising, account of the patient's condition without consuming significantly more time.[96] A related link between relationships and quality of medicine lies in the physician's ability to diagnose the condition correctly. Heuristics also play a role, and the ability of the physician to explore the patient's perspective depends on his or her information gathering capabilities.[97]

Another line of research illustrates the significance of a collaborative doctor-patient relationship with regard to the patient's motivation to seek treatment initially,[98] and to follow the prescribed treat-

[93] DiMatteo, *supra* note 11, at 150 ("Effective communication is essential for the diagnosis and full understanding of the problem a patient brings to the clinical encounter.").

[94] *Id.* at 157 ("More effective physician-patient communication is also associated with more adequate histories given by patients.").

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

[96] *See* DiMatteo, *supra* note 11, at 150 (stating that patients will rarely tell their story for more than two and a half minutes and that if interrupted, patients will typically reiterate their concerns at the end of the visit so that no real time saving is achieved by silencing them early on); Divinsky, *supra* note 67, at 204 (stating that research has estimated that the time it takes patients to describe their condition ranges from six seconds to seven minutes) *But see* ROTER & HALL, *supra* note 12, at 79–92, 114 (stating that doctors are very bad at asking open-ended questions, the skills needed in order to draw out patients' stories).

[97] Rita Charon, *Narrative and Medicine*, 350 NEW ENG. J. MED. 862, 863 (2004) ("[N]arrative competence gives the doctor not only the means to understand the patient, but fresh means to understand the disease itself."); Divinsky, *supra* note 67, at 204 (describing how only when she truly listened to patients was she able to decipher what stopped them from quitting smoking or addressing obesity)

[98] Todres, *supra* note 7, at 690–91.

ment.[99] Physicians' willingness to provide patients with full information in an open and engaging manner has proven a critical component in patients' adherence to a medical regimen and in their ongoing commitment to keeping medical appointments.[100] Studies have shown that, on average, approximately forty percent of patients fail to follow short and long-term treatments, a statistic that cuts across all socio-economic and educational levels.[101] One study found that approximately one-third of patients who received prescriptions were taking the medication in a manner that "posed a serious threat to their health."[102] One explanation for this finding lies in other research, which has found that physicians who prescribe medication tend to conduct shorter visits, in fact using the prescription to avoid open and elaborate communication with their patients.[103] Finally, we find that physicians do very little in terms of communicating with their patients about changes in lifestyle habits that are strongly connected to health and disease prevention (e.g., smoking and weight-related diseases), even though studies have found that physician communication on these issues can have a significant impact on patients' habits.[104] The connection between these findings and the quality of healthcare seems evident when we view the breadth of healthcare services as indicative of a high quality healthcare system and understand the physician's obligations as extending beyond the diagnosis phase.

In addition, some research has found a correlation between doctor-patient communication patterns and health outcomes for patients. In exploring the existence of such a correlation, one study found that "[b]eyond the obvious—the transfer of information patients need to manage their disease effectively—the communication

[99] DiMatteo, *supra* note 11, at 156 ("In the area of adherence, such awareness and recognition [of the need for effective communication] have proven invaluable."); Hall, *supra* note 55, at 478. *But see* Robert Gatter, *Faith, Confidence, and Health Care: Fostering Trust in Medicine Through Law*, 39 WAKE FOREST L. REV. 395, 397 (2004) (critiquing the implied support in the submissiveness of patients entailed in this argument).

[100] ROTER & HALL, *supra* note 12, at 140–44; DiMatteo, *supra* note 11, at 157 ("When physicians offer more information, as well as more positive talk, less negative talk, and more questions about adherence, their patients are more likely to follow the chosen treatment. Physicians' interpersonal manner and nonverbal communication have important effects on patients' subsequent health behaviors and on their keeping of appointments.").

[101] DiMatteo, *supra* note 11, at 150.

[102] ROTER & HALL, *supra* note 12, at 140.

[103] *Id.* at 143.

[104] *Id.* at 143–44.

between physicians and patients can be a source of motivation, incentive, reassurance, and support as well as an opportunity for revision of expectations of both patient and physician."[105] Other studies have emphasized the connection between collaborative communication and "improved recovery from surgery, decreased use of pain medication, and shortened hospital stays, as well as improved physiological changes in blood pressure and blood sugar, improvement of symptoms and better management of chronic conditions."[106] While there is no obvious explanation for the connection between communication and outcome, the various studies conducted since the 1960s seem to provide strong substantiation for the link between the two.

Furthermore, research has shown that patient satisfaction is dependent on effective communication with the physician and on the nature of their relationship. Indeed, perhaps surprisingly, factors relating to the quality of communication physicians had with their patients and their ability to exhibit empathy towards their patients and provide them with adequate information have been shown to be the dominant factors in evaluating the quality of care they received, more so than such elements as the scope of tests ordered by physicians or the quality of their documentation.[107] Specifically, patient satisfaction has been tied to the physician's mode of communication and the social climate during their meeting. A strong connection has been found to exist between patient satisfaction and patient-centered communication in which the physician actively seeks and facilitates the patient's perspective through non-judgmental and open communication, positively-toned statements, and well-developed non-verbal skills (both in terms of deciphering patients' feelings and needs and in generating a warm and open atmosphere).[108] Some studies have established a connection between patients' own evaluation of the treatment they received and physicians' performance in medical tasks.[109] While patients' ability to evaluate quality of medical services is obviously limited,[110] it is a significant factor in shaping a patient's

[105] Sherrie H. Kaplan et al., *Assessing the Effects of Physician-Patient Interactions on the Outcomes of Chronic Disease*, 27 MED. CARE 110, 112 (Supp. 1989).

[106] ROTER & HALL, *supra* note 12, at 146–48. For various studies emphasizing the connection, see DiMatteo, *supra* note 11, at 158.

[107] Hickson et al., *supra* note 35, at 9–12.

[108] ROTER & HALL, *supra* note 12, at 136–38.

[109] *Id.* at 133.

[110] *Id.* at 134.

trust in the particular physician who treated them, as well as in the healthcare system more generally.[111]

Finally, research has established a link between physician well-being and measures of high quality medical care. Physician well-being and satisfaction, tied to several domains, including the quality of their relationship with their patients, have been found to an increase in physician attentiveness and a decrease in phenomena such as risky prescribing practices.[112] Narrative medicine is a strand within medical professional training that demonstrates this line of thought. Narrative medicine promises to "enrich the doctor-patient relationship, improve patient care, and enhance doctors' sense of satisfaction with work" by teaching doctors to listen, to reflect, and to understand the narrative conveyed by the patient, and to demonstrate emotion and more effectively communicate information to the patient.[113] While physicians have traditionally been taught and trained to disconnect from their patients, narrative medicine advocates that doctors should stay in touch with their emotions.[114] This approach dismisses the common justifications in support of emotional detachment, such as time constraints or the emotional burden associated with attachment.[115]

These research findings underscore the importance of communication skills and relationship-building capacities to the assurance of high quality healthcare. These findings thus challenge the perceived distinctions between relevant and irrelevant information and between medical-clinical skills and relationship and communication skills, positing that both are central to high-quality professional care.[116] The

[111] However, people tend to rate their own doctors higher than healthcare providers in general, a tendency that is attributed to cognitive biases. *See* ROTER & HALL, *supra* note 12, at 135.

[112] Mello et al., *supra* note 6, at 43. The recognition that a fresh approach to the doctor-patient relationship holds promise for increased physician wellbeing is what has driven the emergence of the narrative medicine movement. *Id.*

[113] Divinsky, *supra* note 67, at 203.

[114] *Id.*

[115] *Id.*

[116] *See* DiMatteo, *supra* note 11, at 149 ("The role of communication in the physician-patient relationship, however, is sometimes trivialized. It may seem natural to achieve therapeutic success by placing great emphasis on physical examinations, blood tests, x-rays, sonograms, medications, and surgeries. However, available information suggests that when this is done to the exclusion of a meaningful exchange of information and ideas . . . several critical elements of care are adversely affected."). This is also fostered by the fact that the system reimburses physicians for procedures done to patients but not for talking to them, *id.* at 153, and is evident in the prominent definitions of quality of care in the field. Avedis Donabedian, in an article mapping the prevailing approaches to the measurement of quality of medical in-

problems with the distinction between clinical-knowledge skills and communication skills are twofold. First, the notion of a clear divide between clinical and non-clinical medical skills and competencies is questionable. This is due to the interdependence that exists between clinical performance and communication skills and between the perceived quality of care provided and how patients are treated. Second, even where the distinction between the two spheres seems correct, the hierarchy between them is flawed because it assumes the inherent inferiority of relational aspects, which are considered peripheral capabilities needed merely to ensure patient satisfaction and to assuage complaints. Despite the proven significance of relationships to quality of care, research has shown that the traditional mode of communication constitutes the norm and attention has remained focused on physicians' clinical skills and expertise.

Within the medical profession, certain schools, such as narrative medicine, have recognized the benefits of collaborative communication and the need for a deep structural change in the profession's understanding of the doctor-patient relationship. These strands have remained peripheral in the medical landscape, and have failed to garner the requisite support to bring about real change.[117] One explanation could be that these approaches have remained focused on the internal-professional front while neglecting the dynamic role of law in shaping doctor-patient relationships.

In the following Part, we elaborate on some of the exceptional efforts launched by the medical and legal establishments to transform the medical communication culture. This is often driven by the desire to reduce malpractice claims, as empirical data has substantiated the connection between communication skills and the likelihood of making an error on the one hand, as well as the tie between communication and the likelihood of patients suing for malpractice on the

tervention, describes three dominant approaches: (1) outcome of medical services (recovery, post-treatment functioning, and survival rates); (2) process of care (appropriateness and completeness of information obtained through examinations, diagnostic tests, and physicians' technical competence in performing medical intervention); and (3) structure (examining the adequacy and qualification associated with the setting in which treatment was rendered). Avedis Donabedian, *Evaluating the Quality of Medical Care*, 83 MILBANK FUND Q. 691, 692–95 (2005).

[117] Many current medical services still lack "narrative competence," which not only detracts from "the quality of patient care, but it contributes to an ailing health care system, with dissatisfaction and frustration felt by health care consumers and those who care for them." *See* COLUMBIA UNIV. SCH. CONTINUING EDUC., COLUMBIA UNIVERSITY LAUNCHES GRADUATE PROGRAM IN NARRATIVE MEDICINE (2009), *available at* www.narrativemedicine.org/announcement-1.doc.

other.[118] We also suggest why such efforts have enjoyed only limited success so far. While the measures described below represent an understanding that the doctor-patient relationship is in crisis and a new balance is needed to restore trust, these targeted avenues fail to address the root cause of the problem: the need to do away with the incentives provided by the current tort system governing malpractice disputes and to adopt a legal regime that allows for a collaborative doctor-patient relationship to develop.

D. Partial Measures for Improving the System

There have been limited areas in which the connection between communication and malpractice has led to the adoption of important reforms and changes. Such steps have included physician communication training,[119] the institutionalization of ADR avenues in hospitals for addressing doctor-patient disputes,[120] the adoption of laws requiring providers to establish "disclosure conversations" with patients and family members in the aftermath of a serious adverse event,[121] the adoption of "Apology Laws" that shield doctors who apologize for a mistake from legal liability,[122] and protocols for disclosure of medical mistakes by healthcare institutions.[123]

Many of the above efforts have been driven primarily by concern over malpractice litigation and a desire to reduce the number of errors and claims. Enhancing doctor communication skills has been seen as a preventative measure against the occurrence of mistakes based on the realization that at least some errors were a result of poor communication.[124] The establishment of ADR channels and the adoption of the "Apology Laws" have been viewed as a means of encouraging pre-litigation resolution of malpractice disputes by satisfying the patients' and/or family members' need for information

[118] *See* discussion and references *supra* note 65.

[119] *See* Bobbi McAdoo, *Physicians: Listen Up and Take Your Communication Skills Training Seriously*, 29 HAMLINE J. PUB. L. & POL'Y 287, 290–93 (2008) (describing the impressive efforts to introduce communication skills training into the curriculum of medical schools in the years since the publication of INST. OF MED, *supra* note 11).

[120] *See, e.g.*, Gary A. Balcerzak & Kathryn K. Leonhardt, *Alternative Dispute Resolution in Healthcare: A Prescription for Increasing Disclosure and Improving Patient Safety*, PATIENT SAFETY & QUALITY HEALTHCARE, July—Aug. 2008, *available at* http://www.psqh.com/julaug08/resolution.html.

[121] Liebman & Hyman, *supra* note 16, at 123.

[122] Jonathan R. Cohen, *Legislating Apology: The Pros and Cons*, 70 U. CIN. L. REV. 819, 827 (2002); Jonathan R. Cohen, *Advising Clients to Apologize*, 72 S. CAL. L. REV. 1009, 1061–65 (1999)

[123] MASS. COAL. FOR THE PREVENTION OF MED. ERRORS, *supra* note 11, at 22–24, 26.

[124] *See* discussion *supra* Part II.C.

and/or for an apology.[125] These developments have been based on a substantial body of research establishing that patients' decisions to sue in the aftermath of a medical mistake are not based on monetary considerations,[126] but are driven by frustration over lack of communication about medical errors and mishaps.[127] Consequently, numerous U.S. hospitals have adopted internal conflict management schemes[128] to address patient complaints and malpractice disputes.[129]

Interestingly, while these efforts have shown real potential in addressing some of the deep-rooted problems associated with malpractice,[130] the various initiatives have not succeeded in bringing about real change in the communication culture between doctors and patients, and have failed to reduce significantly the communication problems with patients.[131] The explanation for the persistence of the hierarchical, distant, and curt mode of communication in doctor-patient relations has typically focused on the traditional values and culture of the medical profession.[132] While professional culture is certainly a factor in sustaining a closed communication style between doctors and patients, the current legal regime governing malpractice disputes plays a significant role in cutting off communication channels between physicians and patients. This is true not only in the aftermath of a medical mistake, but in a much deeper sense, infiltrating doctor-patient relations from the outset, leading doctors to focus on "reducing risk rather than error."[133]

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[125] Hetzler, *supra* note 15, at 6.

[126] Liebman & Hyman, *supra* note 16, at 30; Tamara Relis, *"It's Not About the Money!": A Theory on Misconceptions of Plaintiffs" Litigation Aims*, 68 U. PITT. L. REV. 701 (2007).

[127] *See supra* note 65 and accompanying text.

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

[129] Balcerzak & Leonhardt, *supra* note 120; Liebman & Hyman, *supra* note 16, at 28–29; Scott, *supra* note 47, at 798; Sheea Sybblis, *Mediation in the Health Care System: Creative Problem Solving*, 6 PEPP. DISP. RESOL. L.J. 493 (2006); Szmania et al., *supra* note 128, at 77.

[130] Balcerzak & Leonhardt, *supra* note 120; Szmania et al., *supra* note 128, at 74–75, 77.

[131] Anderson & D'Antonio, *supra* note 14, at 17 (citing a healthcare professional who described how the conflict resolution skills taught in medical school get "untaught" in the residency period). Naturally, although this could be a result of the quality of particular training and courses offered, *see* Cegala & Broz, *supra* note 125, the view offered in this Article is that there is a deeper explanation for this failure.

[132] Hoecker, *supra* note 52, at 252.

[133] Todres, *supra* note 7, at 677. An additional result of this reaction is the growing practice of defensive medicine. *See id.* at 684–85.

Therefore, we contend that only by displacing the entire malpractice system is it possible to escape its shadow and transform doctor-patient relations in a meaningful way. To that end, we advocate a shift from a tort-based system to the adoption of a no-fault administrative scheme. This proposal is by no means new. As we describe below, no-fault reform proposals emerged as early as the 1970s. While these proposals have been based on varying justifications over the years—ranging from improved compensation for victims to enhanced patient safety—none of the proposals has put forth a justification grounded in the doctor-patient relationship and its impact on the quality of healthcare. In the following Part, we examine whether and under what conditions the shift to no-fault would allow physicians to adopt a collaborative mode of communication and build better relationships with patients, boosting existing efforts within the medical arena to improve communication and transform the doctor-patient relationship.

III. NO-FAULT AS A MEANS OF TRANSFORMING THE DOCTOR-PATIENT RELATIONSHIP

A. The History of the No-Fault Alternative: From Compensation to Learning

Since the mid-1970s the medical and legal literature on malpractice has presented the no-fault compensation scheme for injuries related to medical errors as an attractive alternative to the existing tort-based system.[134] The interest in no-fault has been driven by the emergence of such systems in other countries, with New Zealand and Sweden being the leading models.[135] The developments abroad permeated the U.S. legal system in the late 1980s, in a somewhat different format. The U.S. experiment introduced pockets of no-fault systems in two states—Virginia and Florida,[136] but the calls for a more com-

[134] Barringer et al., *supra* note 43, at 728; Havighurst & Tancredi, *supra* note 23, at 128–32; Eleanor D. Kinney, *Malpractice Reform in the 1990s: Past Disappointment, Future Success?*, 20 J. HEALTH POL. POL'Y & L. 99, 106 (1995); O'Connell, *supra* note 23, at 34–42; Weiler, *supra* note 23, at 944–47. For a detailed discussion relating to the distinctions drawn between *medical errors*, *adverse events,* and the inner distinction between *preventable* and *unpreventable* adverse events, see *supra* note 24 and accompanying text.

[135] *See* Allen Kachalia et al., *Beyond Negligence: Avoidability and Medical Injury Compensation*, 66 SOC. SCI. & MED. 387, 400 (2008).

[136] Barringer et al., *supra* note 43, at 738. These systems were designed to cover specific instances of birth-related injuries, as a substitute for the general torts system. *Id.* In both states, the stimulus for the shift to no-fault was a severe insurance crisis because of which obstetricians were unable to obtain insurance coverage and, conse-

prehensive reform of the medical malpractice system have yet to be embraced.

The interest in the no-fault alternative for medical errors in the United States was linked to what has been termed the "malpractice crisis."[137] This crisis was manifested in soaring insurance rates for practitioners,[138] a shortage of professionals in certain high-risk specialties,[139] and the proliferation of defensive medicine,[140] resulting in rising healthcare and legal costs. The crisis was never perceived as relating to the doctor-patient relationship even though the problem soon gave rise to the battle zone mentality described above, and proponents of no-fault never set as a goal the transformation of relations between patients and physicians through legal reform.

The no-fault option has been hailed by its proponents for its promise of a just, simple, and efficient framework in lieu of the complex, cumbersome, unpredictable, and costly tort option.[141] The no-fault alternative is premised on an administrative scheme offering broad compensation that is not dependent on the question of negligence or personal blame of a healthcare provider.[142] Instead, eligibility is based on a definition of a triggering event.[143] In addition, the system provides more limited compensation to a broader class of claimants, thereby controlling some of the indeterminacies associated with the torts system.[144] This structure has been thought to generate a more equitable, quick, and inexpensive compensation scheme, independent of the overburdened and unpredictable court option.[145]

The global political climate that gave rise to the early no-fault alternatives in the 1970s and 1980s was grounded in the meeting point between two intellectual frameworks: the then prominent social wel-

quently, access to obstetric care was severely limited. *See id.* at 738–39; Maxwell J. Mehlman, *Bad "Bad Baby" Bills*, 20 AM. J.L. & MED 129, 129 (1994); Siegal et al., *Adjudicating Severe Birth Injuries Claims in Florida and Virginia: The Experience of a Landmark Experiment in Personal Injury Compensation*, 34 AM. J.L. & MED. 489, 493 (2008).

[137] Barringer et al., *supra* note 43, at 726.

[138] *See id.* at 728.

[139] *See* Michelle M. Mello et al., *Effects of a Malpractice Crisis on Specialist Supply and Patient Access to Care*, 242 ANNALS SURGERY 621, 626 (2005).

[140] *See supra* note 133 and accompanying text.

[141] *See* Barringer et al., *supra* note 43, at 726; Studdert & Brennan, *supra* note 26, at 220.

[142] Studdert & Brennan, *supra* note 26, at 219.

[143] *Id.*

[144] *Id.* at 220.

[145] *Id.* at 226.

fare paradigm[146] and the rise of an economic approach to law (evidenced in the rise of the market paradigm in the context of healthcare law).[147] As we can see, the end of one era and the rise of another created an atmosphere receptive to the no-fault alternative. Nevertheless, these systems only took hold in countries with elaborate welfare systems and were fiercely criticized in the United States on two major grounds—the need for individual deterrence through personal liability and the higher costs for the public associated with the scope of coverage under such systems.[148]

Deterrence was recognized as a major goal of the torts-based system following the spread of law and economics literature in the 1970s and 1980s.[149] The law and economics school underscored the significance of legal incentives in shaping human behavior to maximize aggregate welfare.[150] Thus, by establishing individual liability, it was believed that a rational doctor would be deterred from acting negligently. As we can see, while liability is placed on an individual healthcare provider, the rationale behind such a policy is a broad-societal one. The resistance to the no-fault alternative stemmed from the position that individual blame was essential for steering physicians' future conduct and the inculcation of safe practices by individuals.[151] Ironically, the early law and economics literature that led to

[146] The social welfare paradigm reigned in the twentieth century, emphasizing values and principles such as solidarity, social responsibility, and a high degree of government involvement in the regulation of markets, and led to the strengthening of social security arrangements in various countries. The United States was no exception, as evidenced by the adoption of workers' compensation systems. *See* Weiler, *supra* note 23, at 910. The social welfare worldview comported with the adoption of a no-fault alternative because such system would allow for a broader and more equitable compensation base. *Id.* at 924.

[147] *See supra* note 71. The spread of the market paradigm in healthcare law and of economic analysis in tort law was indicative of a shift in the broader political climate from a social welfare to a neo-liberal ideology. *See* Ugo Mattei, *The Rise and Fall of Law and Economics: an Essay for Judge Guido Calabresi*, 64 MD. L. REV. 220, 225, 236, 247 (2005). Under a law and economics analysis, efficiency logic is reflected in the primary goals of legal arrangements of the common law. *See* Richard A. Posner, *The Ethical and Political Basis of the Efficiency Norm in Common Law Adjudication*, 8 HOFSTRA L. REV. 487, 502–06 (1980).

[148] Studdert & Brennan, *supra* note 26, at 220.

[149] *See, e.g.*, Saul Levmore, *Carrots and Torts*, *in* CHICAGO LECTURES IN LAW AND ECONOMICS 203, 203–04 (Eric A. Posner ed., 2000); Daniel W. Shuman, *The Psychology of Deterrence in Tort Law*, 42 U. KAN. L. REV. 115, 118 (1993).

[150] *See* William M. Landes & Richard A. Posner, *The Positive Economic Theory of Tort Law*, 15 GA. L. REV. 851, 857–58 (1981).

[151] *See* Studdert & Brennan, *supra* note 26, at 220; *see also* Michelle Mello & Troyen A. Brennan, *Deterrence of Medical Errors; Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1603 (2002).

the rise of deterrence as the new goal of the torts system also justified a shift to a no-fault system based on the torts system's failure to achieve deterrence.[152] It therefore seemed questionable to reject no-fault arrangements based on the grounds of deterrence.[153]

Another major source of criticism of no-fault schemes is related to the costs that operating such systems would allegedly entail. Critics claimed that these systems are prohibitively expensive due to costs associated with the larger pool of claimants.[154] Proponents, on the other hand, emphasized the need to include more justified claims in the compensation scheme than in the current tort system, which presents significant barriers to the pursuit of justified claims.[155] Indeed, the debate could be framed as a controversy over whether the torts system enabled too many or too few claims.[156]

In effect, the question remained which legal arrangement could deliver the goal of just compensation, at a reasonable cost, without sacrificing deterrence. The first comprehensive attempt to provide empirical data that would shed light on the debate was published in the 1990s by a group based in the Harvard School of Public Health (the "Harvard Group"). This was an extensive study of medical injury and malpractice claims in New York that investigated the prevalence of injuries incurred during medical treatment, the incidence of mal-

[152] Guido Calabresi's *Views and Overviews*, published in 1967, played a key role in advancing the idea that a fault-based regime is not an optimal vehicle for achieving efficiency and deterrence: "Fault uses the market in an extensive and unstable way to reduce fault caused accidents, while from the standpoint of market deterrence, we want to use the market in an efficient and stable way to reduce accident costs, whether they are fault-caused or not." Guido Calabresi, *Views and Overviews*, 1967 U. ILL. L.F. 600, 610 (1967).

[153] Studdert & Brennan, *supra* note 26, at 220; *see also* Mello & Brennan, *supra* note 151, at 1603–06 (addressing the critiques voiced against the no-fault option based on deterrence).

[154] Barringer et al., *supra* note 43, at 748.

[155] *E.g.*, Weiler, *supra* note 23, at 921–25. Weiler raises an additional important aspect of the costs of malpractice versus no-fault, arguing that "the resulting costs will be 'afforded' somehow—if not by the broader community, then by the immediate victim and family." *Id.* at 922.

[156] Those who opposed the no-fault reform proposals typically viewed the malpractice crisis (rising insurance premiums) as resulting from (and generating) overlitigiousness. Therefore, while they recognized the need for change, they endorsed reforms such as caps on non-economic damages, shortening statute of limitations, and limiting attorney fees, but left the tort framework in place. *See* Todres, *supra* note 7, at 693–97 (criticizing this approach). Others focused on the need for redressing those injured in the course of medical treatment, claiming that "[t]he [c]risis is [i]njuries, [n]ot [l]iability." Richard L. Able, *The Crisis is Injuries, Not Liability*, 37 NEW DIRECTIONS IN LIABILITY L. 31 (1988).

practice, and the rate of malpractice claims.[157] The study produced fresh data on the state of medical injury revealing that four percent of hospitalized patients experience an "adverse event," approximately quarter of which were a result of negligence[158] and thus were "preventable." Half of the preventable injuries were found to be the result of negligence by the healthcare provider,[159] but in only ten percent or so of these instances, claims were filed.[160] Another striking discovery was that, "[p]aradoxically, many claims that were filed did not appear to involve harmful negligence."[161] Based on the above findings, the Harvard Group called for a shift to an administrative no-fault regime.[162] Indeed, in the years and decades that followed, members of the group became the most vocal advocates of the no-fault alternative.[163] Their New York research was extended to additional jurisdictions and produced an impressive body of research devoted to the topic published in leading legal and medical journals.[164]

The Harvard Group's data generated a lively debate on the adequacy of compensation under each alternative (torts versus no-fault). The group failed, however, to generate conclusive data[165] on either costs[166] or deterrence[167] under each alternative. Their study acknowledged the problem of costs,[168] but posited that this could be controlled through adequate system design by adopting threshold measures and caps on compensation.[169] Furthermore, it seems that

[157] Brennan et al., *supra* note 25, at 370; Lucian L. Leape et al., *The Nature of Adverse Events in Hospitalized Patients: Results of the Harvard Medical Practice Study II*, 324 NEW ENG. J. MED. 377, 377 (1991); A. Russell Localio et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence: Results of the Harvard Medical Practice Study III*, 325 NEW ENG. J. MED. 245, 245 (1991).

[158] Brennan et al., *supra* note 25, at 371–72. For the distinction between "preventable" and "non-preventable errors," *see supra* note 24 and accompanying text.

[159] Brennan et al., *supra* note 25, at 371–72.

[160] Barringer et al., *supra* note 43, at 740.

[161] *Id.*

[162] *Id.*

[163] *E.g.*, PAUL C. WEILER ET AL., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION 142–46 (1993); Weiler, *supra* note 23, at 925–29; Studdert & Brennan, *supra* note 26, at 220–22; David M. Studdert et al., *Medical Malpractice*, 350 NEW ENG. J. MED. 283, 288–89 (2004).

[164] Hyman, *supra* note 1, at 1641–42, 1642 n.6.

[165] *See id.* at 1646.

[166] *See* William G. Johnson et al., *The Economic Consequences of Medical Injuries*, 267 JAMA 2487(1992) (providing various cost estimates).

[167] Mello & Brennan, *supra* note 151, at 1608.

[168] Studdert & Brennan, *supra* note 26, at 220.

[169] *See id.* The Harvard Group, however, did not address a different problem related to the role that cost plays in the very definition of "preventable adverse event,"

the focus on compensation as the sole factor determining costs is too narrow a view as it fails to address major costs associated with the current system (defensive medicine, adjudication, etc.) and the no-fault alternative (administrative costs). This narrow approach may represent a pragmatic recognition that measuring a broader array of costs is a thorny task.[170]

Over time, the issue of deterrence became a major source of resistance to the no-fault option.[171] Although the Harvard Group study was not designed with deterrence in mind, the Harvard Group's later work provides important insights into the inherent difficulties in measuring deterrence.[172] More importantly, the group questioned the validity of an individual-deterrence paradigm by shifting the focus from an individualistic approach to a system-based error-prevention framework and suggested that the tort system's deterrence capacity is questionable at best, while carefully designed no-fault systems are "far better placed to [deter] than negligence-based litigation."[173] Nevertheless, the proposal failed to garner the requisite support for actual policy change.[174] No-fault became a limited solution for displacing

as defined in the IOM report. INST. OF MED., *supra* note 11, at 28. As one commentator rightfully claims, these definitions are not objectively determined since high prevention costs could make an event "unpreventable" and therefore non-compensable. Maxine M. Harrington, *Revisiting Medical Error: Five Years After the IOM Report, Have Reporting Systems Made a Measurable Difference?*, 15 HEALTH MATRIX 329, 345 (2005).

[170] David M. Studdert et al., *Toward a Workable Model of "No-Fault" Compensation for Medical Injury in the United States*, 27 AM. J.L. & MED. 225, 233–34 (2001); David M. Studdert et al., *Can the United States Afford a "No-Fault" System of Compensation for Medical Injury?*, 60 LAW & CONTEMP. PROBS. 1, 19–25 (1997).

[171] Todres, *supra* note 7, at 701; Weiler, *supra* note 23, at 949.

[172] Hyman, *supra* note 1, at 1646–47. While factors such as the relationship between "malpractice risk" and "cost per patient" may at first blush seem indicative of a deterring effect on healthcare providers, they may also reflect added expenditures associated with defensive medicine practices. Mello & Brennan, *supra* note 151, at 1610; Weiler, *supra* note 23, at 916–17.

[173] Studdert & Brennan, *supra* note 26, at 220.

[174] Undoubtedly, the inconclusive nature of the data on deterrence and costs was a major factor in sustaining the status quo. Another important factor hindering reform has been the divergence in the interests of key stakeholders. As the Harvard Group members reflect retrospectively, not only was there divergence among physicians, attorneys, insurers, and consumers, but also a diversity of positions, needs, and interests within each group. *See* Barringer et al., *supra* note 43, at 743–45, 747–50. Without broad political support for such a scheme, a shift to no-fault was unlikely. In addition, in the 1990s there was no sense of urgency for reform because there was no so-called "malpractice crisis" at that time. *Id.* at 742.

narrowly defined pockets of torts litigation as in the case of the "bad baby" and vaccination laws where such crises did in fact materialize.[175]

The dawn of the twenty-first century brought about an important change in the understanding of the malpractice problem: it was no longer an insurance crisis, but a question of quality. The impetus for change was the publication of the provocative Institute of Medicine report ("IOM Report"), *To Err is Human: Building a Safer Health System*, in 1999.[176] The report unveiled fresh data on the prevalence of medical injuries and their causes. It described medical errors as the eighth leading cause of death in the United States, a figure higher than motor vehicle-related or breast-cancer-related deaths.[177] In addition, the report expanded on the various costs associated with medical errors, highlighting the significance of intangible costs such as loss of trust in doctors and the healthcare system or loss of morale by healthcare providers, which had often been overlooked in previous studies.[178] The report laid the foundation for the shift from an individualistic perspective, focused on compensating injured patients and deterring specific healthcare providers, to a systemic approach geared towards prevention of mistakes and learning about the sources of errors more generally.[179] Errors were no longer viewed as resulting from individual mistakes, incompetence, or oversight but from structural characteristics of the delivery of healthcare services. The report eloquently states: "To err is human, but errors can be prevented."[180] This move echoed similar developments in the aviation

[175] In these specific areas there was a real crisis resulting in the case of neonatal injuries in Florida and Virginia, and in the case of vaccines, in a real shortage of vaccinations. *See* Barringer et al., *supra* note 43, at 735–39.

[176] INST. OF MED., *supra* note 11. The roots of this approach could already be found in the early 1990s. *See, e.g.*, Weiler, *supra* note 23, at 937–41.

[177] *See* INST. OF MED., *supra* note 11, at 26. The reliability of the report's findings was later critiqued, questioning the methodology and reliability of the underlying research. *See* Harrington, *supra* note 169, at 345.

[178] INST. OF MED., *supra* note 11, at 2.

[179] *See* Barringer et al., *supra* note 43, at 745–46; Hyman, *supra* note 1, at 1647 & n.28 (describing the shift as "strategically repackag[ing]" the issue from uneven compensations to "systems-based solutions to medical error"); Studdert & Brennan, *supra* note 26, at 217.

[180] INST. OF MED., *supra* note 11, at 5. The Report makes a series of recommendations, which include the establishment of a national center for research on safety and causes of errors, the adoption of both strong mandatory reporting requirements of errors as well as voluntary efforts for analyzing errors and improving quality, strengthening private efforts and regulatory incentives aimed at the promotion of safety programs in healthcare, and the adoption of safe practices at the level where medical services are delivered. *Id.* at 6–14.

and auto industries that accomplished striking breakthroughs in reducing the frequency of errors.

Despite recognizing the tension between the shadow of individual liability in torts and the drive for learning through rigorous ongoing analysis of errors, the IOM Report did not openly endorse large-scale reform in the torts liability system.[181] Nevertheless, by reframing the issue from one relating to insurance premiums to one enhancing the quality of healthcare services, the report set the stage for renewed interest in no-fault systems. The appeal of no-fault schemes this time around was not framed around their potential for delivering compensation to injured patients more equitably and efficiently, but rather around the fact that such schemes open the door for a more inclusive and sincere analysis of errors, generating learning and enhancing patient safety.[182] Even connection to this much-cited report, however, failed to garner the necessary support for reforming the system. Realizing that comprehensive regulatory reform was unlikely, and perhaps premature, the Harvard Group advocated for the adoption of state-level enabling legislation that would allow for experimentation with no-fault schemes on the ground,[183] which could generate learning about both the optimal design of such systems as well as the sources of errors.[184]

As we can see that, over the years, the debate surrounding the no-fault alternative has changed from an insurance crisis to an issue of quality, from individual liability to structural causes, and from compensation and deterrence to learning and prevention. Nevertheless, we believe that the understanding of the problem is not sufficiently broad. "Quality" in both the IOM Report and in the Harvard Group's writings remains focused on clinical skills and medical knowledge. A broader approach would highlight the role played by

[181] *Id.* at 111.

[182] Indeed, in the years following the publication of *To Err is Human: Building a Safer Health System*, the Harvard Group published a series of articles advocating the shift to a no-fault enterprise liability model as a superior means for achieving both the broader systemic goals of prevention and learning and the individual goal of compensation. *See, e.g.*, Barringer et al., *supra* note 43, at 751; Kachalia et al., *supra* note 135; Studdert & Brennan, *supra* note 26, at 220.

[183] Studdert & Brennan, *supra* note 26, at 222; Mello & Brennan, *supra* note 151. For various critiques of a voluntary approach to no-fault, see Hyman, *supra* note 1, at 1647–54.

[184] While the Harvard Group did not ground its proposals for these schemes in a theoretical-legal framework, they seem to comport with innovative regulatory approaches termed "new governance theories," which gained salience from the mid-1990s. *See generally* Michael C. Dorf & Charles F. Sabel, *A Constitution of Democratic Experimentalism*, 98 COLUM. L. REV. 267 (1998).

doctor-patient relations in the delivery of high quality medical services and, in particular, the effect of collaborative communication in that context.[185] Open, mutual, and non-defensive communication is essential for preventing medical errors, as well as for allowing for deep learning to take place. In the following Part, we explain why the doctor-patient relationship should be a relevant justification for the shift to a no-fault regime. This merits special attention.

B. Relationships as a New Justification for No-Fault

Our work seeks to highlight the doctor-patient relationship as a unique type of social interaction that deserves protection in the design of legal regimes. The doctor-patient relationship has always been a central component of the practice of medicine, but has received relatively little attention in legal scholarship, particularly in the malpractice and no-fault literature.[186] Our suggestion to place relationships at the core follows the work of relational feminists and of communitarians, who seek to nurture and protect relationships by instilling an "ethics of care" and such values as connectedness, interdependence, responsibility, and solidarity.[187]

For relational feminists, the initial protected human connection is the mother-child relationship, which serves as a model for other social ties and categories of human relations.[188] The feminist idea was later extended to a broader moral and political vision under which care, mutuality, and human connectedness are seen as essential moral values.[189] Communitarians have sought to revive the place of culture and community in political theory, emphasizing the aspects of collective identity that are inherent for human beings to flourish and

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[185] In a similar vein, Todres has stated that the no-fault alternative "may provide little or no forum for restoring the relationships that are so integral to health care." Todres, *supra* note 7, at 701. We, however, do not see this as an inherent attribute of no-fault proposals, but as a consequence of system design features, which could be designed to promote the enhancement of relationships.

[186] *See infra* notes 193–98 and accompanying text.

[187] *See, e.g.*, SHEILA BENHABIB, SITUATING THE SELF: GENDER, COMMUNITY AND POSTMODERNISM IN CONTEMPORARY ETHICS (1992); CAROL GILLIGAN, IN A DIFFERENT VOICE: PSYCHOLOGICAL THEORY AND WOMEN'S DEVELOPMENT (1982); MARTHA MINOW, MAKING ALL THE DIFFERENCE: INCLUSION, EXCLUSION, AND AMERICAN LAW (1990); Robin West, *Jurisprudence and Gender*, 55 U. CHI. L. REV. 1 (1988). For communitarian writing on the subject, see MARY ANN GLENDON, RIGHTS TALK: THE IMPOVERISHMENT OF POLITICAL DISCOURSE (1991); CHARLES TAYLOR, THE ETHICS OF AUTHENTICITY (1992).

[188] GILLIGAN, *supra* note 188 at 7–11; West, *supra* note 188, at 2–3, 14–17.

[189] BENHABIB, *supra* note 187, at 164 (asking "[a]re we not all 'concrete others'?" and arguing for "a moral theory [that] allows us to recognize the dignity of the generalized other through an acknowledgment of the moral identity of the concrete other"); West, *supra* note 187, at 70–72.

that are essential for maintaining a meaningful social and cultural life.[190] These movements contrasted the emphasis on relationships and related values with the law's tendency to produce atomistic social relations in which every actor advances her own interest and eventually becomes a "lone rights bearer,"[191] stifling opportunities for meaningful interaction.[192]

We find that the doctor-patient relationship is particularly ill-suited for the atomistic culture that has traditionally characterized legal interventions. Instead of supporting these relations, the atomistic legal culture actually harms this relationship and fails to capture the essence of the broader context of healthcare law of which it is a part. The medical literature has recognized the doctor-patient relationship as the dominant relationship in the healthcare setting and has devoted considerable attention to the development of different models of doctor-patient relationships, the manner in which doctors and patients interact under the various models, and the disparate clinical outcomes associated with each model.[193] Specifically, such literature has found a correlation between a collaborative doctor-patient relationship and improved clinical outcomes, as well as satisfaction of both physicians and patients. We therefore find that a collaborative doctor-patient relationship comports with a relational worldview and actively advocate its adoption, through legal and medical channels.

The centrality of the doctor-patient relationship was also acknowledged by healthcare-law scholars who offered it as an organizing principle for the field and contrasted it with a transactional approach to healthcare law.[194] The transactional perspective was criticized for taking "the atomistic view that each medical encounter is a discrete event rather than part of an on-going web of relationships."[195] By contrast, a relationship-centered perspective was depicted as one that "views medical encounters more holistically, as part of a larger context formed by the parties' interactions with each other and their

[190] For representative works that promote this line of argument, see MICHAEL J. SANDEL, LIBERALISM AND THE LIMITS OF JUSTICE (2d ed. 1998), and TAYLOR, *supra* note 187.

[191] GLENDON, *supra* note 187, at 47–75.

[192] This image is even more extreme in the context of torts, where strangers are brought together by an injurious event.

[193] *See* discussion *supra* Part II.C.

[194] *See* Elhauge, *supra* note 71, at 369–71; Mark A. Hall & Carl E. Schneider, *Where is the "There" in Health Law? Can it Become a Coherent Field?*, 14 HEALTH MATRIX 101, 103 (2004).

[195] Hall & Schneider, *supra* note 194, at 103.

relationships with other individuals and institutions."[196] However, we find that where legal scholarship has addressed the topic, it has assumed that the doctor-patient relationship is premised either on separateness[197] or on complete dependency.[198] We also find that the centrality of the doctor-patient relationship and the need for a relational understanding of healthcare law has received only peripheral attention in malpractice scholarship. As we show in this Article, the current malpractice regime and the no-fault alternatives as designed so far have provided little room for relationships to flourish and for patient input to be taken seriously. We therefore suggest the collaborative mode of doctor-patient relationship as a useful framework for the design of legal arrangements in the realm of healthcare generally and in the design of alternatives to the current malpractice regime specifically.

In terms of doctor-patient relationship, there are three major problems with the current malpractice regime and with the traditional justification for no-fault. For one, under both legal schemes, the focus is on the moment of error. The current torts regime has harmed the doctor-patient relationship in two respects. Most clearly, the torts framework makes interaction between physicians and patients in the aftermath of an adverse event combative and confrontational, rupturing their relations and hampering communication between them both in the medical setting and in court. But the torts regime has a more elusive, indirect influence on doctor-patient relations by shaping medical professionals' routine interactions with their patients during medical visits, tests, and procedures. The no-fault reform proposals have the potential to reduce some of the animosity and tensions that currently characterize doctor-patient relations because of the removal of the individual-blame component. Still, their

[196] *Id.*

[197] Such understanding underlies the literature that ascribes to the moral or market paradigms. *See supra* notes 69, 71. This literature has contributed to the rise of the consumerist and default types of doctor-patient relationship, as described above. *See supra* note 64.

[198] Such understanding underlies the professional paradigm that is characterized by a paternalistic doctor-patient relationship. The professional paradigm is the traditional framework that gave absolute primacy to the medical profession's views and practices in decision-making regarding individual treatment and general policy. *See* Elhauge, *supra* note 71, at 372–73. A paternalistic understanding of the doctor-patient relationship is also evident in the yearning for professional authority in more recent literature, as evidenced in the critique of "trust." *See* Robert Gatter, *Faith, Confidence, and Health Care: Fostering Trust in Medicine Through Law*, 39 WAKE FOREST L. REV. 395, 397 (2004) (critiquing Hall's emphasis on trust as encouraging patients to be compliant and docile rather than sophisticated rights-bearing consumers).

contribution to the relationship aspect will in all likelihood remain limited. This is, first and foremost, because any improvement in relationships will merely be a byproduct of the system and not a goal in itself.[199] Second, these proposals, like the torts system, remain focused on medical errors, excluding those instances in which problems in the doctor-patient relationship have not yet resulted in an adverse event.

By contrast, a relationship-centered no-fault alternative envisions a collaborative doctor-patient relationship, creating an environment that cultivates ongoing cooperation on a structural level, whether an adverse event has taken place or not. Such an approach recognizes that relationships develop over time, are dynamic, contextual, and cannot be fully understood when examined as discrete events that occur at a particular point in time. It therefore seeks to detect a broad range of problems along the continuum of care based on the understanding that problems often cannot be neatly categorized into a particular type of dispute (such as "errors" versus "complaints"), that such categorizations may change over time, and that our understanding of the circumstances which may generate errors also changes and depends on our ongoing examination of complaints, problems, and errors.

A second way that the current medical malpractice scheme and the no-fault alternatives have misunderstood the nature of relationships in healthcare law is by focusing on the doctor-patient relationship as a standalone relationship, which provides sufficient context for understanding the circumstances that surround medical errors. As we have shown throughout this Article, while the doctor-patient relationship is a (or perhaps "the") central relationship in healthcare,[200] it exists within a broader web of relationships, feeding into them and being shaped by them—relationships that exist within the healthcare team itself,[201] between providers and managed care organizations, between patients and managed care, and the like.[202] To gain a better understanding of the sources of medical errors, one must not only examine a broader range of problems and complaints

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[199] *See* Studdert & Brennan, *supra* note 26, at 222.

[200] *See* discussion *supra* Part II.C.

[201] *See* Jenny Firth-Cozens, *Cultures for Improving Patient Safety Through Learning: The Role of Teamwork*, 10 QUALITY HEALTH CARE supp. II ii26, ii27, ii29–30 (2011).

[202] Debra S. Feldman et al., *Effects of Managed Care on Physician-Patient Relationships, Quality of Care, and the Ethical Practice of Medicine*, 158 ARCHIVES OF INTERNAL MED. 1626, 1629–30 (1998); David Mechanic & Mark Schlesinger, *The Impact of Managed Care on Patients' Trust in Medical Care and Their Physicians*, 275 JAMA 1693, 1694–95 (1996).

than those defined as "errors," but also examine problems that arise outside the scope of the doctor-patient relationship and could shed light on the reasons for the error as well as the means for preventing such errors in the future.

Finally, the existing torts framework and the proposed no-fault alternative, by focusing on individual compensation for the injured, have remained loyal to the basic atomistic lone rights bearer paradigm, failing to offer a more satisfying alternative to patients that actually addresses their needs and interests. As we and others before us have claimed, most malpractice claimants are not after monetary compensation, certainly not as a sole and principal goal. Many of them would like to learn additional details regarding the circumstances of the injury, receive reassurance that it will not recur in the future, and hear an apology.[203] The no-fault alternative brings us closer to "what plaintiffs want" by cultivating an atmosphere that allows more communication to take place between physicians and patients following an error and by setting prevention and learning about the sources of mistakes as a goal. Nevertheless, by limiting learning to the realm of medical errors and neglecting the need for nourishing relationships as a goal in and of itself, the no-fault alternative has also been relegated to an individualistic perspective. At the same time, both approaches fail to take into account patient input and voice, offering uniform prefixed monetary remedies through a structured process. By contrast, a relational approach would seek to offer a more pluralistic array of processes, which envisage a range of needs according to varying patient characteristics, different problems, and the range of circumstances under which the problem arose.[204]

In the following Part, we further develop these ideas in offering a more concrete vision for the design of a no-fault alternative from a relational perspective.

C. Designing an Alternative with Relationships in Mind

In considering how the law should address medical errors, a broad view should be employed under which the impact of legal arrangements on relationships is examined at various points along the continuum of care, independent of the occurrence of an error. A commitment to advance collaborative relations between physicians and patients would necessitate a comprehensive scheme that address-

[203] *See supra* note 125 and accompanying text.

[204] *See* discussion *supra* Part III.C.

es a wide range of conflicts including, but not limited to, those stemming from medical errors.[205] Under such a scheme, a no-fault regime would play an important part in dealing with adverse events. But other channels would need to be established to address additional types of conflicts, including legal (such as scope of coverage) and non-legal disputes (such as physician demeanor), as well as disputes and problems that arise from the web of relationships that surround the doctor-patient relationship (such as problems among hospital employees). What sometimes seem to be trivial disputes could expose communication problems, thereby preventing future medical errors and improving satisfaction. Such an approach responds to the understanding that the distinction between clinical and communication skills is flawed and recognizes the need to address relationship-related conflicts. A broad approach that targets a wide range of conflicts, including those that are not categorized as "malpractice," is based on the understanding that all conflicts have an impact on quality and potentially relate to safety and prevention. This renders it difficult to discern ahead of time which of these cases would merit compensation. By addressing a broader pool of conflicts on a systematic level, the doctor-patient relationship is strengthened and broader learning is achieved.

Within the framework for addressing medical errors, a no-fault system that is focused on relationships is likely to generate a richer information pool. The expected increase in the information base is a result of greater disclosure of information. Expansion in the pool of available information can be expected due to the removal of physicians' fear of personal liability, which eliminates some of the strongest barriers to information gathering.[206] In addition, the commitment and trust that come with a stronger relationship between physicians and patients can also be expected to enhance information sharing and disclosure. By removing the legal disincentives for information sharing and by creating positive professional incentives and a supportive climate for disclosure, physicians will divulge more errors and near misses; they will also adopt a more robust understanding of what constitutes each of these categories. Expansive information exchange and disclosure can also be expected to reinforce other proac-

[205] Conflicts stemming from medical errors are one type of dispute that arises in the context of the doctor-patient relationship. The potential for patient complaints to shed light on malpractice-related issues was recognized by Hickson and his co-authors who advocated for the establishment of a broad dispute resolution system that would draw on patient complaints to provide advance warning on potential malpractice allegations. *See* Hickson et al., *supra* note 35.

[206] *See* Studdert & Brennan, *supra* note 26, at 218.

tive efforts to engender a more mutual and collaborative doctor-patient relationship (e.g., communication-skills initiatives and ADR schemes). It will also enable improved learning and decisions that are more just in their allocation of compensation. By expanding the information base on medical errors and related incidents, a no-fault system—premised on the enhancement of relationships—is likely to be able to realize more fully the very goals that no-fault proponents have advanced—compensation and learning.

In terms of compensation, a richer database would make it possible to better distinguish those claimants who deserve compensation from those who do not, something the torts system has been unable to do satisfactorily. Furthermore, a system that enshrines the importance of the doctor-patient relationship can buoy physician willingness to assist patients in recognizing when a claim is merited, as well as in the process of preparing and submitting such claim. While the various existing no-fault systems already boast of such cooperation, we believe that it can be expected to flourish in an environment that enshrines a collaborative ethos.[207]

As for learning, by expanding the dispute base, we can expect richer, more rigorous data gathering that could promote learning on the sources of errors and on the effectiveness of the various means for preventing them, and could generate insights into the connection between other types of disputes and doctor-patient relations. While in the past, disputes were perceived as negative developments and were therefore dealt with grudgingly and suspiciously on an ad-hoc basis, in recent decades this view has changed with entities recognizing the positive potential of learning from disputes for evaluation and improvement.[208] Disputes provide an important source of data about the quality of healthcare, professional practices, patient expectations,

[207] Research on no-fault systems outside the United States has established a link between the shift to no-fault and increased physician collaboration in the claiming process. Specifically, research findings indicate that Swedish physicians are particularly helpful and cooperative in the claim filing process, with sixty to eighty percent assisting patients in the process. Kachalia et al., *supra* note 135, at 389. In fact, patients often seek the physician's advice on whether to file a claim or not, although they are not required to do so by law. *Id.* Unlike Sweden, in New Zealand, the statistics have been somewhat less positive, but this is tied to the former lack of a "Chinese wall" between the claiming and disciplinary avenues, a situation that has since been modified with the hope of achieving a higher level of cooperation by physicians. *Id.* at 391. Here, physicians' participation in the claiming process is required, with the physician filing the claim form. *Id.* at 391.

[208] *See* CATHY COSTANTINO & CHRISTINA MERCHANT, DESIGNING CONFLICT MANAGEMENT SYSTEMS: A GUIDE TO CREATING PRODUCTIVE AND HEALTHY ORGANIZATIONS ix (1996) (recognizing the contribution of disputes to learning and improvement).

sources of errors, and the potential and limitations of current policies. A relationship-based no-fault system would therefore commit to promoting learning that extends beyond the realm of medical errors and relates to the realm of relationships.[209] In some cases, lessons drawn from non-legal complaints may shed light on sources of medical errors as well.[210] Indeed, in a system that is committed to learning, definitions and categorizations can be expected to change over time.[211] Such a system should therefore seek to create a rich database and be committed to ongoing analysis and evolution.

A no-fault system whose primary justification is grounded in the doctor-patient relationship could also prove instrumental in addressing some of the criticism voiced against no-fault enterprise liability schemes. As mentioned above, one of the early criticisms raised against no-fault reform proposals was that the removal of individual blame would hinder deterrence.[212] The answer provided by the Harvard Group, the leading proponents of such reform, was that rather than advancing deterrence, such systems should advance error pre-

[209] For example, over time, recurring medical errors may uncover difficulties in physicians' ability to elicit certain types of information from patients, which in turn, undermines patient trust in the physician and reduces their adherence to the regimen recommended by the doctor and their inclination to return to the same physician in the future. Compensation to the injured will not address the difficulty in terms of the doctor-patient relationship. Other measures would need to be adopted, such as individual training and education of physicians as well as organizational policies that encourage the establishment of a more effective doctor-patient relationship that generates trust and encourages patients to divulge personal, intimate information that is relevant to their medical condition. For the connection between doctor-patient communication and the ability to draw relevant information on patient history and symptoms, see *supra* notes 93–97 and accompanying text.

[210] Consider, for example, repetitive complaints by patients about the intake process in emergency rooms, which could uncover that not enough attention is given to the initial questioning of patients about their condition and symptoms. While complaints could be framed as being about long waits, rude conduct, and the like, our approach would allow the hospital to generate important lessons on the adequacy of information gathering on patients during these crucial early stages. *See* Orna Rabinovich-Einy, *Deconstructing Dispute Classifications: Avoiding the Shadow of the Law in Dispute System Design,* 12 CARDOZO J. CONFLICT RESOL. 55, 71–78 (2011) (demonstrating that the distinction between small-scale "non-litigable" disputes over matters such as long waits and malpractice disputes may at times become blurred).

[211] The understanding of what constitutes an injury that is a result of medical treatment may change over time with developments in technology and change in social values and views on these matters. For example, our understanding of what constitutes a preventable injury will undoubtedly change as globally accessible digital medical records become the norm. *See* Ethan Katsh et al., *Is There an App for That? Electronic Health Records (EHRs) and a New Environment of Conflict Prevention and Resolution,* 74 LAW & CONTEMP. PROBS. 31, 51 (2011) (describing the disruptive nature of technological innovations such as electronic health records).

[212] *See supra* note 171 accompanying text.

vention and patient safety through learning about the sources of errors.[213] Because of the dynamic and evolving nature of medical knowledge and clinical skills, the need for multi-disciplinary cooperation in the delivery of medical services, and the strained conditions under which providers render medical treatment, it is often difficult to discern what went wrong and how such instances could be prevented in the future. In this environment, the incentives provided by the torts system are unfavorable to the type of rigorous root-cause analysis such complex environments require. As we have shown above, the shift from deterrence to learning was driven by the realization that medical errors were rooted in systemic causes and cognitive biases rather than individual incompetence or oversight.[214] Such emphasis reinforces positive incentives for improving healthcare instead of attempting to direct conduct through sanctions, the success of which has proven questionable at best. Where relationships occupy center stage, we can expect even more rigorous, richer learning and more effective prevention efforts because of the broader pool of disputes and complaints such learning will be based on. This is attributable to the system's interest in different dispute types and to providers' strong sense of duty and commitment to disclose problems and take part in addressing them in a collaborative climate.

Another source of criticism of no-fault liability schemes is related to their cost. As we have shown, the cost calculation by both proponents and opponents has been incomplete, ignoring such components as administrative costs (courts versus administrative schemes) and potential savings (reduction in defensive medicine practices). The new justification we offer for a no-fault system reveals additional elements of potential savings. For example, the broadening of the scope of disputes addressed by the system and the focus on relationships can be expected to lower the overall rate of disputes due to prevention and early intervention.[215] This, in turn, could translate into higher productivity, improve doctors' wellbeing, and lower the rates of employee attrition, providing significant savings that may offset

[213] *See supra* notes 172–73 and accompanying text.

[214] *Id.*

[215] WILLIAM URY ET AL., GETTING DISPUTES RESOLVED: DESIGNING SYSTEMS TO CUT THE COSTS OF CONFLICT (1988), is the book that signifies the birth of the field of "dispute system design" and whose principal insight was that conflicts that took place in closed settings could be addressed most effectively through systemic, pre-designed avenues, thereby also playing a key role in the prevention of future disputes.

some of the costs associated with a no-fault system.[216] In addition, we can expect some of the costs of the no-fault compensation scheme to be offset by those cases in which patients refrain from pursuing claims altogether because they are satisfied with the overall quality of care they received and the information provided regarding the error.

A third compelling critique against no-fault systems has been that these compensation schemes end up excluding a substantial group of eligible claimants because of their threshold requirements. As described earlier, these requirements were introduced as a necessary price for curbing the costs associated with a broader base of potential beneficiaries.[217] Under a broad compensation scheme, these claimants will not be excluded but will be referred to the relevant patient complaint unit where an investigation into their claim can be initiated and alternative remedies may be awarded. In addition, the data concerning such complaints will not be ignored and lost but will be included in the overall database and will contribute to the efforts to enhance quality of care. Ideally, hospitals and other such enterprises will implement a centralized unit that will serve as a clearinghouse, channeling appropriate claims to the no-fault compensation schemes, while referring other types of disputes to parallel channels charged with redressing them. Such design would enable both addressing different types of disputes and promoting deep learning on the quality of care, broadly defined.

IV. CONCLUSION

This Article uncovers the vicious cycle that drives the delivery of medical services today; the rise in malpractice litigation as a result of patient empowerment and increased legal scrutiny of medical standards has generated widespread fear of being sued among physicians, which has translated into the adoption of defensive medicine practices and a defensive mode of communication. Paradoxically, by limiting communication channels, providers have actually increased the likelihood of making an error and, where an adverse event has taken place, the likelihood of being sued. This, in turn, reinforces physicians' concerns over malpractice litigation. Over the years, there have been attempts to break this vicious cycle. These efforts have failed to transform this cycle into a virtuous one because they have either ignored the role relationships play in the malpractice context

[216] DAVID B. LIPSKY ET AL., EMERGING SYSTEMS FOR MANAGING WORKPLACE CONFLICT: LESSONS FROM AMERICAN CORPORATIONS FOR MANAGERS AND DISPUTE RESOLUTION PROFESSIONALS 7 (2003).

[217] *See supra* note 169 and accompanying text.

altogether or have attempted to transform such relations by focusing mainly on post-error interactions between physicians and patients.

In our view, a virtuous cycle can emerge only if we take relationships seriously. The relationships-centered approach to malpractice that we advance identifies the harm to the doctor-patient relationship caused by the existing legal regime as the main source of the current crisis. While the law does not explicitly address relationships in healthcare, the legal arrangements that govern malpractice have had a deep impact on the type of interactions that have emerged between doctors and patients over the years, steering physicians away from a collaborative model and cultivating an oppositional mode of communication. By focusing on relationships, the law would be committed to examining its impact on the doctor-patient relationship and to advancing a collaborative relationship. As we have shown, this would not only improve the wellbeing and satisfaction of physicians and patients alike but would also reduce errors, enhance safety, and improve the quality of medical services. In order to realize the transformation, the current legal regime of individual fault and blame must be displaced, and a new alternative should be designed with relationships in mind. The proposed no-fault alternative, which we have advanced in this Article, holds a promise for such a transformation. Its integrative impetus takes seriously both the doctor-patient relationship and the additional concerns that are typical to no-fault, including compensation, cost, deterrence, safety, and learning.