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Doctors and Lawyers: Pathways to Collaboration

***331** DOCTORS AS ADVOCATES, LAWYERS AS HEALERS

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Inadvertently, I seemed to have caused a small ruckus in the audience at the recent conference on conflict resolution in health care which was sponsored by Hamline University's law school. [FN2] In my opening remarks in a panel session devoted to conflicts over patient care, I alluded to physicians owing a “fiduciary” duty their patients.

“You have to stop burdening doctors with more duties,” retorted one angry audience member during Q&A. “Doctors already have enough on their plates.”

“The doctor-patient relationship is therapeutic,” said another emphatically. “It's a disservice to suggest otherwise.”

“Psst,” whispered one of my co-panelists as the audience was getting warmed to their task of setting me straight. “I think they think you're talking about financial arrangements.”

Where to start, I wondered. The fiduciary nature of the doctor-patient relationship had not even been the major focus of my remarks, but it was quickly becoming a focal point of controversy. And I sensed that it was a counterintuitive - and therefore disturbing - concept among many in this mixed audience of mediation, health care, and legal professionals. I tried to put the concept in familiar terms.

“Who thinks doctors should act in the best interests of their patients?” I asked. Everyone raised their hands.

***332** “Who thinks doctors should not harm patients?” Again, all the hands went up.

“Who thinks doctors should not abandon their patients?” More hands. So far so good.

“Who thinks doctors owe a duty to be loyal to their patients?” Hesitation, but more than half the hands went up. Who knows, maybe they sensed a Socratic trap, or didn't understand the question, or just were getting tired of the game. I quit while I was ahead.

“If you agree with those statements,” I said, “you understand the basic foundation for what it means for doc-

tors to owe a fiduciary obligation to their patients.” The audience had calmed down a bit. “I'm not talking about doctors being stewards of their patients' financial affairs,” I continued. “I'm talking about doctors putting their patients' interests above their own.” The moderator called time, and we all headed to our small group breakout sessions to discuss what the various speakers' opening remarks might mean in the context of conflict resolution in health care settings.

Counterintuitive Concepts: A Tool for Learning

As practitioners of the Socratic method, law professors use questions to probe their students' learning about the law, and sometimes they may turn a question on its head in order to deepen their students' understanding of the law. The use of counter-examples and counterintuitive propositions can be helpful devices to get the students' attention and to move them out of their comfort zone so that they may begin to see other ways of viewing what their first instinct told them was a simple question with an obvious answer.

Challenging gut reactions or settled beliefs, whether intentionally or inadvertently, can also be quite irritating to people, so I have learned to pay attention when I sense that a student (or an audience) is getting angry. While I may be opening up a useful opportunity for real learning, I have to take it carefully. Like ***333** mediators and psychotherapists, speakers also need to understand when they are touching on core concerns in order to move the process along, but without blowing it up.

This essay explores a couple of counterintuitive propositions to see what they may add to our understanding of the role of doctors and lawyers in health care conflict resolution. It will first explain what is meant by a fiduciary relationship. It will then discuss how taking this fiduciary concept seriously may unsettle our conventional views of doctors as healers and lawyers as advocates. Indeed, taking it seriously may turn these views on their heads. Finally, this essay will explore whether viewing doctors as advocates and lawyers as healers, consistent with our core understandings of the professional and ethical responsibilities of practitioners in each profession, might improve the prospects for conflict resolution in health care.

In particular, the conference organizers had asked the panelists in our afternoon session to focus on conflict resolution in patient-care disputes - for example, in cases where a medical error has occurred which has harmed the patient, or in cases where doctors and patients or their surrogates disagree over what kind and how much continued treatment is appropriate, which may occur when the doctors believe that continuing aggressive care is medically inappropriate or unethical and patients or their surrogates continue to insist that “everything be done.” (These are often called cases of “medically futility,” and I will use this short-hand terminology to refer to such cases). [FN3] It is thus in these two contexts that this essay will advance the image of the doctor as advocate for his patient and the lawyer as healer for her client in health care conflict resolution. (To avoid switching genders throughout when using the singular pronoun, I have arbitrarily ***334** assigned doctors as male and their patients as female, and lawyers as female and their clients as male.)

I. The Meaning of a Fiduciary Relationship

A fiduciary is someone who is required to act for the benefit of another person and who owes to the other person the duties of good faith, trust, confidence, and candor on all matters within the scope of their relationship. [FN4] A fiduciary relationship is distinguishable from a typical business or “arm's-length” transaction between two parties. As Justice Cardozo once famously said, “Many forms of conduct permissible in a work-

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aday world for those acting at arm's length, are forbidden to those bound by fiduciary ties." [FN5]

Generally, one person stands in a fiduciary role to another when that person, due to special training, expertise, or other qualification, holds potential power and influence over the other. Thus, fiduciary obligations often attach to professionals, such as lawyers, doctors, and accountants. By virtue of their superior knowledge and skills, professionals are in a potential position to take unfair advantage of a lay individual who seeks their services. Both law and ethics seek to temper this power imbalance by imposing duties of care and loyalty on the fiduciary, as well prohibiting the fiduciary from putting his own self-interest above that of his beneficiary. [FN6]

***335** A. Physician as Fiduciary

The concept of the physician as a fiduciary for his patient has a long and honorable history in medical ethics. According to Dr. Laurence B. McCullough, its roots can be traced to two 18th-century physicians, Dr. John Gregory (Scottish) and Dr. Thomas Percival (English), who were early proponents of establishing ethical standards for medical practitioners largely as a response to the entrepreneurial nature of medicine at the time. [FN7] Steeped in Scottish moral philosophy, Gregory particularly feared that medicine "had become commercial, a trade or means to the end of the physician's self-interest. . . . Gregory took the view that medicine involved a life of service and sacrifice in the care of patients - the physician as moral fiduciary." [FN8] Gregory and ***336** Percival helped to lay the ethical groundwork for distinguishing medicine as a profession from medicine as a business by establishing the physician's fiduciary obligations towards his patient as a foundational tenet of the ethical practice of medicine.

While neither Gregory nor Percival used the term "fiduciary," McCullough observes that they effectively advanced this ethical concept in their writings on medical ethics by focusing on three components of it:

1. Physicians and surgeons should be competent;

2. Physicians and surgeons should use their competence for the benefit of patients, "keeping individual self-interest in a systematically secondary place"; and

***337** 3. Physicians and surgeons should maintain medicine as a public trust in service to patients and society, not as a guild that puts a group's self-interest first. [FN9]

This concept of the physician as fiduciary has become well accepted in both U.S. law and the ethical tenets of American professional medical associations. [FN10] As one court has observed:

> ***338** The existence of this fiduciary relationship indicates that there is more between a patient and his physician than a mere contract under which the physician promises to heal and the patient promises to pay. There is an implied promise, arising when the physician begins treating the patient, that the physician will refrain from engaging in conduct that is inconsistent with the "good faith" required of a fiduciary. The patient should, we believe, be able to trust that the physician will act in the best interests ***339** of the patient thereby protecting the sanctity of the physician-patient relationship. [FN11] While the exact nature and scope of a physician's fiduciary obligations have not been fully defined legally in cases or statutes, [FN12] the fiduciary relationship between physician and patient has been found to include, at a minimum, legal duties of physicians to act competently, to obtain the patient's informed consent, to not ***340** abandon their patients, to keep their patients' information confidential, and to disclose financial interests in

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clinical research. [FN13]

Similarly, the ethical tenets of medical societies cast a fiduciary quality over the doctor-patient relationship, even if they do not use that term expressly. The AMA's Principles of Medical Ethics state: "A physician shall, while caring for a patient, regard responsibility to the patient as paramount." [FN14] Indeed, the primacy of patient welfare has been central to medical ethics dating back to Hippocrates. [FN15] As stated by the AMA, "The relationship between patient and physician is based on trust and gives rise to physicians' ethical obligations to place patients' welfare above their own self-interest and above obligations to other groups, and to advocate for the patients' welfare." [FN16]

***341** The physician's ethical duties that flow from this trust relationship parallel his legal duties, and include duties to use sound medical judgment and provide competent care, to be honest, to safeguard patient confidences, to provide continuity of care, to make relevant information known to patients, and to advise them of potential conflicts of interests. [FN17]

At bottom, the fiduciary relationship between physician and patient is founded on trust. The need to maintain trust within the patient-physician relationship was a theme that arose frequently at the Hamline conference as the participants discussed what made conflict resolution in health care settings potentially different from that in other industries. Fiduciary law and ethics promote patients' trust in doctors by assuring patients that their interests will be placed above their doctors' and others' interests. As one commentator has observed:

> For generations, physicians have earned the trust of their patients by professing to place patient welfare before all other concerns. This tradition of elevating patient interests above other interests had endured through the ages as a guiding tenet of medical practice. The willingness of patients to turn to physicians for care, to speak openly about intimate and potentially embarrassing information, and to rely on their physician's recommendations depends in large part on the ability of patients to trust that ***342** physicians are acting primarily to advance the interests of their patients. [FN18] The preservation of trust underlies much of the ethical discussion surrounding the doctor-patient relationship. [FN19] Moreover, recent empirical research has shown that trust has positive benefits for patient healing. [FN20]

***343** B. Lawyer as Fiduciary

Lawyers have been called the quintessential fiduciary. [FN21] Although the ABA's Model Rules of Professional Conduct use the term "fiduciary" with respect to a lawyer's responsibilities for the safekeeping of clients' property and avoidance of sexual relations with clients, [FN22] the fiduciary role of lawyers, like that of doctors, encompasses more than avoiding financial or other conflicts of interest. As the New York Court of Appeals explained:

> Sir Francis Bacon observed, "[t]he greatest trust between [people] is the trust of giving counsel" . . . . This unique fiduciary reliance, stemming from people hiring attorneys to exercise professional judgment on a client's behalf - "giving counsel" - is imbued with ultimate trust and confidence. . . . The attorney's obligations, therefore, transcend those ***344** prevailing in the commercial market place. . . . The duty to deal fairly, honestly and with undivided loyalty superimposes onto the attorney-client relationship a set of special and unique duties, including maintaining confidentiality, avoiding conflicts of interest, operating competently, safeguarding client property and honoring the clients' interests over the lawyer's. [FN23] Much like doctors' duties to their patients, lawyers' ethical and legal obligations to their clients include fiduciary duties to provide competent representation, [FN24] to be honest, [FN25] to safeguard the client's

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***345** confidences, [FN26] to make relevant information known to clients, [FN27] to not abandon their clients, [FN28] and to avoid conflicts of interest. [FN29] Much like the doctor-patient relationship, the lawyer-client relationship is founded on trust and confidence, giving rise to a paramount duty of undivided loyalty. [FN30]

***346** II. Doctors as Advocates

One of the doctors, a pediatrician, in my small group breakout session recounted the following story that happened several years ago. He had a child patient who had undergone surgery one morning by a pediatric surgeon. The pediatrician had gone over to the hospital in the afternoon to check on how the child was doing, and he found the parents still sitting in the surgical waiting area for families. They were distraught, not having heard anything from the surgeon as to how the surgery had gone and how their child was doing. The pediatrician left to find the surgeon, and as he hurried up to him in the hallway, he angrily demanded, “How can you leave those parents waiting for news about their child for over four hours?” To which the surgeon coolly responded, “Who are you, the patient's advocate?”

The doctor said that story had stuck with him ever since, but he was not sure why. I would guess that story stuck with him because the surgeon's characterization seemed dissonant or counterintuitive to call a physician the “patient's advocate.” Indeed, it was likely made as a put-down. [FN31]

***347** The transition from the doctor's role as a fiduciary to his role as the “patient's advocate”, however, is a natural and positive one. If the doctor as a fiduciary is putting the patient's interests above his own or others' interests, then when the needs of the patient require it, the doctor advocates for the patient's interests. Advocating for the patient's welfare reflects the long-standing beneficence principle of medical ethics. [FN32] To carry out their ethical duty of beneficence (acting in the patient's best interests) and duty of loyalty (respecting and promoting the patient's autonomy to define her best interests), physicians should be able to adopt the advocacy role for their patients as easily and naturally as lawyers have traditionally adopted it for their clients.

While it may seem counterintuitive, this view of the physician's advocacy role is not new. Indeed, the AMA has called on physicians to advocate for their patients' welfare in order to promote the physician-patient relationship, [FN33] and other ***348** professional societies have endorsed the view of doctors as their patient's advocate. [FN34] Commentators have also characterized the role of a physician as the patient's advocate. [FN35]

A clarifying distinction is in order. This essay discusses the doctor's role as patient advocate in a conflict over care with the patient (or patient's family), not in a dispute over money involving third parties (such as insurance companies). Commentary on doctors being their patients' advocates often arises in the context of coverage disputes involving a health insurer's or managed care company's denial of payment for treatment considered medically necessary by the doctor. This has been referred to as “economic ***349** advocacy,” [FN36] and it has a distinctly adversarial flavor to it, with the doctor advancing the patient's interest by protesting or appealing a third-party payor's denial of coverage of treatment for the patient, much as a lawyer might pursue a client's interest in an administrative review or court proceeding. By contrast, the view ***350** of patient advocacy that is relevant to this essay might be called “care advocacy,” and it arises when decision-making over the care that the patient receives is or was largely under the control of the doctor (as opposed to a third party who is making payment decisions). This care-oriented view of patient advocacy also finds support in AMA professional statements. [FN37]

In essence, the fiduciary duty of doctors gives rise to their duty to be their patients' advocates by acknow-

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ledging the primacy of serving their patients' best interests, just as it has done for lawyers with respect to their clients. Despite ever-increasing pressures of commercialization in medicine, the principle of caveat emptor in the marketplace has not supplanted the professional ethics of primum non nocere and beneficence in medicine. Loyalty and trust remain central to the doctor-patient relationship, and they are the defining characteristics that distinguish the relationship from an arm's-length commercial relationship. [FN38] So long as doctors continue to claim the mantle of professional and ***351** not mere business contractor, they are privileged by the trust invested in them by patients, and also burdened by the duty of loyalty and devotion to patient welfare above their own that their status as fiduciaries entails.

III. Lawyers as Healers

The image of lawyers as zealous advocates for their clients is imprinted in lawyers' minds and reflected in the eyes of the public. When I was fresh out of law school many years ago, I rented my first apartment in a new city where was I was joining a large law firm. Upon learning that I was a lawyer, my landlord gave me an appraising look which clearly implied that I was not measuring up. "What I want in my lawyer," he said, "is an animal." He paused, then added, "A vicious one." Within my first year of practice, a partner who was sending me out to deal with a difficult client situation cautioned me, with real concern, "I hope you ate raw meat and iron nails for breakfast."

"Zealous" has connotations of being "tough," "aggressive," and "single-minded," which might have positive implications if one imagines the primary role of the lawyer as warrior or "Rambo" [FN39] or "hired gun" [FN40] protecting the client in a brutal dog-eat-dog world. "Advocacy" has connotations of "partisanship," or taking the client's side in a contest against someone else. Not surprisingly, the image of the zealous advocate is usually invoked in litigation contexts, particularly in the criminal law context where the criminal defendant is standing alone, accused, and protected only by his defense attorney from the great weight of government ***352** prosecution forces arrayed against him. [FN41] In common human relationships, however, most people are probably not looking for a "zealot" or for "zealotry" when they seek a lawyer's advice to help them consider and chart their various personal, family, financial, and commercial options in life. In fact, in the most recent version of the ABA Model Rules of Professional Conduct, zeal is an obligation only of the lawyer in her role as an advocate in an adversary context, not in her role as an advisor, negotiator, or evaluator. [FN42] As for partisanship, or taking the client's side: in more tempered terms, that is already the primary obligation of the fiduciary, who serves her beneficiary's interests above all others.

***353** In short, referring to an attorney as a "fiduciary" more fully captures the range of her professional and ethical obligations today than calling her a "zealous advocate."

The primacy of zeal in the lawyer's role has steadily diminished in professional ethics codes over the years with little fanfare or even much overt acknowledgement by the general practicing bar. At the same time, attention to alternative obligations and values in the lawyer-client relationship has steadily increased. While the lawyer as zealous advocate still lingers in the legal lexicon, there is increasing interest in the historical role of lawyer as counselor (as in "counselor-at-law") and healer of societal conflicts.

The predecessor to the current ABA Model Rules of Professional Conduct was the ABA Model Code of Professional Responsibility, which was adopted in the 1960's. The Model Code promoted the image of zealous advocate through Canon 7, which famously provided: "A lawyer should represent a client zealously within the bounds of the law." [FN43] The Model Rules, most recently revised in 2002, have moderated this classic ethical

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exhortation and now more temperately provide: "A lawyer shall act with reasonable diligence and promptness in representing a client." [FN44] ***354** References to "zeal" do not appear in the black-letter Model Rules and have been relegated to the Preamble and to the commentary following the Rules. [FN45] Even there, a duty of "zeal" is tempered by clarifying limits on what is meant by it:

> A lawyer must also act with commitment and dedication to the interests of the client and with zeal in advocacy upon the client's behalf. A lawyer is not bound, however, to press for every advantage that might be realized for a client. . . . The lawyer's duty to act with reasonable diligence does not require the use of offensive tactics or preclude the treating of all persons involved in the legal process with courtesy and respect. [FN46]

The transition from zeal to diligence as a professional obligation of lawyers has evolved over time. [FN47] Some legal ***355** observers have been critical of what they see as a movement in legal ethics away from giving highest professional priority to the role of lawyers as zealous advocates, while others believe this trend is not moving fast enough. [FN48]

***356** As the image of the lawyer as zealous advocate has been tempered in professional ethics statements over the years, alternate images and roles for the lawyer in the lawyer-client relationship have been given renewed attention by the legal profession. The ABA Model Rules of Professional Conduct reflect broader lawyering roles when they carefully distinguish the lawyer as advocate from the lawyer as advisor to the client or negotiator on the client's behalf. [FN49] ABA Model Rule 2.1 expressly allows lawyers acting as advisors to take into consideration non-legal as well legal considerations in advising clients: "In rendering advice, a lawyer may refer not only to law but to other considerations such as moral, economic, social and political factors, that may be ***357** relevant to the client's situation." [FN50] Some legal commentators have long championed the role of lawyers as moral or ethical advisors. [FN51]

In fact, the problems that clients bring to lawyers often require more than legal knowledge or skills to solve. [FN52] In approaching a client's problems from more than a purely legal perspective, including ethical and moral dimensions as well as social, financial, and interpersonal considerations, a legal counselor or advisor takes on the primary role of a problem-solver. As a problem-solver, a lawyer can be viewed as a healer: collaborating in the treatment of a client's business or personal ***358** problems and restoring him to psychological or financial health, mending the client's relationships, getting a client in trouble back on a road to recovery, prescribing courses of action to prevent future legal ills, and so on. Indeed, during the past decade, a strong professional movement has emerged that characterizes "law as a healing profession." [FN53]

The image of the lawyer as healer is not new, and there have been numerous calls for the legal profession to revitalize this role with new vigor. Historically, law has been identified as one of the three healing professions, together with medicine and the clergy. [FN54] Two decades ago, former Chief Justice Warren E. Burger wrote that "[t]he obligation of our profession is, or has long been thought to be, to serve as healers of human conflict." [FN55] In a later ***359** speech to the American Bar Association, he elaborated on this view of the legal profession:

> The entire legal profession - lawyers, judges, law teachers - has become so mesmerized with the stimulation of the courtroom contest that we tend to forget that we ought to be healers--healers of conflicts. Doctors, in spite of astronomical medical costs, still retain a high degree of public confidence because they are perceived as healers. Should lawyers not be healers? Healers, not warriors? Healers, not procurers? Healers, not hired guns? [FN56]

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In contrast to the lawyer as zealous advocate or hired gun, alternative role models for lawyers, reflecting a sense of the potential healing nature of legal counsel, are increasingly prevalent in legal writings and professional statements. A rich literature has developed which describes the lawyer as the client's "friend," [FN57] a ***360** "wise counselor," [FN58] and a "problem-solver." [FN59] Some of greatest ***361** lawyers in history have promoted a kinder, gentler, and more constructive role for attorneys, envisioning them as peacemakers [FN60] ***362** and consensus-builders. [FN61] Recently emerging developments have also envisioned numerous alternative ways of practicing law and pursuing life in the legal profession, including "religious ***363** lawyering," [FN62] "preventive law," [FN63] "collaborative law," [FN64] and "therapeutic jurisprudence." [FN65]

***366** Professor Susan Daicoff has articulated two themes that are common to these new approaches to lawyering practice and law as a healing profession. First, in trying to make things better (or at least, not worse) for people involved in the legal system, "[t]hey explicitly or implicitly attempt to optimize the psychological and emotional wellbeing of the individuals involved. . . . [they] often work to preserve, maintain, restore, or create good interpersonal relationships." [FN66] Second, in analyzing and resolving legal problems, these approaches consider more than purely legal rights and liabilities, and more broadly take account of "the psychological, social, emotional, and relational consequences of various legal courses of action." [FN67]

***367** These developments portray the role of the lawyer who advances the client's cause, not so much by adopting and promoting positions adverse to others, but by carefully helping the client to identify more comprehensively the real nature of his best interests in both legal and non-legal senses, and helping the client to achieve these interests in ways that are most beneficial to him and least harmful to others. Scholars and practitioners of therapeutic jurisprudence, in particular, consider ways that law and lawyers can offer healing to clients and others within the legal system and adopt, as in medicine, the aspiration to "above all, do no harm." [FN68] By focusing more broadly on improving the client's overall welfare and well-being rather than taking a more narrow approach to "winning" the client's case, these new approaches portray the lawyer as healer.

IV. Application to Conflict Resolution in Health Care Settings

If we took seriously the roles of doctors as advocates and lawyers as healers, which fundamentally derive from their duties as fiduciaries, what effect might this have on conflict resolution in health care settings? At the Hamline conference, our session focused on conflict resolution over care provided within the ***368** doctor-patient relationship, and we focused on two examples of potential disputes over patient care: medical error and medical futility. What does it mean for a doctor to remain the patient's advocate after a medical error has occurred, or when the doctor believes that the care the patient or her surrogates are requesting is futile and should not be provided? What does it mean for a lawyer representing the patient, a doctor, or the hospital to serve as a healer in these situations?

A. Doctors as Advocates in Patient Care Disputes

In the aftermath of a medical error or during a course-of-care dispute, the doctor still remains a fiduciary to the patient so long as the doctor-patient relationship has not actually been terminated. [FN69] As long as he remains the patient's doctor, despite severe strains on the relationship, the doctor is still obligated to serve the patient's best interests, and to put the patient's interests above his own interests. Although often the relationship may now be experienced by both doctor and patient (or family) as more adversarial than before, the ethical and legal nature of the relationship remains the same: a fiduciary one. Continuing to serve the patient's best interests

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and putting the patient's interests above the doctor's own interests means continuing to serve as the patient's advocate, however counterintuitive that may feel or difficult that may be to do in real life.

As the Hamline participants repeated throughout the conference, the existence of trust is what distinguishes the doctor-patient relationship from other kinds of relationships where conflicts may occur. What the patient (or family) feels after ***369** medical error or during a care dispute is likely to be a sense of betrayal of trust - particularly if the doctor or others on the health care team begin to avoid dealing with them. Doctors need constantly to remind themselves that they remain the patient's fiduciary, and that their paramount duty in the wake of harmful error or other patient-care conflict is to do what it takes to maintain that trust by continuing loyalty to the patient's best interests, even above their own interests.

In our small group, we focused on what we called the “continuum of care” and the “continuum of caring” that should be provided to patients after medical errors. Some participants said their health care facilities had adopted the LEAP approach to handling medical errors: Listen, Explain, Apologize, and Plan not to do again. Others emphasized the core value of respect for patients, which is another way of characterizing the duty of loyalty. Respecting patients (being loyal to their interests) meant informing them and explaining what had happened; righting the wrong to the extent possible; and taking responsibility for it. For these participants, restoring trust in the relationship was key, and maintaining the relationship by offering “care” as well as “caring” was ethically required. In practical terms, care meant continuing to provide treatment as needed, both for the underlying condition as well as for any harmful effects from an error. Caring meant continuing to disclose facts as they became known; listening to the patient and family and being compassionate and respectful; and taking steps to ensure that it would not happen to other patients in the future.

Without using the formal legal and ethical language of fiduciary relationship, the members of this small group were nonetheless clearly adopting it as their vision of how doctors should behave after a medical error had harmed a patient. However counterintuitive that concept may have seemed at first, it played out in their intuitive and practical understandings of how they thought doctors should behave after a medical mistake. Their recommendations implicitly required the doctor and health care team to advocate for their patient's best interests, to remain loyal, ***370** and not to abandon the patient however tense or adversarial the feelings and positions may seem to have become, especially if risk managers and lawyers had become involved. In short, they saw the proactive resolution of medical error disputes as simply one aspect of care along a continuum of care that should be provided to the patient to promote the healing process. [FN70]

These participants' views find extensive support in recent medical ethics opinions and commentary. The AMA's Council on Ethical and Judicial Affairs has written:

> Physicians' unique role as patient advocates also requires them to participate in the investigation regarding the cause of the harm. . . . Should the physician be responsible for serious harm to a patient, the physician must acknowledge responsibility to the patient. Many times, this will facilitate preserving trust, and will allow continuity of care with the same health care team, instead of a patient having to build new relationships with other caregivers. This will be most important when decisions need to be made promptly in response to the harm that has occurred. However, if the disclosure injures the patient's trust in the physician or otherwise damages the patient's relationship with the physician so severely that the patient prefers to obtain subsequent care from someone else, the ***371** physician has a responsibility to assist the patient in obtaining continuing care. [FN71] Since July 2001, the Joint Commission on Accreditation of Healthcare Organizations (“Joint Commission”) has required that patients be told of “unanticipated outcomes”

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of care. [FN72] Many health care professionals and organizations now regard disclosure of medical error to be a clear ethical obligation. [FN73]

***372** Beyond simple disclosure, many health care professionals and organizations have outlined steps to promote patient well-being after an adverse event which parallel the steps that our small group reflected in their LEAP paradigm. For example, Harvard hospitals have issued a consensus statement that identifies four essential steps to full communication about preventable adverse events: (1) tell the patient and family what happened, (2) take responsibility, (3) apologize, and (4) explain what will be done to prevent future events. [FN74] Numerous other professional organizations and authors have offered similar steps to disclosing and resolving controversy over adverse outcomes of care, including the offer of compensation and an apology. [FN75] As one commentator has summarized:

> ***373** Caregivers should also be honest and open about the incident and about what is being done to prevent a recurrence. The lack of an explanation, and of an apology if appropriate, may be experienced by the patient as extremely punitive and distressing and may be a powerful stimulus to complaint or litigation. Clinicians should ensure continuity of care and maintain the therapeutic relationship. After an injury, patients and families need more support, not less, although both patients and clinicians may ***374** feel a natural wish to distance themselves from one another after an adverse event. [FN76]

These numerous calls for reform in dealing with patients in the aftermath of medical errors run counter to the real-world practice of most health care professionals to say nothing, admit nothing, do nothing, and not apologize or even express sympathy lest it be taken as an admission of liability. [FN77] While reflecting the ***375** traditional advice of many legal counsel to "deny and defend," this culture of silence may result as much or more from factors within the culture of medicine as from fear of malpractice liability. [FN78]

Consistent with understanding the doctor-patient relationship as a fiduciary one, however, the theme that all of these ***376** reform proposals have in common is that promoting the patient's welfare should be the paramount consideration after a medical error has occurred. They in effect call on doctors to be their patient's advocate, and to do promptly and voluntarily all those things that usually have been left to a plaintiff's lawyer as the traditional patient's advocate to extract through the adversarial litigation process: information about what happened, proof of culpability, and compensation. Indeed, these proposals go further in advocating for patient welfare by acknowledging that the patient's well-being is affected by emotional and psychological considerations, as well as physical and financial ones, and by protecting future patients from harm through remedial systems to ensure that the same error does not happen again. Far from approaching the patient as an adversary in the aftermath of a medical error, these reform proposals all place the patient squarely at the ethical center of providers' duties of care and continued loyalty, and thereby implicitly acknowledge their roles as fiduciaries of, and advocates for, the patient. [FN79]

Because our session focused on patient care disputes after medical error, we did not have time at the Hamline conference to do more than acknowledge conflict resolution in end-of-life or medical futility disputes, nor is there scope in this article to provide an extended analysis of what it might look like in these cases. It will have to suffice here simply to say that resolving conflict in ***377** these situations would look a great deal the same as in those situations involving medical errors. As fiduciaries, doctors would continue to serve their patients' best interests, despite disagreements over what treatment best promotes those best interests. When doctors recommend de-escalation of care in patients for whom they regard continued aggressive treatment as futile, they genuinely believe that they are trying to promote the patient's best interests. So when the family rejects a doctor's recommendations, what does that mean for continuing to serve as the patient's fiduciary and advocate?

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So long as the therapeutic relationship exists, a doctor remains a fiduciary - and therefore the patient's advocate - in cases involving disputes over end-of-life care. As long as the patient is still under the doctor's care, the doctor should continue as much as possible to work on the patient's side, and to not allow the conflict to degenerate into entrenched adversarial positions. Working with the lawyer as healer in a conflict situation, the doctor and other members of the health care should keep working to reach consensus and not let feelings of personal antagonism blossom into antagonistic communications. Often these disputes begin as a result of poor communication with a patient or her surrogates, and continued poor communication can make the treatment relationship spiral out of control. [FN80] Once everybody digs in their heels, it can be extremely difficult to get anyone to back off from a prior position.

Transparent and realistic communications about the patient's prognosis, delivered with empathy and from the earliest stages of a doctor's growing belief that continued aggressive treatment may not be in the patient's best interests, can convey the message that, no matter what, the doctor is trying to fulfill his fiduciary duties of care and loyalty to the patient to the best of his ***378** abilities. Different families may have different reasons for resisting a shift to less aggressive care, and in order to advocate for a palliative alternative for the patient, caregivers should make every effort to understand and address those reasons, not just dismiss them as unreasonable. [FN81] A doctor is no less a fiduciary to a patient who has a challenging family than to a patient who has a challenging physiological make-up: loyalty to the patient's best interests is still a core duty, however time-consuming it may be to maintain it. By allowing sufficient time for the family or other surrogate to absorb the information and come to terms with it, such compassionate communications will go a long way to assuring a patient's family that the doctor is truly on the patient's side and advocating for the patient's best interests rather than abandoning the patient, which the family may think is happening if doctors too abruptly decide and unilaterally announce that it is time remove a patient from life-sustaining treatment.

B. Lawyers as Healers in Patient Care Disputes

What would it look like if lawyers took seriously their role as healers in the resolution of conflicts over patient care involving either medical errors or treatment options at the end of life? Such lawyers would begin by exploring what would serve their clients' best interests, whether the client is the patient, a doctor, or a hospital. And they would construe their client's “best interests” broadly to include moral and ethical considerations, the psychological and emotional well-being of the client and others involved in the dispute, financial ramifications, and the ***379** maintenance of interpersonal, professional, and business relationships.

The literature is filled with evidence that resorting to litigation in these circumstances is likely in no one's best interests, for providers and patients alike, even though taking a defensive and adversarial posture that casts a patient care conflict in a pre-litigation framework is likely still the norm in many health care settings. Doctors experience great emotional, psychological, and financial costs when a medical malpractice case is undertaken against them and can suffer from a constellation of negative feelings and behaviors that have been termed “malpractice stress syndrome.” [FN82] Angry and bitter patients or families seek lawyers when health care providers do not continue to make the patient's well-being their paramount concern, and when they feel that they can no longer trust their providers to be acting in their best ***380** interests. [FN83] Patients who become litigants also experience significant negative psychological impact. [FN84]

Providing good communication and good care after a medical error or during negotiations over care for a terminally ill patient is not only consistent with being the patient's fiduciary to promote her best interests, it is also

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likely to be good strategic behavior to avoid getting sued. [FN85] Some of the most well-known ***382** and highly regarded experts in the literature on medical errors recently summarized the field to date:

> The movement toward full transparency in health care is accelerating rapidly. Not only is open disclosure of serious unanticipated outcomes to patients, including apology if there has been an error or system failure, the right thing to do, but it also has enormous potential to enhance patient-centered outcomes. It may well decrease the likelihood and negative outcomes of lawsuits. Not the least, it could greatly improve the well-being of caregivers involved in these events and, ultimately, the quality of care for the patients. [FN86]

The lawyer can play a healing role if the client is the patient (or patient's family/surrogate) by spending time helping them to gather information, reflect on the situation and options, and discern what, all things considered, would be in the patient's best interests. In the case of medical error, this is not as obvious as some plaintiff's malpractice lawyers may think, and who may assume that going after a big jury verdict is always in the patient's or family members' best interests. [FN87] Research shows that what patients and their families want above all is immediate and complete information about what happened. [FN88] Numerous studies ***383** show that after errors, "patients want an explicit statement that an error has occurred, information about why the error happened, how recurrences will be prevented, and an apology." [FN89]

Dealing with the emotional and psychological impact of medical error on patients and their families is also important, especially immediately after harm has occurred. The lawyer should try to identify these needs and help to get them addressed and ameliorated by talking first with the client and then with the health care team. When patients or their relatives know about an error, they may feel guilt over not having prevented it, fear of retribution from their health care providers if they complain or ask questions about it, and isolation when the health care providers avoid acknowledging or discussing it. [FN90] Generating information ***384** and discussing options for patients and their families that may promote their best interests should be the primary goals of the healing lawyer after medical error.

If the client is the doctor or the hospital, the lawyer can play a healing role by encouraging open and transparent dialogue with the patient and her relatives from the outset of learning about a medical error. There is consensus that this is the ethically right thing for doctors and hospitals to do, and so a lawyer who is seeking to promote the best interests of her doctor or hospital client should, at a minimum, counsel them about these ethical obligations. [FN91] In light of the psychological and emotional effects that committing a serious error can have on the lives of physicians, a healing lawyer should also be prepared to help her physician client find appropriate professional support, and to encourage the hospital to provide such support to the health caregivers affected by the error. [FN92] The traditional legal advice of legal counsel to ***385** "deny and defend" may not be in the client's best interests, since provider silence surrounding the adverse event may motivate the patient to file a lawsuit as the only way she will be able to get answers to her questions. [FN93]

In light of the paramount interests of a hospital in preventing future errors, hospital counsel should encourage a conflict resolution process that maximizes the opportunity to openly discuss and analyze the error in order to ensure it will not recur, in contrast to the prospect of litigation which tends to drive errors underground and thus loses the opportunity to learn from ***386** them and avoid the same mistakes in the future. [FN94] Hospital counsel for Children's Healthcare of Atlanta strongly believes that if the value of patient-centered care is to mean anything, it must be reflected in the care (medical as well as emotional, psychological, and financial) provided to the patient after a medical error. [FN95] If patient-centered care is a value espoused by the hospital, then hospital counsel should explore with her client how promoting the patient's welfare after an error may serve

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the hospital's best interests. This discussion may include ethical as well as practical considerations, such as the hospital's ethical integrity in adhering to its core principles as well as its reputation within the community, which may depend on how well the patient and the family are treated after the error. [FN96]

In addition, the healing lawyer should familiarize herself with disclosure programs and protocols that have recently been developed by professional organizations as well as hospitals elsewhere. [FN97] The Veteran's Affairs hospital in Lexington, ***387** Kentucky was the first to publish the results of its change in policy after two significant adverse jury verdicts in medical malpractice cases. Shifting away from litigation strategies to a policy of “extreme honesty” that encompassed full disclosure to patients, their families, and their attorneys and included assisting the patients in the filing of claims, the VA hospital experienced much lower costs in claims paid out. [FN98] Children's Healthcare of Atlanta has recently adopted an interest-based, patient-centered approach to claims management that focuses on addressing and promptly resolving unanswered questions about treatment and outcomes of care, rather than waiting for and defending litigation. In addition to being consistent with the hospital's mission and values as well as maintaining the hospital's reputation in the community, Children's policy of staying focused on the patient's best interests has significantly reduced its claims-related costs. [FN99]

Others have reported similar advantages both in terms of lowered costs to the hospital and other benefits to all concerned when they shift from the traditional “deny and defend” adversarial approach to conflict resolution and adopt a more open and ***388** collaborative one. [FN100] The healing lawyer should let her doctor or hospital client know about the increasing number of resources on open and effective communication methods in the aftermath of a medical error. [FN101] And while there is debate in the literature over ***389** whether or not full disclosure and transparency in the wake of medical error actually will reduce the number of malpractice claims filed or costs overall, [FN102] there appears to be sufficient ***390** evidence to date that hospitals are both doing good as an ethical matter and doing well as a practical matter with these programs that a healing hospital lawyer should be familiar with them and advise her clients about them.

These programs reflect the past decade's scholarly growth as well as professional interest in conflict resolution in health care settings more generally. The Joint Commission has recently developed a new accreditation standard requiring a health care organization's leadership to address conflict management. [FN103] Notably, the Joint Commission recognizes the link between managing conflict and promoting patient safety within the organization: “Conflict can be successfully managed without being resolved. The goal of this standard is not to resolve conflict, but rather to create the expectation that organizations will develop and implement a conflict management process so that conflict does not adversely affect patient safety or quality of care.” [FN104] While the standard addresses the whole range of conflicts that can take place within an organization and affect patient safety, it is instructive for ***391** lawyers who are attempting to promote healing resolutions after a medical error to realize that health care leaders nationally are clearly being charged to support proactive conflict management on their premises in order to promote patient safety and quality of care. [FN105]

This new standard may provide a salutary push in the right direction for viewing doctors as patient advocates and lawyers as healing problem-solvers in the aftermath of an adverse event because it offers the opportunity to introduce an array of conflict management and resolution tools which have been underutilized in health care settings to date. Researchers and scholars in the field of conflict resolution have observed that the health care industry has historically been slow to adopt alternative dispute resolution (ADR) tools and techniques. [FN106] Some commentators have ***392** discussed formal ADR options for dispute resolution in health care, such as binding arbitration and medical malpractice screening panels. [FN107] Others have encouraged that the less-formal process of mediation be more often used to resolve conflicts over medical errors. [FN108] Most recently,

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some observers have noted that mediation ***393** presupposes that a dispute already exists, and they advocate for earlier interventions to manage and resolve a situation before it grows into a full-blown conflict requiring mediation or more formal ADR processes. [FN109]

The reform proposals and recently adopted disclosures programs discussed above [FN110] often fall within this last group of conflict management tools, which includes communication and ***394** negotiation skills and seeks to diffuse a situation before it develops into a larger, more entrenched dispute. [FN111] "Collaborative law" is a relatively new and similar development in legal practice originally developed in the family law field, and it has recently been proposed as another option for the resolution of cases involving medical error. [FN112] Like the other new initiatives, collaborative law envisions early and open discussions among the parties affected by the error. In this model, the parties are represented by attorneys who have agreed in advance to work collaboratively toward resolution and to withdraw if the matter does not settle. By agreeing in advance that other lawyers will handle the case if it goes to litigation, collaborative lawyers' interests are aligned with their clients' to negotiate a compromise satisfactory to all.

All of these various conflict management and resolution tools provide options that health care lawyers who desire to promote their client's best interests should be familiar with and tailor appropriately to the particular circumstances. Just as one hopes for a speedy, uncomplicated, and complete recovery from an illness, so too should all the parties affected by a medical error hope for an efficient, compassionate, and complete resolution of the adverse consequences from it. The health care lawyers involved such situations can help promote that healing process.

While there was insufficient time at the Hamline conference to address resolution of conflicts over patient care at the end of life, a brief word is in order. Just as for medical errors, there is also a growing body of literature recommending some form of alternative dispute resolution process for addressing ***395** conflicts over treatment considered medically futile. These conflict resolution proposals place the healing of the family and caregivers as central concerns when healing of the patient may not be a realistic option. Whether advising families or providers, a lawyer can help promote this healing by encouraging open communication and transparent negotiation before the conflict becomes intractable.

One process familiar to the ADR community is the principled-negotiation approach of Getting to Yes: (1) separate the people from the problem, (2) focus on people's interests, not their positions, (3) invent options for mutual gain, and (4) negotiate on the basis of objective criteria. [FN113] Children's Healthcare of Atlanta has expressly adopted this approach to malpractice claims management. [FN114] Recent commentators have also encouraged adoption of this model of communication and negotiation for patient care disputes at the end of life. Reflecting on the history of the medical futility debate over the past 20 years, these commentators have observed:

> Until now, most of the effort has been focused on ways to override the requests of family members, but the history of the futility debate shows that this approach comes at a great cost in terms of our commitment to respecting the rights of minorities and unpopular views. The best solution - though perhaps the most difficult - is to turn our efforts toward tolerating the demands for care that we believe to be futile, and finding ways to better support the emotional needs of each other in those ***396** rare cases where we are called on to provide this care. [FN115] Others have also written thoughtfully about the use of mediation (as well as good communication and negotiation skills) to reconcile disputes over care options at the end of life. [FN116]

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***397** V. Conclusion

What would conflicts look like if patients were cared for by doctors who viewed themselves as healing advocates? How would conflicts be handled if patients and their providers were represented by lawyers who viewed themselves as zealous healers? The purpose of this essay is to nudge both professions toward adopting and internalizing these alternative and perhaps counterintuitive self-images. The hope of this author is that by doing so, the best interests of patients and providers can be served when conflicts over patient care arise.

This essay began with the proposition that lawyers and doctors are fiduciaries with respect to their clients and patients. Their primary fiduciary obligations of care and loyalty require them to promote their clients' and patients' interests above their own self-interests or others' interests. These ethical and legal duties distinguish the fiduciary relationship from an arm's-length commercial transaction, where both parties are generally free to pursue and maximize their own self-interests.

While these fiduciary principles may seem comfortable to accept in theory, they are often difficult to apply in practice after tension in the fiduciary relationship has developed, such as after a medical error or when disagreements arise over what treatments ***398** may be appropriate for a patient. As long as the fiduciary relationship exists, however, doctors continue to owe an obligation to promote their patients' best interests and welfare. As medical ethics statements have recognized, putting patients' interests first can entail doctors having to be their patient's advocate, even when doing so may conflict with their own self-interests or desires. Doctors may intuitively perform their ethical obligations of beneficence and non-maleficence when the fiduciary relationship is going well. The real challenge to remaining the patient's fiduciary and advocate comes when the relationship is strained. However counterintuitive it may seem, it is at this point that these fiduciary obligations may become even more important to honor.

Similarly, in exercising their fiduciary duties of loyalty and care to their clients, lawyers need to stay open-minded about where their clients' best interests truly lie. So ingrained in many lawyers' psyches is the role of zealous advocate that they often intuitively view that role as limited to advancing a narrow set of client interests, especially monetary ones. Lawyers need to develop collaborative skills to help clients discern and pursue their best interests in light of a variety of considerations, including ethical, practical, social, psychological, and financial factors, in order to maximize their clients' overall welfare. However counterintuitive it may seem, lawyers can often serve their clients' best interests by helping to restore the peace when the patient-provider relationship becomes strained. Whether the client is the patient or the provider, the lawyer can utilize well-rounded problem-solving skills to become a healer to maintain (through preventive measures) or restore (through intensive or emergency measures) the client's emotional, financial, interpersonal, and psychological stability and well-being.

Although the culture of health care has historically been resistant to adopting new approaches to managing and resolving conflict, there is hope that recent trends among the early adopters of these new approaches may help to change the culture of health ***399** care. [FN117] Doctors acting as their patients' advocates and lawyers serving as healers of conflict can help to speed these healthy developments.

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[FN2]. 2007 Symposium on Advanced Issues in Dispute Resolution, "An Intentional Conversation about Conflict Resolution in Health Care," Nov. 8-10, 2007 (Hamline University School of Law, Saint Paul, Minnesota).

[FN3]. Addressing the appropriateness of this terminology, and indeed the whole field of so-called "medical futility," is beyond the scope of this essay. For an excellent overview of the "three generations" of the medical futility debate over the past 20 years, see generally Jeffrey P. Burns & Robert D. Truog, Futility: A Concept in Evolution, 132 Chest 1987 (2007).

[FN4]. Black's Law Dictionary (8th ed. 2004).

[FN5]. Meinhard v. Salmon, 164 N.E. 545, 546 (N.Y. 1928).

[FN6]. Lester Brickman, The Continuing Assault on the Citadel of Fiduciary Protection: Ethics 2000's Revision of Model Rule 1.5, 2003 U. Ill. L. Rev. 1181, 1185-86 (2003) (discussing imposition of fiduciary duties as way to protect beneficiary by limiting fiduciary's superior ability to exert undue power and influence and limiting fiduciary from taking own self-interest into account when dealing with beneficiary); Kim Johnston, Patient Advocates or Patient Adversaries? Using Fiduciary Law to Compel Disclosure of Managed Care Financial Incentives, 35 San Diego L. Rev. 951, 958-63 (1998) (discussing inequality in fiduciary relationship due to fiduciary's superior skills or knowledge and the law's resulting imposition of higher duties of loyalty and care on the fiduciary).

[FN7]. Laurence B. McCullough, John Gregory (1724-1773) and the Invention of Professional Relationships in Medicine, 8 J. Clin. Ethics 11, 13-16, 18 (1997) (describing commercial character of medicine in Gregory's day which he railed against and responded to by inventing:

[The] ethical concept of the physician as the moral fiduciary of the patient.... Thus, Gregory argues, medicine should not be practiced as a trade, as a form of commerce in which the pursuit of self-interest rules the roost.... Gregory did forge the concept of being a fiduciary as the core meaning of medicine as a profession in the ethical sense of the term");

Laurence B. McCullough, Power, Integrity, and Trust in the Managed Practice of Medicine: Lessons From the History of Medical Ethics, 19 Soc. Philos. Pol'y 180, 187, 191, 194 (2002) [hereinafter McCollough, Power, Integrity, and Trust] (describing the competitive marketplace for medical services in 18th century Britain where "[e]ntrepreneurial ... self-interest was the norm," and patients "could not be confident that their practitioners knew what they were doing, nor could they be confident that the practitioner's recommendations were intended mainly to benefit them rather than the practitioner.... Gregory's remedy to these problems was to invent the concept of the physician being a fiduciary of the patient."). See also generally id. at 187-198.

[FN8]. Laurence B. McCullough, Bioethics in the Twenty-First Century: Why We Should Pay Attention to Eighteenth-Century Medical Ethics, 6 Kennedy Instit. Ethics J. 329, 331-32 (1996) (emphasis added). See also Laurence B. McCullough, The History of Medical Ethics Is Crucial for a Critical Perspective in the Continuing Development of Ethics Consultation, 1 Am. J. Bioethics 55, 56 (2001):

Gregory articulated the meaning of 'professional' in terms of fiduciary responsibility. The physician should be in a position to reach reliable clinical judgments about the health-related interests of patients; make protection and promotion of those interests the primary moral concern, with the pursuit of self-interest relegated to a secondary status; and have confidence that acting on the first two will result in comfortable remuneration.

Chevernak and McCullough have extended this fiduciary relationship to physician-leaders within a health care organization and to the health care organization itself. Frank A. Chervenak & Laurence B. McCullough,

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The Moral Foundation of Medical Leadership: The Professional Virtues of the Physician as Fiduciary of the Patient, 184 Am. J. Obstet. Gynecol. 875, 876 (2001) (arguing "that the concept of the physician as the moral fiduciary of the patient should be the moral foundation of management decisions by physician leaders" and describing the four professional virtues that form the basis of the physician's fiduciary relationship to the patient as self-effacement, self-sacrifice, compassion, and integrity); McCullough, Power, Integrity and Trust, supra note 7, at 203 (stating that "[h]ealth-care organizations have fiduciary obligations to the entire population of patients for which they are responsible").

[FN9]. Laurence B. McCullough, Practicing Preventive Ethics - The Keys to Avoiding Ethical Conflicts in Health Care, Physician Executive (Mar./Apr. 2005), available at http://findarticles.com/p/articles/mi_m0843/is_2_31/ai_ n13503450 (last visited Apr. 6, 2008); see also Frank A. Chervenak & Laurence B. McCullough, Dilemmas of Cooperation for Physician Leaders, 33 Physician Executive 46 (2007), at Table 2 (consistent with Gregory's view of professional medical ethics, "[f]iduciary responsibility requires physicians to commit to intellectual integrity by practicing evidence-based medicine and to commit to moral integrity by keeping self-interest systematically secondary and maintaining and strengthening medicine as a public trust for the benefit of future physicians, patients, and society."). For a comprehensive history of John Gregory and his role in the development of medical ethics, see generally Laurence B. McCullough, John Gregory and the Invention of Professional Medical Ethics and the Profession of Medicine (1998).

[FN10]. See, e.g., American Academy of Neurology, Code of Professional Conduct, 1.2, available at http://www.ama-assn.org/ama/pub/category/print/13339.html (last visited Apr. 6, 2008) ("The neurologist has fiduciary and contractual duties to patients. As a fiduciary, the neurologist has an ethical duty to consider the interests of the patient first. As a party to an implied contract, the neurologist has a duty to practice competently and to respect patients' autonomy, confidentiality, and welfare."); Bernard Lo, Resolving Ethical Dilemmas: A Guide For Clinicians 29-30 (3d ed. 2005) (discussing patients' vulnerability, lack of expertise, and reliance on physicians as reasons for imposing fiduciary duties in patient-physician relationship to promote patient's best interests); Maxwell J. Mehlman, Dishonest Medical Mistakes, 59 Vand. L. Rev. 1137, 1147-53 (2006) [hereinafter Mehlman, Dishonest Medical Mistakes] (discussing nature of fiduciary relationship); Maxwell J. Mehlman, The Patient-Physician Relationship in an Era of Scarce Resources: Is There a Duty to Treat?, 25 Conn. L. Rev. 349, 367-70 (1993) (noting that "[w]hile there is some lingering debate over whether the patient-physician relationship is properly termed a fiduciary relationship [some characterize it as a "confidential" relationship], most courts and commentators now agree that it is" and generally discussing the nature of this relationship); David Orentlicher, Health Care Reform and the Patient-Physician Relationship, 5 Health Matrix 141, 147 (1995):

Traditionally, the patient-physician relationship has been viewed as a fiduciary relationship in which the physician owes the patient a fundamental duty to place the patient's interests first, above not only the physician's personal interests but also the interests of other patients. This duty of loyalty arises primarily from the unequal relationship between patients and physicians. Physicians are expected to place the interests of their patients foremost because they possess an inherent power over their patients. (citation omitted).

Marc A. Rodwin, Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System, 21 Am. J.L. & Med. 241, 242 (1995) [hereinafter Rodwin, Strains in the Fiduciary Metaphor] ("The idea that physicians are or should be fiduciaries for their patients ... is a dominant metaphor in medical ethics and law today and is presumed by much of the legal and ethical analysis of physicians' conflicts of interest."). Despite this broad legal and ethical consensus, some cases and commentary have challenged the characterization of the doctor-patient relationship as a fiduciary one. See, e.g., Gunter v. Huddle, 724 So.2d 544, 546 (Ala.Civ.App. 1998) ("Alabama caselaw holds that a physician-patient relationship is not a fidu-

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ciary relationship as a matter of law."). See generally Marc A. Rodwin, Medicine, Money, and Morals: Physicians' Conflicts of Interest (1993) 179-211 [hereinafter Rodwin, Medicine, Money, and Morals] (discussing generally fiduciary law and the professions, and observing (at 210) that the "fiduciary ideal, implicit in much of medical ethics and some of medical law, needs reinforcement.").

[FN11]. Petrillo v. Syntex Laboratories, Inc., 499 N.E.2d 952, 961 (Ill. 1986) (stating that "it is well settled ... throughout the United States ... that there exists, between a patient and his treating physician, a fiduciary relationship founded on trust and confidence") (citations omitted), cert. denied sub nom., Tobin v. Petrillo, 483 U.S. 1007 (1987). See also Canterbury v. Spence, 464 F.2d 772, 782 (D.C. Cir.) ("The patient's reliance upon the physician is a trust of the kind which traditionally has exacted obligations beyond those associated with arms length transactions"), cert. denied, 409 U.S. 1064 (1972). See generally Johnston, supra note 6, at 963-66 (discussing legal and ethical support for holding physician as fiduciary).

[FN12]. Commentators have noted both the indeterminacy of the boundaries of the fiduciary duties owed by physicians, as well as wondered how those boundaries should be defined in the increasingly complex practice of medicine where physicians may be thought to owe duties not only to patients but to employers, insurers, and the public. See e.g. Mehlman, Dishonest Medical Mistakes, supra note 10, at 1154-72 (discussing scholarly criticism and legal developments that may undermine the fiduciary duty of health care professionals); Michelle Oberman, Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts, 94 Nw. U. L. Rev. 451, 457-68 (2000) (discussing the limited fiduciary nature of the doctor-patient relationship and challenges to maintaining the doctor's fiduciary role in contemporary health care settings); Rodwin, Strains in the Fiduciary Metaphor, supra note 10, at 242, 247-52, 255 (generally discussing legal and ethical gaps between fiduciary ideal and practice and observing that:

Although doctors perform fiduciary-like roles and hold themselves out as fiduciaries in their ethical codes, the law holds doctors accountable as fiduciaries only in restricted situations.... [T]he law today goes only a small way in holding doctors to fiduciary standards. There are also significant social and financial demands for doctors to serve interests other than patients.).

[FN13]. Rodwin, Strains in the Fiduciary Metaphor, supra note 10, at 247-48, Rodwin, Medicine, Money, and Morals, supra note 10, at 184.

[FN14]. AMA Principles of Medical Ethics, Principle VIII, available at http://www.ama-assn.org/ama/pub/category/2512.html (last visited Apr. 6, 2008).

[FN15]. Rodwin, Medicine, Money and Morals, supra note 10, at 8, 268-70 ('Since the time of Hippocrates, the central canon of medical ethics has promoted the patient's welfare above all else", and citing excerpts from national and international medical codes of ethics reflecting the primacy of patient welfare). See also Project of the ABIM Foundation, ACP-ASIM Foundation, and European Federation of Internal Medicine, Medical Professionalism in the New Millennium: A Physician Charter, 136 Ann. Intern. Med. 243, 244 (2002) [hereinafter Medical Professionalism in the New Millennium] (adopting as one of three fundamental principles of medical professional the "[p]rinciple of the primacy of patient welfare. This principle is based on a dedication to serving the interest of the patient. Altruism contributes to the trust that is central to the physician-patient relationship. Market forces, societal pressures, and administrative exigencies must not compromise this principle.").

[FN16]. AMA Code of Medical Ethics, Op. E-10.015 The Patient-Physician Relationship, available at http://www.ama-assn.org/apps/pf_new/f_online?f_

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[FN17]. See id.; AMA Principles of Medical Ethics, Principles I and II, supra note 14; and AMA Code of Medical Ethics, Opinion E-10.01 Fundamental Elements of the Patient-Physician Relationship, available at http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/E-10.01.HTM&&s_t=&st_p=&nth=1&prev_pol=policyfiles/HnE/E-9.132.HTM&nxt_pol=policyfiles/HnE/E-10.01.HTM& (last visited Apr. 6, 2008).

[FN18]. Orentlicher, supra note 10, at 147-48.

[FN19]. The concept of "trust" in the patient-physician relationship has recently enjoyed fresh examination in medical ethics and law literature. See generally Mark A. Hall, The Importance of Trust for Ethics, Law, and Public Policy, 14 Cambridge Q. Healthcare Ethics 156 (2005) (discussing growing recognition of importance of trust and surveying competing public policy theories about trust); Mark A. Hall, Law, Medicine, and Trust, 55 Stan. L. Rev. 463, 469 [hereinafter Hall, Law, Medicine, and Trust] (generally providing comprehensive discussion of the nature and significance of trust and its relationship to law and observing that "[w]e are now witnessing a robust revival of trust as a topic in discussions of medical ethics and professionalism."). See also Mark A. Hall, Can You Trust A Doctor You Can't Sue?, 54 DePaul L. Rev. 303 (2005) (discussing implications of medical trust for malpractice reform); Mark A. Hall & Robert A. Berenson, Ethical Practice in Managed Care: A Dose of Realism, 128 Ann. Intern. Med. 395, 397 (1998) (in context of physician financial incentives, arguing that "the primary goal of role-based medical ethics should be the preservation of patients' trust in their physicians. Trust is important primarily because of its therapeutic role, not simply because of its intrinsic, theoretical value."). But see Robert Gatter, Faith, Confidence, and Health Care: Fostering Trust in Medicine Through Law, 39 Wake Forest L. Rev. 395, 398, 424 (2004) (recognizing "emerging medical trust movement" but questioning role of law in promoting patient trust and suggesting that "a healthy skepticism toward medicine rather than faith [trust] in it, may be the best mechanism for coping with the vulnerability of illness").

[FN20]. See Hall, Law, Medicine, and Trust, supra note 19, at 478-82 (2002) (discussing empirical research showing that trust has therapeutic benefits, including the placebo effect); Gatter, supra note 19, at 399-400, 416-17 (2004) (noting that researchers have established "a positive correlation between medical trust and certain desirable health-related behaviors" by patients, and also questioning placebo effect).

[FN21]. Brickman, supra note 6, at 1191. See also Restatement (Third) of the Law Governing Lawyers § 16 cmt. b (2000) ("A lawyer is a fiduciary, that is, a person to whom another person's affairs are entrusted in circumstances that often make it difficult or undesirable for that other person to supervise closely the performance of the fiduciary. Assurances of the lawyer's competence, diligence, and loyalty are therefore vital.").

[FN22]. Model Rules of Prof'l Conduct R. 1.8 cmt. 17:

The relationship between lawyer and client is a fiduciary one in which the lawyer occupies the highest position of trust and confidence. The relationship is almost always unequal; thus, a sexual relationship between lawyer and client can involve unfair exploitation of the lawyer's fiduciary role, in violation of the lawyer's basic ethical obligation not to use the trust of the client to the client's disadvantage.

Rule 1.15 cmt. 1 ("A lawyer should hold property of others with the care required of a professional fiduciary."). All references to ABA Model Rules of Professional Conduct (2002) and ABA Model Code of Professional Responsibility (1969) in these footnotes may be found in Richard Zitrin et al., Legal Ethics, Rules, Stat-

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utes, and Comparisons: 2008 Edition (2007).

[FN23]. In re Cooperman, 633 N.E.2d 1069, 1071 (N.Y. 1994) (citations omitted). See also Brickman, supra note 6, at 1182 ("The principal fiduciary obligations imposed on the lawyer include duties of confidentiality, loyalty, safeguarding property, giving disinterested advice, and acting fairly towards the client."); Fred C. Zacharias, The Pre-employment Ethical Role of Lawyers: Are Lawyers Really Fiduciaries, 49 Wm. & Mary L. Rev. 569, 605, 607-08 (2007) ("Common law defining fiduciary duties limits the ways in which lawyers may pursue their own interests to the detriment of clients.... Fiduciary law ordinarily requires a lawyer to place the interests of his client above the attorney's own interests.... [F]iduciary law is based on notions of trust and loyalty" .) .

[FN24]. Model Rules of Prof'l Conduct R. 1.1.

[FN25]. Restatement (Third) of the Law Governing Lawyers § 16 (2000):

[A] lawyer must, in matters within the scope of the representation: (1) proceed in a manner reasonably calculated to advance a client's lawful objects, as defined by the client after consultation; (2) act with reasonable competence and diligence; (3) comply with obligations concerning the client's confidences and property, avoid impermissible conflicting interests, deal honestly with the client, and not employ advantages arising from the client-lawyer relationship in a manner adverse to the client.

Comment e states that "[t]he responsibilities entailed in promoting the objectives of the client may be broadly classified as duties of loyalty" .

[FN26]. Model Rules of Prof'l Conduct R. 1.6 cmt. 2 ("A fundamental principle in the client-lawyer relationship is that, in the absence of the client's informed consent, the lawyer must not reveal information relating to the representation. ... This contributes to the trust that is the hallmark of the client-lawyer relationship.").

[FN27]. Model Rules of Prof'l Conduct R. 1.4 cmt. 5 ('The guiding principle is that the lawyer should fulfill reasonable client expectations for information consistent with the duty to act in the client's best interests").

[FN28]. Model Rules of Prof'l Conduct R. 1.16 cmt. 7 ("A lawyer may withdraw from representation in some circumstances. The lawyer has the option to withdraw if it can be accomplished without material adverse effect on the client's interests.").

[FN29]. Model Rules of Prof'l Conduct R. 1.7 cmt. 1 ("Loyalty and independent judgment are essential elements in the lawyer's relationship to a client,") and cmt. 10 ("The lawyer's own interests should not be permitted to have an adverse effect on representation of a client."); Model Rules of Prof'l Conduct R. 1.8 cmt. 5 ("Use of information relating to the representation to the disadvantage of the client violates the lawyer's duty of loyalty."). See also Model Rules of Prof'l Conduct R. 1.9-1.11 (dealing with various kinds of conflict of interest).

[FN30]. Estate of Re v. Kornstein Veisz & Wexler, 958 F.Supp. 907, 925 (S.D.N.Y.1997). ("As made emphatically clear by the Court in Cooperman, clients must be able to maintain extraordinary confidence in their attorneys, and attorneys must be unyielding in representing their clients with undivided loyalty."). See also Model Rules of Prof'l Conduct R. 1.6 cmt. 2 (referring to trust as "the hallmark of the client-lawyer relationship"); Model Rules of Prof'l Conduct R. 1.7 cmt. 1, supra note 29; Zacharias, supra note 23, at 22 ("Similarly, the traditional designation of lawyers as fiduciaries rests on a belief that clients of all stripes are unusually dependent on lawyers, in part because they reveal confidences to the lawyers. The common image is that laypersons trust lawyers to look after their interests, are vulnerable in their transactions with lawyers, and are hesitant to dis-

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charge counsel or to shop around once having consulted an attorney.") (citations omitted).

[FN31]. Patient advocates may be lower-status hospital employees who in theory are supposed to help patients get care, but who in reality simply protect "the hospital from any potential claims by answering and appeasing patient complaints." Lee J. Johnson, The Risks of Being a "Patient Advocate," 81 Med. Econ. 72 (2004), available at http:// medicaleconomics.modernmedicine.com/memag/Medical+Malpractice:+ Risk+Management/Malpractice-Consult/ArticleStandard/Article/detail/108581 (last visited Apr. 6, 2008). See also E. Haavi Morreim, By Any Other Name: The Many Iterations of "Patient Advocate" in Clinical Research, 26 IRB: Ethics and Human Research 1, 2 (Nov/Dec. 2004) ("Perhaps the most familiar patient advocate to most laypersons is a hospital employee who addresses a range of inpatient concerns from food that is too cold, to nurses who respond too slowly, to physicians who communicate poorly."); National Patient Safety Foundation, The Role of the Patient Advocate: A Consumer Fact Sheet, http:// www.npsf.org/pdf/paf/PatientAdvocate.pdf (last visited Apr. 6, 2008) (discussing professional advocates, such as social workers, nurses, or chaplains, who may be hired by hospitals and called "patient representatives" or "patient advocates", and observing that these "advocates can often be very helpful in cutting through red tape").

[FN32]. Tom. L. Beauchamp & James F. Childress, Principles of Biomedical Ethics 271-72 (4th ed. 1994) ("[T]he idea that beneficence expresses the primary obligation in health care is ancient. Throughout the history of health care, the professional's obligations and virtues have been interpreted as commitments of beneficence."). See also AMA Code of Medical Ethics, Opinion E-10.015 The Patient-Physician Relationship ("Within the patient-physician relationship, a physician is ethically required to use sound medical judgment, holding the best interests of the patient as paramount"), available at http:// www.amaassn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/E-10.015.HTM&&s_t=&st_p=&nth=1&prev_pol=policyfiles/HnE/E-9.132.HTM&nxt_ pol=policyfiles/HnE/E-10.01.HTM& (last visited Apr. 6, 2008).

[FN33]. AMA Code of Ethics, Opinion E-10.015, supra note 16 and accompanying text; Opinion E-10.01 Fundamental Elements of the Patient-Physician Relationship, (discussing how physicians can best contribute to collaborative patient-physician relationship by "serving as their patients' advocate), available at http://www.amaassn.org/apps/pf_new/pf_online?f_
n=browse&doc=policyfiles/HnE/E10.01.HTM&&s_t=&st_p=&nth=1&prev_
pol=policyfiles/HnE/E-9.132.HTM&nxt_pol=policyfiles/HnE/E-10.01.HTM& (last visited on Apr. 6, 2008). See also infra note 37.

[FN34]. See, e.g., ACP - American College of Physicians, Ethics Manual, available at http://www.ama-assn.org/ama/pub/category/13347.html (last visited on Apr. 6, 2008) (referring to "the traditional role of physician as patient advocate"); ACP - ASIM Section 4, available at http://www.ama-assn.org/ama/pub/category/13361.html (last visited on Apr. 6, 2008) (in the context of resource allocation, referring to the doctor's "primary role as a patient's trusted advocate"); American College of Obstetricians and Gynecologists, Code of Conduct, Section I(2), available at http://www.ama-assn.org/ama/pub/category/13336.html (last visited on Apr. 6, 2008) ("[t]he obstetrician-gynecologist should serve as the patient's advocate and exercise all reasonable means to ensure that the most appropriate care is provided to the patient."); American College of Surgeons, Statements on Principles, available at http://www.ama-assn.org/ama/pub/category/13350.html (last visited Apr. 6, 2008) (surgeons pledge "to place the welfare and the rights of my patient above all else"). Contrast the older American College of Physicians ethics manual, American College of Physicians, Ethics Manual, Part I, 101 Ann. Intern. Med. 129, 134 (1984)

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(recognizing the potential for conflicts of interest and stating that "[u]nder the covenant of personal medical care the physician is ordinarily the advocate and the champion of his patient, upholding the patient's interests above all others") with the newer edition, American College of Physicians, Ethics Manual, 128 Ann. Intern. Med. 576, 577, 588 (4th ed. 1998) ("More than ever, concerns about justice challenge the traditional role of physician as patient advocate.... Increasingly, decisions about resource allocations challenge the physician's primary role as patient advocate.").

[FN35]. See, e.g., Norman G. Levinksy, The Doctor's Master, 211 New Eng. J. Med. 1573 (1984) ("In caring for anindividualpatient,thedoctormustactsolely as that patient's advocate, against the apparent interests of society asa whole, ifnecessary.").

[FN36]. E. Haavi Morreim, Balancing Act: The New Medical Ethics of Medicine's New Economics 88-90 (1995):

[T]he physician's chief resource duty is advocacy, particularly economic advocacy. While we can no longer suppose that physicians are obligated to commandeer what does not belong to them, they do have power duties, first, to advocate vigorously on behalf of their own individual patients and, second, to advocate on all patients' behalf in order to improve resource policies.

Many of the references to advocacy in professional ethics statements and scholarly commentary focus on doctors serving as their patient's advocate in coverage disputes with health plans over payment for treatment. The AMA has also articulated an ethical duty of economic advocacy in the context of managed care disputes. See AMA, Report of the Council on Ethical and Judicial Affairs, CEJA Report 1-A-01, at 3 (2001) [hereinafter CEJA Report 1-A-01], available at http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja_1a01.pdf (maintaining that "physicians have a duty of patient advocacy that should not be altered by the system of health care delivery, and that requires physicians to advocate for any care they believe will materially benefit their patients"); AMA Opinion E-8.13, http://www.ama-assn.org/ama/pub/category/8498.html (last visited Apr. 6, 2008) (in the context of managed care, stating that "[t]he duty of patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the system of health care delivery. Physicians must continue to place the interests of their patients first."). See generally Bethany J. Spielman, Managed Care Regulation and the Physician-Advocate, 47 Drake L. Rev. 713, 716-20 (1999) (discussing three conceptions of physician advocacy role); Maxwell J. Mehlman, Medical Advocates: A Call for a New Profession, 1 Widener L. Symp. J. 299, 320-23 (1996) (arguing that rather than physicians serving in this economic advocacy role, a new profession of "medical advocate" should be developed; these medical advocates would be specially trained, motivated, and monitored to do their job "to make the health care system work as well as possible for the individual patient."); William Sage, Physicians as Advocates, 35 Hous. L. Rev. 1529 (1999) (cautioning against imposing a lawyer-like duty and adversarial role on physicians to be their patient's advocate in coverage disputes with payors).

[FN37]. Report of the Council on Ethical and Judicial Affairs, CEJA Report 2-A-03, Ethical Responsibility to Study and Prevent Error and Harm in the Provision of Health Care 4-5 (2002) [hereinafter CEJA Report 2-A-03] (discussing physicians' responsibility to act as patient advocates and to promote the patient's best interests by continuing care in the aftermath of harmful error and taking responsibility to investigate and acknowledge the error). See infra note 71 and accompanying text.

[FN38]. CEJA Report 1-A-01, supra note 36, at 2 (2001):

Trust is central to the patient-physician relationship.... One important manifestation of this obligation of fidelity is the ethical obligation not to abandon a patient, which would undermine physicians' trustworthiness....

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The patient-physician relationship is held to high standards of conduct. ... This characterization of the patient-physician relationship differs significantly from the contractual view of the relationship in which patients seek care and physicians provide it. Ethically, it would be insufficient to view health care as an ordinary service and to allow care that patients request from physicians to be governed by the maxim 'let the buyer beware.' (citations omitted).

[FN39]. See Allen K. Harris, The Professionalism Crisis - the "Z" Words and Other Rambo Tactics: The Conference of Chief Justices' Solution, 53 S.C. L. Rev. 549, 569 (2001) ("The phrase 'zealous advocacy' is frequently invoked to defend unprofessional behavior and a 'Rambo', or 'win at all costs', attitude.").

[FN40]. For an entertaining account of the history of the image of the lawyer as a "hired gun," see Michael I. Krauss, The Lawyer as Limo: A Brief History of the Hired Gun, 8 U. Chi. L. Sch. Roundtable 325 (2001).

[FN41]. Monroe H. Freedman traces the history of the lawyer-as-zealous-advocate role to Henry Lord Brougham, who in 1820 defended Queen Caroline from charges of adultery by King Henry IV and who famously said:

[A]n advocate, in the discharge of his duty, knows but one person in all the world, and that person is his client. To save that client by all means and expedients, and at all hazards and costs to other persons, and, amongst them, to himself, is his first and only duty; and in performing this duty he must not regard the alarm, the torments, the destruction which he may bring upon others.

Monroe H. Freedman, Henry Lord Brougham and Zeal, 34 Hofstra L. Rev. 1319, 1322 (2006) ("Inspired by Brougham almost two centuries ago, the 'traditional aspiration' of zealous advocacy remains 'the fundamental principle of the law of lawyering' and 'the dominant standard of lawyerly excellence' among lawyers today."). (citations omitted).

[FN42]. Model Rules of Prof'l Conduct Preamble, § 2 (2002):

As a representative of clients, a lawyer performs various functions. As advisor, a lawyer provides a client with an informed understanding of the client's legal rights and obligations and explains their practical implications. As advocate, a lawyer zealously asserts the client's position under the rules of the adversary system. As negotiator, a lawyer seeks a result advantageous to the client but consistent with requirements of honest dealings with others. As an evaluator, a lawyer acts by examining a client's legal affairs and reporting about them to the client or to others.

[FN43]. Model Code of Prof'l Responsibility Canon 7 (1969).

[FN44]. Model Rules of Prof'l Conduct R. 1.3. The duty of zealous advocacy of Canon 7 of the Model Code found its corollaries in Model Rules 1.2(d), 1.3, and 3.1. See Zitrin, supra note 22, at 541 (comparison chart). Like Rule 1.3, these other rules do not refer to either zealousness or advocacy. Rule 1.2(d) forbids a lawyer from counseling a client to engage in fraudulent or criminal activity. Rule 3.1 forbids a lawyer from advancing non-meritorious claims or contentions on behalf of a client. Even the commentary to Rule 3.1 avoids the use of a "z" word and clarifies the prohibition on frivolous claims: "The advocate has a duty to use legal procedure for the fullest benefit of the client's cause, but also a duty not to abuse legal system." Model Rules of Prof'l Conduct R. 3.1 cmt. 1. The Preamble provides similar caveats when it uses a "z" word: "These principles [underlying the Rules] include the lawyer's obligation zealously to protect and pursue a client's legitimate interests, within the bounds of the law, while maintaining a professional, courteous and civil attitude toward all persons involved in the legal system." Model Rules of Prof'l Conduct Preamble, §9. These provisions hardly project an image of a

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warrior, or Rambo, or a "vicious animal" that my former landlord wished for in his lawyer.

[FN45]. Comments are interpretive only. The Preamble provides: "Comments do not add obligations to the Rules but provide guidance for practicing in compliance with the Rules." Model Rules of Prof'l Conduct Preamble, §14.

[FN46]. Model Rules of Prof'l Conduct R. 1.3 cmt. 1.

[FN47]. See John W. Allen, Lawyers as Healers, 80-OCT Mich. B. J. 42, 43 (2001), stating that:

Zealousness has not been part of the lawyers' ethical canons since the 1908 canons were replaced in 1969 by the Model Code of Professional Responsibility (MCRP), Canon 7.... Even under MCPR, this was only an 'axiomatic norm' and not a standard of conduct, nor a rule of discipline. The Model Rules of Professional Conduct ... eliminate 'zealousness' entirely from any of their text.... Thus 'competence,' not 'zealousness,' is the standard of professional behavior for lawyers in the 21st century.

Anita Bernstein, The Zeal Shortage, 34 Hofstra L. Rev. 1165, 1165-68 (2006) (commenting that "zeal may have hit its peak in 'vigor' about a hundred years ago," and outlining the downgrading of zeal in successive versions of the ABA professional codes); John Conlon, It's Time to Get Rid of the "Z" Words, 44-FEB Res Gestae 50, 50 (2001) ("Lest there by any doubt that the old standard of zeal was in fact being replaced, the Comments to Rule 1.3 in the Annotated Model Rules comparing the Model Rules to the Model Code succinctly state that 'Rule 1.3 substitutes reasonable diligence and promptness for zeal."'); Harris, supra note 39, at 568, observing that:

One of the leading causes of the decline of professionalism is the probably misconception by many lawyers that former Canon 7's duty of zealous representation remains a requirement of the ABA Model Rules of Professional Conduct, which have been adopted in some form in forty-two states and the District of Columbia ....[when Oklahoma replaced the Model Code with the Model Rules] it replaced the black-letter duty of "zealous representation" of Canon 7 with the duty of "diligent representation" in Rule 1.3. The duty of 'zealous representation' was purposely omitted from Model Rule 1.3.

See generally Geoffrey C. Hazard, Jr., W. William Hodes & Peter R. Jarvis, The Law of Lawyering § 6.2 (3d ed. Supp. 2008) (discussing the evolution of the professional statements and the distinction between diligence and "zeal").

[FN48]. For commentators on the side of retaining zealous advocacy as a primary ethical obligation of lawyers, see Bernstein, supra note 47 (arguing that zeal has been misunderstood in theory and practice, chronicling a decline of zeal in the legal profession and legal education, and advocating renewed efforts to ease what she calls a zeal shortage and to restore passionate and partisan commitment to clients as a core professional responsibility); Monroe H. Freedman & Abbe Smith, Understanding Lawyers' Ethics 71-127 (3d ed. 2004) (defending zealous representation as the "pervasive ethic" of lawyering); Monroe H. Freedman, In Praise of Overzealous Representation - Lying to Judges, Deceiving Third Parties, and Other Ethical Conduct, 34 Hofstra L. Rev. 771, 771 (2006) ("For more than a century, the lawyer's ethic of zeal has required, and has inspired, entire devotion to the interests of the client, warm dedication in the maintenance and defense of his rights, and the exertion of the lawyer's utmost learning and ability."); Abbe Smith, Defending Defending: The Case of Unmitigated Zeal on Behalf of People Who Do Terrible Things, 28 Hofstra L. Rev. 925, 958-59 (2000) (arguing that "[e]specially in representing clients accused of crime, most of whom are poor and are all too often poorly represented, lawyers should err on the side of overzeal rather than underzeal."); Sylvia Stevens, Whither Zeal? Defining 'Zealous Representation', 65-JUL Or. St. B. Bull. 27 (2005) (noting that the current Model Rules have departed from earlier the earlier ABA Canons of Professional Ethics (1908) and Model Code of Professional Responsibility (1969) which

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required or at least exhorted zealousness, and exploring this dilution to a "tepid standard of zeal"). For commentators who have offered critiques of and alternatives to zealous advocacy as the primary professional virtue, see Conlon, supra note 47 (urging elimination of the "z" words from the comments in the Model Rules); Bruce A. Green, Thoughts about Corporate Lawyers after Reading the Cigarette Papers: Has the "Wise Counselor" Given Way to the "Hired Gun"?, 51 DePaul L. Rev. 407 (2001) (concluding that the ABA should encourage corporate counsel to return to the "wise counselor" ethic rather than that of the "hired gun"); Sage, supra note 36, at 1547-51 (describing backlash against ideal of zealous advocacy within the legal profession); Fred C. Zacharias & Bruce A. Green, Reconceptualizing Advocacy Ethics, 74 Geo. Wash. L. Rev. 1, 66-67 (2005) (comparing two standard conceptions of advocacy ethics-- "Brougham's model of zealous advocacy and [David] Hoffman's emphasis on personal conscience and discretion" - and offering a third conception: "advocates owe fidelity to the court as well as to the client and therefore-- contrary to Brougham--may not do everything legally permissible to promote the client's cause. Under this [third] conception, limits on advocacy and partisanship are not derived from personal morality, as Hoffman and others would have it, but are implicit in lawyers' professional undertakings.").

[FN49]. See supra note 42.

[FN50]. Commentary to Model Rule 2.1 provides: "It is proper for a lawyer to refer to relevant moral and ethical considerations in giving advice. Although a lawyer is not a moral advisor as such, moral and ethical considerations impinge upon most legal questions and may decisively influence how the law will be applied." Model Rules of Prof'l Conduct R. 2.1 cmt. 22. See Sanford Levinson, The Lawyer as Moral Counselor: How Much Should the Client Be Expected to Pay?, 77 Notre Dame L. Rev. 831 (2001-2002) (examining some implications of Rule 2.1).

[FN51]. See, e.g., Thomas L. Shaffer & Robert F. Cochran, Lawyers, Clients, and Moral Responsibility 40-54, 112-134 (1994) (discussing the value of and a framework for moral counseling); Fred C. Zacharias, Reconciling Professionalism and Client Interests, 36 Wm. & Mary L. Rev. 1303, 1357-62 (1995) (proposing codifying a duty to engage in a moral discourse with clients). See also Shaffer & Cochran infra note 57.

[FN52]. See Paul Brest & Linda Hamilton Krieger, Lawyers as Problem Solvers, 72 Temple L. Rev. 811 (1999) (observing that "of the ten 'fundamental lawyering skills' identified by the ABA's MacCrate Commission Report, fewer than half related exclusively to the law"); Angela Olivia Burton, Cultivating Ethical, Socially Responsible Lawyer Judgment: Introducing the Multiple Lawyering Intelligences Paradigm Into the Clinical Setting, 11 Clin. L. Rev. 15 (2004) (discussing the range of logical-mathematical, linguistic, narrative, interpersonal, intrapersonal, categorizing, and strategic intelligences that are needed by a lawyer to provide independent professional judgment for a client); Carrie J. Menkel-Meadow, When Winning Isn't Everything: The Lawyer as Problem-Solver, 28 Hofstra L. Rev. 905, 912 (2000) ("Legal analysis is a necessary, but not sufficient, condition of good problem solving"). See infra note 59 for discussion of non-legal problem-solving skills needed for good lawyering.

[FN53]. See generally, Susan Daicoff, Law as a Healing Profession: The "Comprehensive Law Movement," 6 Pepp. Disp. Resol. L.J. 1 (2006); Marjorie A. Silver, The Affective Assistance of Counsel: Practicing Law as a Healing Profession (2007).

[FN54]. Steven Keeva, Transforming Practices: Finding Joy and Satisfaction in Legal Life 102 (1999):

It has often been said that the law is one of the great healing professions, that while medicine heals the

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body and the clergy heals the soul, the law heals societal rifts. David Link [former Dean of Notre Dame Law School] believes it is time for lawyers to reclaim their role as healers, which extensive historical research tells him was in fact the original role of lawyers - or the people who eventually came to be known as lawyers.

See David T. Link, Healing, Jurist (Oct. 2, 2000), http:// jurist.law.pitt.edu/idea1000.htm (describing the origins of the legal professions, like the other two ancient professions, in healing, and observing that the "primary goal of a healing lawyer is peacemaking").

[FN55]. Warren E. Burger, Isn't There a Better Way?, 68 A.B.A. J. 274 (1982). See Steven Keeva, Once More, With Healing: Ex-Law Dean Heads Center Dedicated to Alternative Approaches to Practice, ABA Journal, May 2004, available at http://www.abajournal.com/magazine/once_more_with_healing/ (discussing impact of Chief Justice Burger's words on David Link, former Dean of Notre Dame Law School, who observed: "Lawyers need to know that their clients want peace and harmony in their lives, and that they need to facilitate that, rather than exacerbate the problems. The real goal should be maintaining dignity on both sides, whether the parties are corporations or married couples." Link went on to help establish the International Centre for Law and Healing in 2002, now called the International Center for Law and Renewal, at http://www.healingandthelaw.org/

[FN56]. Warren E. Burger, Annual Message on the Administration of Justice at the Midyear Meeting of the American Bar Association 13 (Feb. 12, 1984) (transcript on file with the author). See infra note 62 discussing the healing role for lawyers within the religious lawyering movement.

[FN57]. The concept of "lawyer as friend" was first articulated by Harvard Professor Charles Fried in The Lawyer As Friend: The Moral Foundations of the Lawyer-Client Relationship, 85 Yale L. J. 1060, 1071 (1979) (terming the lawyer as a "special-purpose friend," and explaining that "[a] lawyer is a friend in regard to the legal system. He is someone who enters into a personal relation with you ... [t]hat means that like a friend he acts in your interests, not his own; or rather he adopts your interests as his own."). For other explorations of the concept of lawyer-as-friend, see Anthony T. Kronman, The Lost Lawyer: Failing Ideals of the Legal Profession 131-132 (1993):

[T]he sense in which a lawyer may sometimes be said to act as his client's friend. Friends take each other's interests seriously and wish to see them advanced; it is part of the meaning of friendship that they do. It does not follow, however, that friends always accept uncritically each other's accounts of their own needs. Indeed, friends often exercise a large degree of independent judgment in assessing each other's interests, and the feeling that one sometimes has an obligation to do so is also an important part of what the relation of friendship means.

Stephen R. Morris, The Lawyer As Friend: An Aristotelian Inquiry, 26 J. Legal Prof. 55 (2002) (discussing the lawyer-client relationship as an "advantage-friendship"); Thomas L. Shaffer & Robert F. Cochran, Jr., "Technical" Defenses: Ethics, Morals, and the Lawyer as Friend, 14 Clin. L. Rev. 337 (2007) (distinguishing the approaches of the lawyer as "godfather," the lawyer as "hired gun," and the lawyer as "guru," and recommending an alternative approach: "The approach we recommend, the practice of our preferred lawyer, the lawyer as friend, raises the moral issue with the client, engages the client in moral conversation, and seeks to arrive at moral decisions with the client.").

[FN58]. Geoffrey C. Hazard, Jr., Lawyer as Wise Counselor, 49 Loy. L. Rev. 215, 219 (2003):

As a wise counselor, the lawyer assumes hypothetically the role of judge and counsels the client according to the outcome that the lawyer determines a court would reach.... Beyond this, a wise counselor could view a situation in still broader perspective, much as an arbitrator who is not strictly bound by the law or a judge engaged in settlement mediation. From this perspective, the issue could be framed as, "What is fair and just all things considered.";

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Fred Zacharias, Lawyers as Gatekeepers, 41 San Diego L. Rev. 1387, 1389-90, 1405 (2004) (with respect to Elihu Root's famous statement that “half of the practice of a decent lawyer consists in telling would-be clients that they are damned fools and should stop,” the author observes that “Elihu Root was an aggressive, ultra-partisan lawyer. Yet he warned us that the lawyer's job consists as much of standing in the way of misguided client pursuits as of implementing client desires.... We are gatekeepers, and we should never forget it.”) See generally David A. Binder et al., Lawyers AS Counselors: A Client-Centered Approach (2004); Robert F. Cochran, Jr. et al., The Counselor-At-Law: A Collaborative Approach to Client Interviewing and Counseling (2d ed. 2006).

[FN59]. Brest & Krieger, supra note 52, at 811 (observing that the ABA MacCrate Commission Report placed the skill of “problem solving” at the top of its list of ten fundamental lawyering skills, “even ahead of legal analysis”); Menkel-Meadow, supra note 52, 910-11:

The ideal legal problem solver needs these modern skills, in addition to more conventional advocacy and argument: question framing, investigative skills, quantitative skills for valuation of cases and issues, listening and hearing, as well as talking, emotional awareness and empathy (differentiated from sympathy), creativity, the ability to synthesize, as well as analyze, coordinate and implement (a “reality tester”), manage conflict, superintend meeting and group facilitation, and offer expertise in decision making (for groups, individuals, clients, organizations and selves.) (citations omitted);

Janet Reno, Lawyers as Problem Solvers: Keynote Address to the AALS, 49 J. Leg. Educ. 5, 6, 10 (1999):

The good lawyer must be able to identify risk, assess the true value of a dispute, and work collaboratively with others to negotiate a swift and comprehensive resolution. A good lawyer must try to resolve a client's problem in a way that does not make the problem worse. A good lawyer has a duty to assist the client in maintaining continuing, positive relationships.... We [at the U.S. Dept. of Justice] want to hire lawyers who are problem-solvers and peacemakers....

In response to the growing sense of importance to be educating lawyers to be problem-solvers, law schools have begun to change their curriculum. California Western School of Law, for example, houses the Center for Creative Problem-Solving, available at http://www.cwsl.edu/main/default.asp?nav=creative_ problem_solving.asp&body=creative_problem_solving/home.asp (last visited Apr. 6, 2008). See also Lisa A. Kloppenberg, “Lawyer as Problem-Solver:” Curricular Innovation at Dayton, 38 U. Tol. L. Rev. 547 (2007).

[FN60]. Abraham Lincoln wrote:

Discourage litigation. Persuade your neighbors to compromise whenever you can. Point out to them how the nominal winner is often a real loser--in fees, expenses, and waste of time. As a peace-maker the lawyer has a superior opportunity of being a good man.... Never stir up litigation. A worse man can scarcely be found than one who does this.

Roy P. Basler, ed., The Collected Works of Abraham Lincoln, vol. II, at 81 (1953). See also Edward D. Re, The Lawyer as Counselor and Peacemaker, 77 St. John's L. Rev. 515, 518 (2003) (quoting Lincoln and observing that “lawyers, who have traditionally been honored for their skill as advocates and litigators, have it within their power to be honored as healers and peacemakers, and that, in addition to serving as ministers of justice, they can also become our ministers of peace.”); The Honorable D. Brooks Smith, The Lawyer as Peacemaker, 63 Univ. Pitt. L. Rev. 909, 910, 914 (2002), urging that:

[W]e need to be peacemakers - people who assist others in resolving conflicts rather than reflexively following a course that will only add pain to pain.... But you, as lawyers who are also peacemakers, can be a genuine moral force. You can bring your judgment to bear on helping people to solve their problems. You can be the voice that urges people to come together.

See infra note 62 discussing the peacemaking role within the religious lawyering movement.

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[FN61]. Mahatma Gandhi wrote:

I had learnt the true practice of law. I had learnt to find out the better side of human nature and to enter men's hearts. I realized the true function of a lawyer was to unite parties riven asunder. The lesson was so indelibly burnt into me that a large part of my time during the twenty years of my practice as a lawyer was occupied in bringing about private compromises of hundreds of cases. I lost nothing thereby - not even money, certainly not my soul.

Mohandas K. Gandhi, An Autobiography: The Story of My Experiments With Truth 134 (Beacon Press ed. 1993). See also Carrie Menkel-Meadow, The Lawyer as Consensus Builder: Ethics for a New Practice, 70 Tenn. L. Rev. 63, 66 (2002) (criticizing conventional ethics rules for failing to provide guidance and best practices for lawyers who serve in new roles of mediation and facilitation, and arguing that the "failure of the Model Rules to recognize the role of lawyers in 'peacemaking,' dispute prevention or resolution, and legal problem solving marks an absence in what is publicly recognized as among the most important roles a lawyer performs - that of a 'constructive lawyer.'").

[FN62]. Scholars within the religious lawyering movement often view the lawyer in peacemaking and healing roles. See e.g. Joseph G. Allegretti, The Lawyer's Calling: Christian Faith and Legal Practice 64-80 (1996) (discussing the role of lawyers as peacemaker and healer, rather than hired gun); Russell G. Pearce & Amelia J. Uelman, Religious Lawyering's Second Wave, 21 J.L. & Religion 269, 280-81 (2005-2006) (chronicling the history of the religious lawyering movement and offering goals for lawyers to "develop methods for engaging in constructive conversation that acknowledges differences while seeking to build on those values that are shared and respect those that are not ... [and to] serve as leaders in healing divisions in society both in the United States and abroad."); L. Timothy Perrin, Lawyer as Peacemaker: A Christian Response to Rambo Litigation, 32 Pepp. L. Rev. 519, 542 (2005) (generally exploring how the teachings of Jesus might inform the way that a Christian lawyer engages in practice, and concluding that "Jesus teaches his followers to break the never-ending cycle of insult and retaliation, which leads to mutual destruction, through a number of transforming initiatives, which, when practiced, bring hope and healing. The image of the lawyer as hired gun or the lawyer as Rambo lawyer gives way to the image of the lawyer as peacemaker."); Thomas L. Shaffer, Lawyers as Prophets, 15 St. Thom. L. Rev. 469 (2002-2003) (adopting the school of thought that "the way to be a lawyer and a good person, both at the same time, in teaching or writing about or practicing law is to be, at the same time, a Jew faithful to Torah, a Christian who follows Jesus."); Mary C. Szto, Lawyers as Hired Doves: Lessons from the Sermon on the Mount, 31 Cumb. L. Rev. 27, 28 (2000-2001):

My thesis is that the [Sermon on the Mount] requires a radical spiritual model of lawyering, which includes active engagement with clients' motives, a refusal to be a tool of vengeance, and a resolute desire to be a peacemaker and healer. I call this model 'lawyers as hired doves,' in sharp contrast with the predominant 'hired gun' motif in American lawyering.

[FN63]. Edward A. Dauer, Jurisprudence: A Forward to the Special Theme Issue, 5 Psychol. Pub. Pol'y & L. 800, 801 (1999) [hereinafter Dauer, Jurisprudence: A Forward to the Special Theme Issue] (explaining that "the objective of lawyers practicing [preventive law] has been to help their clients achieve their personal or organizational or familial or corporate goals, by optimizing the arrangements that are relevant to those goals and by minimizing the chance that the purpose is confounded by unnecessary legal risks."); Dennis P. Stolle & David B. Wexler, Therapeutic Jurisprudence and Preventive Law; A Combined Concentration to Invigorate the Everyday Practice of Law, 39 Ariz. L. Rev. 25, 27 (1997) ("Preventive law is a perspective on law practice that seeks to minimize and avoid legal disputes and to increase life opportunities through legal planning. A key tool of the preventive lawyer is the regular "legal checkup."); Bruce J. Winick, The Expanding Scope of Preventive Law, 3

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Fla. Coastal L.J. 189, 195 (2002) (discussing preventive law as a way of legal practice which attempts, through periodic legal check-ups, to identify a client's potential future legal problems, including litigation, and to reduce or eliminate them, and analogizing preventive law to preventive medicine: “Just as physicians and other health care professionals can prevent future illness through periodic legal check-ups ... attorneys (including even trial lawyers) can use a variety of mechanisms to identify and avoid future legal difficulties.”) (citations omitted). The National Center for Preventive Law is housed a California Western School of Law School, and is available at http:// www.preventivelawyer.org/main/default.asp (last visited Apr. 6, 2008).

[FN64]. The collaborative law movement originally grew out of the family law specialty and the frustration of some attorneys with the high psychic and other costs associated with handling divorce and custody cases in adversarial proceedings in the courts. See Gay G. Cox & Robert J. Matlock, The Case for Collaborative Law, 11 Tex. Wesleyan L. Rev. 45 (2004) (describing the history and implementation of collaborative law practice in Texas); David A. Hoffman, Collaborative Law: A Practitioner's Perspective, 12 No. 1 Disp. Resol. Mag. 25, 28 (2005):

The collaborative law (CL) process involves a written commitment by the lawyers and their clients to collaborative, good faith negotiation and to refer the case to other counsel if litigation is needed. The theory behind CL is that, by agreeing to the disqualification of counsel from litigation, the parties and their CL counsel are aligning everyone's incentives toward a negotiated resolution... . Most of the negotiation in a CL case is done in ‘four-way meetings' in which the parties and counsel participate.

Brian Roberson, Let's Get Together: An Analysis of the Applicability of the Rules of Professional Conduct to Collaborative Law, 2007 J. Disp. Resol. 255, 256-57 (2007):

Since the threat of litigation is removed from the realm of possibility of the collaborative lawyer and client, the parties should be free in four-way negotiations to identify essential interests of each client, setting the tone for a more cooperative atmosphere and allowing for all involved to work towards the ideal of a positive sum gain for both parties.

Pauline H. Tesler, Collaborative Law: A New Paradigm for Divorce Lawyers, 5 Psychol. Pub. Pol'y & L. 967, 979 (1999):

The real power of the model emerges out of profound changes in role and behavior when the lawyer enters fully into the spirit of a collaborative representation. The clear commitment by everyone that decisions ordinarily will not be made by any third party alters dramatically how each participant engages in negotiations. Each participant bears full personal responsibility, from the start, for generating creative alternatives that might meet the legitimate needs of both parties. That is the sole agenda. If the lawyers cannot sustain creative problem solving, the process grinds to a halt and terminates, and the lawyers have failed.

The professional ethics of collaborative law have been debated, largely due to the disqualification agreement of counsel by which they agree to withdraw in the event the case goes to litigation. See David A. Hoffman, A Healing Approach to the Law: Collaborative Law Doesn't Have to Be an Oxymoron, The Christian Science Monitor, Oct. 9. 2007, available at http:// www.csmonitor.com/2007/1009/p09s01-coop.html (discussing support for collaborative law as reflected by ABA's formal opinion (no. 07-447), five state ethics committee' approval, and a majority of states which have groups of lawyers who practice collaborative law); Eileen Libby, Putting a Kindler, Gentler Face on Litigation, ABA Journal, January 2008, available at http:// www.abajournal.com/magazine/putting_a_kinder_face_on_litigation/ (contrasting Colorado Bar Association's ethics committee opinion that collaborative law violates the state's ethics code as creating a conflict of interest with the ABA's formal opinion that collaborative law does not violate the ABA Model Rules of Professional Conduct if the client's informed consent is obtained).

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[FN65]. David B. Wexler & Bruce J. Winick, Law in a Therapeutic Key: Developments in Therapeutic Jurisprudence xvii (1996):

Therapeutic jurisprudence is the study of the role of law as a therapeutic agent.... The therapeutic jurisprudence heuristic suggests that the law itself can be seen to function as a kind of therapist or therapeutic agent. Legal rules, legal procedures, and the roles of legal actors (such as lawyers and judges) constitute social forces that, like it or not, often produce therapeutic or antitherapeutic consequences. Therapeutic jurisprudence proposes that we be sensitive to those consequences, and that we ask whether the law's antitherapeutic consequences can be reduced, and its therapeutic consequences enhanced, without subordinating due process and other justice values.

Therapeutic jurisprudence has generated enormous interest among legal scholars, judges, and practitioners, and its founders sponsor a Web site with extensive resources. See International Network on Therapeutic Justice, http:// www.law.arizona.edu/depts/upr-intj/ (last visited Apr. 6, 2008). Preventive law (see supra note 63) and therapeutic jurisprudence have been merged to combine the practical lawyering skills of preventive law with therapeutic jurisprudence's theoretical framework and psychological goals of healing. See generally Dennis P. Stolle et al., Integrating Preventive Law and Therapeutic Jurisprudence: A Law and Psychology Based Approach to Lawyering, 34 Cal. W.L. Rev. 15 (1997).

[FN66]. Daicoff, supra note 53, at 7 ("All of the vectors seek to resolve the legal dispute or matter in a way that prevents harm to, preserves, or enhances individuals' interpersonal relationships, psychological wellbeing, opportunities for personal growth, mental health, or satisfaction with the process and outcome of the matter.").

[FN67]. Id. at 1-2, 5, 9 (discussing nine "vectors" of the comprehensive law movement, including preventive law, collaborative law, and therapeutic jurisprudence, and identifying the two unifying features among them all as "(1) a desire to maximize the emotional, psychological, and relational well being of the individuals and communities involved in each legal matter, and (2) a focus on more than just strict legal rights, responsibilities, duties, obligations, and entitlements." ... [These "rights plus" considerations include] "the social, psychological, and emotional consequences of various courses of action; the communities in which the individuals involved exist; and the parties' emotions, feelings, needs, resources, goals, psychological health, relationships, values, morals, and financial concerns.")

[FN68]. See supra note 65; Charity Scott, Judging in a Therapeutic Key: Therapeutic Jurisprudence and the Courts, 25 J. Leg. Med. 377, 379 (2004) (book review):

[Therapeutic jurisprudence] scholars analyze these therapeutic and anti-therapeutic consequences and ask to what extent the law, lawyers, and judges should attempt to maximize the potential for therapeutic outcomes. TJ suggests that people's encounters with the legal system, like their encounters with the health care system, ideally should leave them better off, not worse off, than they were before the encounter. In other words, like medicine, law should strive first to "do no harm." (citations omitted).

[FN69]. 61 Am. Jur. 2d Physicians, Surgeons, Etc. § 217 (2008) (providing that if a physician "would discontinue his services before the need for them is at an end, he is bound first to give due notice to the patient and afford the latter ample opportunity to secure other medical attendance of his own choice"). See infra notes 70-71 and accompanying text (acknowledging physician's continuing role in care after medical error).

[FN70]. A similar perspective is thoughtfully advanced in Jonathan Todres, Toward Healing and Restoration for All: Reframing Medical Malpractice Reform, 39 Conn. L. Rev. 667, 670 (2006) ("Redress for medical malpractice should be part of the continuum of care in the health care delivery system, incorporating into its processes

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medicine's goals of alleviating suffering and providing healing.”).

[FN71]. CEJA Report 2-A-03, supra note 37, at 4-5 (June 2003). See also AMA Ethical Op. E-8.12:

It is a fundamental ethical requirement that a physician should at all times deal honestly and openly with patients.... Situations occasionally occur in which a patient suffers significant medical complications that may have resulted from the physician's mistake or judgment. In these situations, the physician is ethically required to inform the patient of all the facts necessary to ensure understanding of what has occurred. Only through full disclosure is a patient able to make informed decisions regarding future medical care.

[FN72]. Standard RI 2.90, Joint Commission on Accreditation of Healthcare Organizations, Comprehensive Accreditation Manual for Hospitals provides: “Patients and, when appropriate, their families are informed about the outcomes of care, treatment and services that have been provided, including unanticipated outcomes.” Quoted in Doug Wojcieszak et al., The Sorry Works! Coalition: Making the Case for Full Disclosure, 32 Jt. Comm. J. on Quality & Patient Safety 344 (2006) [hereinafter Wojcieszak, Sorry Works! Coalition], available at http://www.jointcommission.org/NR/rdonlyres/5E597FEF-6F86-480DA1E2-CDD6CB491D3E/0/Sorry_Works.pdf.

[FN73]. See, e.g., Nancy Berlinger, After Harm: Medical Error and the Ethics of Forgiveness 40-50 (2007) (discussing the ethical underpinnings of telling the truth about medical mistakes); Michael D. Cantor et al., Disclosing Adverse Events to Patients, 31 Jt. Comm. J. on Quality & Patient Safety 5 (2005) (discussing ethical arguments and legal support for disclosure, and recommending practical approaches to disclosure), available at http:// www.jcrinc.com/ppdf/pubs/pdfs/JQS/JQPS-01-05-Cantor.pdf; Medical Professionalism in the New Millennium, supra note 15, at 244 (stating that “[w]henever patients are injured as a consequence of medical care, patients should be informed promptly because failure to do so seriously compromises patient and societal trust”); CEJA Report 2-A-03, supra note 37, at 3 (“when asked what should be done when a patient is injured, medical ethicists find the answer to be rather straightforward, regardless of whether the injury was inadvertent or preventable - information regarding the injury should be disclosed to the patient”); Wojcieszak, Sorry Works! Coalition, supra note 72; Albert W. Wu et al., To Tell the Truth: Ethical and Practical Issues in Disclosing Medical Mistakes to Patients, 12 J. Gen. Intern. Med. 770 (1997). See also infra notes 75-76 and accompanying text.

[FN74]. Consensus Statement of the Harvard Hospitals, When Things Go Wrong: Responding to Adverse Events 8-10 (Mar. 2006), available at http:// www.ihi.org/NR/rdonlyres/A4CE6C77-F65C-4F34-B323-20AA4E41DC79/0/RespondingAdverseEvents.pdf.

[FN75]. See e.g. Geri Amori, Risk Management Pearls on Disclosure of Adverse Events (ASHRM 2006); Thomas H. Gallagher et al., Disclosing Unanticipated Outcomes to Patients: The Art and the Practice, 3 J. Patient Safety 158, 159-163 (2007) [hereinafter Gallagher, Disclosing Unanticipated Outcomes to Patients] (discussing implementation, including disclosure process and support system, of the National Quality Forum's Safe Practices for Better Healthcare - 2006 Safe Practice no. 4, which provides: “Following serious unanticipated outcomes, including those that are clearly caused by systems failures, the patient and, as appropriate, family should receive timely and transparent clear communication concerning what is known about the event.”); Thomas H. Gallagher & Wendy Levinson, Disclosing Harmful Medical Errors to Patients: A Time for Professional Action, 165 Arch. Intern. Med. 165 (2005) (calling on medical and health care professionals and organizations to take affirmative steps to improve disclosure practices); Thomas H. Gallagher & Mary Hardy Lucas, Should We Disclose Harmful Medical Errors to Patients? If So, How?, 12 J. Clinical Outcomes Mgmt. 253 (2005) (discussing medical error disclosure and providing practical steps); Aaron Lazare, Apology in Medical

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Practice: An Emerging Clinical Skill, 296 JAMA 1401 (2006) (proposing a conceptual framework for analyzing apologies); Lucian Leape, Full Disclosure and Apology - An Idea Whose Time Has Come, Physician Executive 16-18 (Mar./Apr. 2006) (discussing ethical, therapeutic, and practical arguments for, and barriers to, disclosure); Carol B. Liebman & Chris Stern Hyman, A Mediation Skills Model to Manage Disclosure of Errors and Adverse Events to Patients, 23 Health Aff. 22 (2004) [hereinafter Liebman & Hyman] (discussing model of communication skills and processes to be used both during and after the disclosure conversation); Michael S. Woods, Healing Words: The Power of Apology in Medicine 39-48 (2004) (discussing the four "R" s of apology: recognition, regret, responsibility, and remedy); Doug Wojcieszak et al., Sorry Works! Disclosure, Apology, and Relationships Prevent Medical Malpractice Claims 26-65 (2007) [hereinafter Wojcieszak, Sorry Works! Disclosure] (discussing steps to managing an adverse event, implementing an institutional disclosure policy, and apologizing). Numerous Web-based resources are available to provide guidance in developing a disclosure policy. The American Hospital Association keeps an up-dated bibliography on resources on error disclosure at http://www.aha.org/aha/resource-center/bibliography/disclosure.html (last visited Apr. 6, 2008). The American Society for Healthcare Risk Management of the American Hospital Association published in 2003 and 2004 a three-part monograph series on disclosure of unanticipated events, available at http://www.ashrm.org/ashrm/resources/monograph.html (last visited Apr. 6, 2008). The Sorry Works! Coalition is an advocacy organization for appropriate disclosure, apology, and upfront compensation after adverse medical events, and keeps an updated Web resource center at http://www.sorryworks.net/ (last visited Apr. 6, 2008).

[FN76]. Charles Vincent, Understanding and Responding to Adverse Events, 348 New Eng. J. Med. 1051, 1054 (2003) (citation omitted). See also Christine W. Duclos et al., Patient Perspectives of Patient-Provider Communication After Adverse Events, 17 Int'l J. for Quality in Health Care 479 (2005) (concluding that "[c]onfronting an adverse medical event collaboratively helped both patients and providers with patients' emotional, physical, and financial trauma and minimized the anger and frustration commonly experienced").

[FN77]. Several recent studies reveal a lack of disclosure and apology in actual practice after medical error. E.g., Robert J. Blendon et al., Views of Practicing Physicians and the Public on Medical Errors, 347 N. Engl. J. Med. 1933, 1934 (2002) (finding that only about a third of physicians and members of the public responding to survey who had experienced a medical error in their own care or family member's care reported that health professionals involved in the error had discussed it with them or apologized); Thomas H. Gallagher et al., Choosing Your Words Carefully: How Physicians Would Disclose Harmful Medical Errors to Patients, 166 Arch. Intern. Med. 1585, 1589, 1591 (2006) [hereinafter Gallagher, Choosing Your Words Carefully] (discussing "disclosure gap" between patients' desire to be told about errors and actual physician practices, and reporting that in survey of physician responses to hypothetical scenarios of "clear-cut serious errors," only 42% would explicitly state that an "error" had occurred, and while 61% would express regret, only 33% would explicitly apologize); Albert W. Wu et al., Do House Officers Learn from Their Mistakes?, 12 Quality & Safety in Health Care 221, 224 (2003) (in survey of house officers who had made significant mistakes, only 24% had discussed them with the patient and only 21% had apologized; in internal morning report or morbidity and mortality conferences where an error was discussed among professional colleagues, in nearly half (48%) of these cases "the tough issues were not addressed"). See also Lauris C. Kaldjian, Reporting Medical Errors to Improve Patient Safety: A Survey of Physicians in Teaching Hospitals, 168 Arch. Int. Med. 40 (2008) (finding that only a minority of faculty and resident physicians utilize internal or external reporting systems to report errors: 17.8% in study acknowledged reporting minor error resulting in prolonged treatment or discomfort, and 3.8% reported major error resulting in death or disability).

[FN78]. Gallagher et al., Disclosing Unanticipated Outcomes to Patients, supra note 75, at 158-59 (2007)

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(describing various impediments and problems in actual practice of disclosing unanticipated outcomes to patients and recommending ways to improve disclosure performance); Thomas H. Gallagher et al., US and Canadian Physicians' Attitudes and Experiences Regarding Disclosing Errors to Patients, 166 Arch. Int. Med. 1605, 1609 (Aug. 14/28, 2006) (finding through survey that medical malpractice environment was "not the overwhelming determinant of physicians' attitudes about error disclosure"); David A. Hyman & Charles Silver, Believing Six Improbable Things: Medical Malpractice and "Legal Fear", 28 Harv. J.L. & Pub. Pol'y 107, 109-112 (2004) (fear of legal liability does not account for "massive underreporting of errors throughout the health care system"); Lauris C. Kaldjian, An Empirically Derived Taxonomy of Factors Affecting Physicians' Willingness to Disclose Medical Errors, 21 J. Gen. Intern. Med. 942, 946 (2006) (discussing various barriers to physician disclosure, including attitudinal barriers such as perfectionism and competitiveness; uncertainties about how, what, and when to disclose; lack of control after disclosure; and various fears and anxieties, such as over legal liability, loss of reputation, and threat to identity as healer); Lauris C. Kaldjian et al., Facilitating and Impeding Factors for Physicians' Error Disclosure: A Structured Literature Review, 32 Jt. Comm. J. on Quality & Patient Safety, 188 196 (2006) (analyzing impediments to error disclosure and finding, in addition to fear of legal liability, that other factors included fear of professional repercussions, blame, shame, perfectionism, and guilt); Marlynn Wei, Doctors, Apologies, and the Law: An Analysis and Critique of Apology Laws, 40 J. Health L. 107, 146-154 (2007) (discussing non-legal barriers to disclosure that are embedded within long-standing professional norms and traditions in medicine, such as fears about loss of professional control, shattering the image (held by patients and doctors alike) that doctors are infallible healers, potential loss of patient trust, guilt, shame, and loss of reputation). See also John Banja, Medical Errors and Medical Narcissism 47-85 (2005) (describing personality traits related to "medical narcissism," such as emotional disengagement, ideological rigidity and compulsiveness, that may impede physicians' willingness or ability to discuss medical errors with patients).

[FN79]. A few commentators have expressly found these ethical obligations to flow from the fiduciary nature of the doctor-patient relationship. See Berlinger, supra note 73, at 48 ("The physician who is contemplating the disclosure of medical error should perceive that the 'fiduciary character of the doctor-patient relationship' causes and entitles him to speak if he has injured a patient through error"); Wu, supra note 73, at 772-73 (arguing that "a physician's responsibility to disclose a mistake to a patient can be derived from the fiduciary character of the doctor-patient relationship" and concluding that "the fiduciary character of the doctor-patient relationship indicates that a physician has the ethical duty to disclose error to a patient when disclosure furthers the patient's health, respects the patient's autonomy, or enables the patient to be compensated for serious, irreparable harm.").

[FN80]. Burns & Truog, supra note 3, at 1991 (in authors' experience, "ethics consults on 'futility' cases are far more commonly about breakdowns in communication and trust and far less often intractable disputes over the value assigned to medical facts").

[FN81]. Arthur E. Kopelman, Understanding, Avoiding, and Resolving End-of-Life Conflicts in the NICU, 73 Mt. Sinai J. Med. 580 (2006) (identifying five common reasons parents may ask for continued life support for a very seriously ill infant, discussing communication strategies to address them, and addressing time constraints and inadequate training as barriers to optimal communication by physicians).

[FN82]. Louise Andrew & John-Henry Pfifferling, Managing Malpractice Stress, available at http://www.magmutual.com/risk/malpractice-stress1.html (last visited Apr. 6, 2008) (symptoms include feelings of isolation, lowered self-esteem, anger, fatigue, depression, and insomnia); Carl E. Couch & Stan Thiebaud, Who Supports Physicians in Malpractice Cases?, Physician Executive 30, 31 (Mar./Apr. 2002) (identifying stages of emotional response to a medical malpractice suit as shock, denial, isolation, shame, fear, anger, depres-

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sion, and resolution); Edward A. Dauer, A Therapeutic Jurisprudence Perspective on Legal Responses to Medical Error, 24 J. Legal Med. 37, 43-44 (2003) [hereinafter Dauer, Therapeutic Jurisprudence] (discussing anti-therapeutic consequences of malpractice claims for physicians and possibly related adverse impact on patient safety); Maxwell J. Mehlman, The Shame of Medical Malpractice, 27 J. Leg. Med. 17, 24-27 (2006) (discussing feelings of shame felt by physicians defending malpractice lawsuits); Kenneth C. Olson, Recognizing the Symptoms of Malpractice Stress Syndrome, 17 Psychiatric Times (Apr. 2000), available at http://www.psychiatrictimes.com/p000470.html (surveying studies that identify emotional an psychological toll on physicians, including guilt, grief, denial, anger, isolation, negative self-image, and depression). See also David M. Studdert et al., Claims, Errors, and Compensation Payments in Medical Malpractice Litigation, 354 N. Eng. J. Med 2024, 2031 (2006) (discussing exorbitant overhead costs of malpractice system).

[FN83]. Gerald B. Hickson et al., Factors that Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries, 267 JAMA 1359, 1362 (1992) [hereinafter Hickson, Factors that Prompted Families] ("The desire for information, perception of being misled, anger with the medical profession, desire to prevent injuries to others, recognition of long-term sequelae, and advice by knowledgeable acquaintances, as well as need for money, appeared to contribute to families' decisions to file medical malpractice claims."); Gerald B. Hickson et al., Obstetricians' Prior Malpractice Experience and Patients' Satisfaction with Care, 272 JAMA 1583, 1586-87 (1994), finding that:

[T]he frequency with which physicians are sued is related in part to patients' satisfaction with interpersonal aspects of medical care.... [M]any physicians who are sued frequently have problems communicating and establishing rapport with their patients.... Addressing patients' concerns may not only decrease the incidence of malpractice litigation but is also desirable in and of itself.

Charles Vincent & Magi Young, Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action, 343 Lancet 1609, 1611-12 (1994) (finding from study of respondents who sued doctors that "[f]eelings of anger were expressed by 90%, bitterness by 80%, betrayal by 55% and strong feelings of humiliation by 40%," and finding that four primary factors in reasons to sue were desire to hold providers accountable, to get a full explanation, to ensure that a similar event did not happen to others in the future, and to receive compensation and admission of negligence; 37% said receiving an explanation and apology after incident might have prevented litigation).

[FN84]. Daniel W. Shuman, When Time Does Not Heal: Understanding the Importance of Avoiding Unnecessary Delay in the Resolution of Tort Cases, 6 Psychol. Pub. Pol'y & L. 880, 886-91 (2000) (describing stresses of tort litigation on plaintiffs).

[FN85]. See Gerald B. Hickson & A. Dale Jenkins, Identifying and Addressing Communication Failures as a Means of Reducing Unnecessary Malpractice Claims, 68 NC Med. J. 362, 363 (2007) (risk of being sued for medical malpractice "is predicted by the practitioner's inability to communicate effectively and establish and maintain rapport with patients, especially in the face of an adverse event"); Gerald B. Hickson et al., Patient Complaints and Malpractice Risk in a Regional Healthcare Center, 100 South. Med. J. 791 (2007) (finding that patient dissatisfaction was significantly associated with malpractice risk); Gerald B. Hickson et al., Patient Complaints and Malpractice Risk, 287 JAMA 2951, 2951, 2955 (2002) (observing based on previous research that malpractice litigation "risk appears related to patients' dissatisfaction with their physicians' ability to establish rapport, provide access, administer care and treatment consistently with expectations, and communicate effectively" and discussing study finding that unsolicited patient complaints were positively associated with physicians' risk management outcomes (from opening files to multiple lawsuits); Gerald B. Hickson et al., Obstetricians' Prior Malpractice Experience and Patients' Satisfaction with Care, 272 JAMA 1583, 1583 (1994)

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(concluding from study that "[p]hysicians who have been sued frequently are more often the objects of complaints about the interpersonal care they provide even by their patients who do not sue."); LaRae I. Huycke and Mark M. Huycke, Characteristics of Potential Plaintiffs in Malpractice Litigation, 120 Ann. Int. Med. 792, available at http:// www.annals.org/cgi/content/full/120/9/792 (finding that miscommunication between patient and provider clearly contributed to patients' calls to plaintiff's malpractice attorneys and that poor patient-provider relationship preceded injury in over half of cases); Wendy Levinson et al., Physician-Patient Communication: The Relationship with Malpractice Claims among Primary Care Physicians and Surgeons, 277 JAMA 553, 558 (1997) (finding that specific, routine behaviors of primary care physicians were associated with malpractice risk, such as length of visit, use of orienting questions that help patients develop appropriate expectations and ask timely questions; active listening and the use of facilitating questions that allow patients to talk and indicate physicians' interest; and use of humor); H. T. Stelfox et al., The Relation of Patient Satisfaction with Complaints against Physicians and Malpractice Lawsuits, 118 Am. J. Med. 1126, 1131 (2005) (reporting study findings that lower patient satisfaction survey scores were associated with higher physician malpractice lawsuit rates). But see Kathleen M. Mazor et al., Disclosure of Medical Errors: What Factors Influence How Patients Respond?, 21 J. Gen. Intern. Med. 704, 708 (2005) [hereinafter Mazor et al., Disclosure of Medical Errors] (commenting that "empirical evidence on the relationship between disclosure and legal consequences is limited ... [and studies] do not provide evidence that full disclosure can prevent legal action"); Hector P. Rodriguez et al., Relation of Patients' Experiences with Individual Physicians to Malpractice Risk, 20 Int'l J. for Qual. in Health Care 5, 8-10 (2008) (although study found that higher physician-patient interaction quality and better care coordination were associated with a decreased risk of patient complaints, it did not find a significant relationship between malpractice lawsuits and patient satisfaction survey measures or patient complaints). See also infra note 102 relating to debate over impact of disclosure on costs and filing of medical malpractice claims.

[FN86]. Gallagher et al., Disclosing Unanticipated Outcomes to Patients, supra note 75, at 164 (2007).

[FN87]. Hickson et al., Factors that Prompted Families, supra note 83, at 1359 ("Obtaining money may not be the only goal for some families who file suit).

[FN88]. Mazor et al., Disclosure of Medical Errors, supra note 85, at 708 (finding that full disclosure has positive effect in terms of patient/family satisfaction and trust, reduces likelihood of changing physicians, and in some cases may reduce likelihood of seeking legal advice); Kathleen M. Mazor et al., Health Plan Members' Views About Disclosure of Medical Errors, 140 Ann. Intern. Med. 409, 416 (2004) (same); Kathleen M. Mazor et al., Communicating with Patients About Medical Errors: A Review of the Literature, 164 Arch. Intern. Med. 1690, 1692 (2004) (collecting studies that show strong patient and family preferences for disclosure).

[FN89]. Gallagher, Choosing Your Words Carefully, supra note 77, at 1585 (2006). See also Thomas Gallagher et al., Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors, 289 JAMA 1001, 1004 (2003) [hereinafter, Gallagher, Patients' and Physicians' Attitudes] (study finding that "[p]atients wanted to know what happened, the implications of the error for their health, why it happened, how the problem will be corrected, and how future errors will be prevented.").

[FN90]. Tom Delbanco & Sigall K. Bell, Guilty, Afraid, and Alone- Struggling with Medical Error, 357 N. Eng. J. Med. 1682, 1683 (2007) (also observing that '[a]bove all, silence and evasion breed distrust"). See also Duclos et al., supra note 76, at 483:

Though two types of trauma (physical and emotional would be expected and have been addressed in the literature, we uncovered a third type (financial) that proved in some cases to be the salient influence on patient's

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subsequent actions.... This study adds that patients should be asked specific questions about emotional trauma as well as financial trauma. (citation omitted).

Gallagher, Patients' and Physicians' Attitudes, supra note 89, at 1005 (study finding that "[h]earing that an error occurred would make patients feel sad, anxious, depressed, or traumatized. Patients feared additional errors, were angry that their recovery had been prolonged, and were frustrated that the error was preventable.").

[FN91]. William Winslade & E. Bernadette McKinney, To Tell or Not to Tell: Disclosing Medical Error, 34 J.L. Med. & Ethics 813, 814-16 (2006) (discussing how the ethical health lawyer should counsel a physician who committed a medical error that harmed a patient, and recommending full disclosure to hospital and to patient/relatives, an apology, and acceptance of responsibility for ethical and practical reasons; and providing a sample dialogue between attorney and client regarding disclosure). See also supra notes 50-51 and accompanying text (discussing how lawyers may refer to moral and ethical considerations in advising clients) and supra note 73 and accompanying text (discussing the ethics of disclosure).

[FN92]. See Gallagher, Patients' and Physicians' Attitudes, supra note 89, at 1005-06 (study finding that:

Physicians felt upset and guilty about harming the patient, disappointed about failing to practice medicine to their own high standards, fearful about a possible lawsuit, and anxious about the error's repercussion regarding their reputation.... Health care workers' emotional needs following medical errors may also be going unmet.... Better institutional support for caregivers involved in errors would help them focus their attention on the affected patient.);

Antonella Surbone et al., Confronting Medical Errors in Oncology and Disclosing Them to Cancer Patients, 25 J. Clin. Oncology 1463, 1465-66 (2007) (discussing emotional distress experienced by physicians after medical error and observing that "[a]ny medical error, by increasing patients' suffering, has negative repercussions on the inner and professional lives of oncologists. Working through error involves the spiritual work of restitution and forgiveness, and empathetic communication with patients is an essential step."); Amy D. Waterman et al., The Emotional Impact of Medical Errors on Practicing Physicians in the United States and Canada, 33 Jt. Comm. J. Quality & Patient Safety 467, 474 (2007), concluding that:

After a medical error, it is appropriate that most attention is directed at meeting the physical and emotional needs of the affected patient. Yet this study suggests that physicians also may experience significant emotional distress and job-related stress following errors that, at present, go largely unaddressed. Only when health care institutions commit resources to patients, physicians, and other involved hospital staff can all those negatively affected by medical errors receive the support they need.

[FN93]. Edward A. Dauer & Leonard J. Marcus, Adapting Mediation to Link Resolution of Medical Malpractice Disputes with Health Care Quality Improvement, 60 Law & Contemp. Probs. 185 (1997) [hereinafter Dauer & Marcus] (observing that "'[s]tonewalling,' which is what many defense attorneys instinctively and routinely advise, nearly guarantees a suit that might otherwise be avoided."). See supra notes 83 and 85 relating to patients' reasons to file lawsuit.

[FN94]. Dauer & Marcus, supra note 93, at 198-212 (discussing how voluntary mediation can achieve patient safety and quality of care objectives); Edward A. Dauer, Postscript on Health Care Dispute Resolution: Conflict Management and the Role of Culture, 21 Ga. St. U. L. Rev. 1029, 1050-51 (2005) [hereinafter Dauer, Postscript] (discussing link between patient safety and potential conflict and observing that "[c]ollaboration is essential. Whatever inhibits collaboration inhibits the quality of care.").

[FN95]. Dale C. Hetzler, Superordinate Claims Management: Resolution Focus From Day One, 21 Ga. St. U. L.

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Rev. 891, 897-98 (2005) (arguing that "[i]t would be inconsistent for Children's to embrace these corporate positions [of being a model for treating children and espousing values of integrity, respect, and nurturing] and not embrace interest-based approaches for dealing with unanswered questions about care and treatment outcomes.").

[FN96]. Id. at 898 (observing that patients who become plaintiffs "will tell [their] friends, neighbors, and others not only about their perception of the occurrence but also how Children's treated them when they voiced their questions and concerns.").

[FN97]. See generally Berlinger, supra note 73, at 69-78 (discussing a few of these programs: Veterans Affairs Medical Center, Catholic Healthcare West, and COPIC 3R's program); Thomas H. Gallagher, David Studdert, & Wendy Levinson, Disclosing Harmful Medical Errors to Patients, 356 N. Eng. J. Med. 2713 (2007) (surveying a number of prominent disclosure programs and discussing the National Quality Forum's 2006 safe-practice guideline on disclosure of serious unanticipated outcomes). See also infra notes 98-100 and accompanying text.

[FN98]. Steven S. Kraman & Ginny Hamm, Risk Management: Extreme Honesty May Be the Best Policy, 131 Ann. Intern. Med. 963, 965-66 (1999), discussing disclosure policy and observing that:

Despite following a policy that seems to be designed to maximize malpractice claims, the Lexington facility's liability payments have been moderate and are comparable to those of similar facilities. We believe this is due in part to the fact that the facility honestly notifies patients of substandard care and offers timely, comprehensive help in filing claims; this diminishes the anger and desire for revenge that often motivate patients' litigation. (citation omitted).

[FN99]. Hetzler, supra note 95, at 896-902.

[FN100]. E.g., Virginia L. Morrison, Heyoka: The Shifting Shape of Dispute Resolution in Health Care, 21 Ga. St. U. L. Rev. 931, 951-54 (2005) (identifying claims reductions and cost savings at various health care organizations after adopting disclosure programs); COPIC, "Recognize, Respond, Resolve": A Successful Approach to Disclosure, Physician Insurer 16-19 (4th Quarter 2007), available at http://www.callcopic.com/physician-insurer-article (discussing 3Rs program initiated in 1999 by COPIC, a Colorado medical professional liability insurance company); Will Shanley, Insurer's Plan: Cut Malpractice Suits, The Denver Post, July. 2, 2007, at C01, available at http:// www.denverpost.com/ci_6277831 (discussing COPIC's 3R policy); Saying "I'm Sorry" Is Starting to Pay Off with Reduced Lawsuits and Legal Costs, Healthcare Risk Management (Oct. 2005), available at http://www.ahcpub.com/hot_topics/? htid=1&httid=1646 (discussing University of Michigan Health System's full-disclosure policy which resulted in a 50% drop in claims over three years and a drop is cost per claim from $70,000 to $30,000 per claim); Karl A. Slaikeu & Diane W. Slaikeu, Confidential from General Counsel to CEO: "I'm Fed Up, and We're Not Going to Take This Anymore!", 5 J. Health Care L. & Pol'y 335, 340-43 (2002) (discussing legal defense savings of 50-80% by organizations who shifted away from litigation-oriented dispute resolution approach to more collaborative methods for resolving conflicts). See generally Sorry Works! Coalition, Disclosure Policies and Programs, http:// www.sorryworks.net/disclosepolicy.phtml (discussing nine hospital full-disclosure programs, their characteristics, and associated cost savings).

[FN101]. See supra notes 74-75 and 97-100. There is also a growing literature on forgiveness in the context of disclosing and apologizing for medical errors. See, e.g., Berlinger, supra note 73, at 81-91 (discussing forgiveness in the context of Western religious traditions and medical culture); Kathleen M. Mazor, Health Plan Members' Views on Forgiving Medical Errors, 11 Am. J. of Manag. Care 49, 51-52 (2005) (discussing study's finding

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that "patients consider some circumstances more forgivable than others" and commenting that "[f]orgiveness is seen as an important step for physicians, patients, and families in the emotional healing that follows error and injury. It has been argued that physicians must apologize and be forgiven, after an error has occurred, before trust can be reestablished and the patient and physician can move forward.") (citation omitted); Richard G. Roberts, The Art of Apology: When and How to Seek Forgiveness, 14 Fam. Pract. Manag. 44-49 (2007), available at http://www.aafp.org/fpm/20070700/44thea.pdf (discussing when and how to apologize and observing that "[f]or the patient, it begins the healing. For the professional, it allows forgiveness.").

[FN102]. See David M. Studdert et al., Disclosure Of Medical Injury To Patients: An Improbable Risk Management Strategy, 26 Health Aff. 215, 219-20 (2007) (modeling litigation consequences of disclosure and finding ninety-five percent chance that total malpractice claim volume would increase and ninety-four percent chance that total direct compensation costs would increase). But see The Talking Cure, Harvard Magazine, 60, 63 (Mar./Apr. 2008), available at http://harvardmagazine.com/2008/03/the-talking-cure.html (noting the controversy that this 2007 article by Studdert and others ignited, and providing commentary of a senior insurance administrator for the Harvard teaching hospitals which have adopted a full-disclosure policy: "This may save us money - I don't know... We did it because we recognized that we really had to support the physicians in their ability to do the right thing in their care of the patients. We'll see how the money plays out."); Cherri Hobgood et al., Parental Preferences for Error Disclosure, Reporting, and Legal Action After Medical Error in the Care of Their Children, 116 Pediatrics 1276, 1285 (2005) ("Physicians' fear that disclosure will result in legal action should be tempered by the strong and consistent findings that disclosure decreases the likelihood of legal action compared with when patients learn of the error through other means in all but severe errors."); Morrison, supra note 100, at 951-54 (identifying claims reductions and cost savings at various health care organizations after adopting disclosure programs); Wojcieszak, Sorry Works! Disclosure, supra note 75, at 17-25 (discussing how mitigating patients' anger is key to reducing malpractice claims and costs). See also David M. Studdert et al., The Authors Respond, 26 Health Aff. 904, 904-05 (2007), defending their 2007 study above:

[N]o published research has formally evaluated the effect of disclosure on litigation.... Among its many virtues, disclosure represents a valuable opportunity to correct a well-documented shortcoming of the medical malpractice system: Most patients who sustain debilitating injury from negligent care obtain no compensation. To ignore this phenomenon and how it intersects with the disclosure movement is misguided.

Proposed federal legislation presupposes that cost savings will result from programs of disclosure, apology, and compensation where appropriate. See Hillary R. Clinton & Barak Obama, Making Patient Safety the Centerpiece of Medical Liability Reform, 354 N. Eng. J. Med. 2205 (2006) (discussing proposed National Medical Error Disclosure and Compensation (MEDiC) Bill (S. 1784) which would require program participants to apply a percentage of legal defense cost savings to lowering liability insurance premiums and fostering patient-safety initiatives). See also supra notes 83 and 85 relating to patients' reasons for filing lawsuits.

[FN103]. Standard LD.2.40 provides: "The organization manages conflict between leadership groups to protect the quality and safety of care." In Joint Commission on Accreditation of Healthcare Organizations, 2009 Leadership Chapter, Hospital Program, at 6, available at http:// www.jointcommission.org/NR/rdonlyres/0376B4EC-0F1A-42E0AD237D7D1680E3C3/0/09_ ld_hap_prepubstds.pdf (last visited Apr. 6, 2008). The revised leadership chapter will become effective January 1, 2009. See http:// www.jointcommission.org/AccreditationPrograms/Hospitals/Standards/hap_prepub_ stds.htm (last visited Apr. 6, 2008).

[FN104]. Id. at 7.

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[FN105]. Id. at 6:

[I]t is important that organizations identify an individual skilled in managing conflict who can help the organization implement its conflict management process; this allows organizations to manage conflict quickly, and many times without seeking assistance from outside the organization. These skilled individuals can also help their organizations to more easily manage, or even avoid, future conflicts.

[FN106]. Coby J. Anderson & Linda L. D'Antonio, A Participatory Approach to Understanding Conflict in Health Care, 21 Ga. St. U. L. Rev. 817 (2005) (discussing frustration within the ADR community over the health care community's lack of acceptance of conflict resolution principles; differences in perceptions between health care professionals and ADR professionals on the nature and scope of conflicts in health care; and the need to understand the culture of health care in order to successfully promote conflict resolution processes within health care institutions); Dauer, Postscript, supra note 94, at 1035-42 (discussing resistance of the health care industry to ADR and possible explanations for it); Debra Gerardi, The Culture of Health Care: How Professional and Organizational Cultures Impact Conflict Management, 21 Ga. St. U. L. Rev. 857, 861 (2005) (noting that "[m]any ADR practitioners express frustration at the obvious disconnect between the great need for better conflict management within health care organizations and the lack of responsiveness by the industry" and generally discussing the culture of health care, professional subcultures, and factors to consider in redesigning conflict management services for health care organizations); Marc R. Lebed & John J. McCauley, Mediation Within the Health Care Industry: Hurdles and Opportunities, 21 Ga. St. U. L. Rev. 911 (2005) (discussing historical resistance to using mediation in health care and identifying various barriers to and opportunities for greater utilization in the future).

[FN107]. Ellwood F. Oakley, III, The Next Generation of Medical Malpractice Dispute Resolution: Alternatives to Litigation, 21 Ga. St. U. L. Rev. 993 (2005) (discussing arbitration and screening panels); Thomas B. Metzloff, The Unrealized Potential of Malpractice Arbitration, 31 Wake Forest L. Rev. 203 (1996) (discussing potential benefits of arbitration of medical malpractice cases and possible reasons it has not been widely utilized). But see Kenneth A. DeVille, The Jury Is Out: Pre-Dispute Binding Arbitration Agreements for Medical Malpractice Claims, 28 J. Leg. Med. 333, 388 (2007) (generally discussing and critiquing the use of pre-dispute binding arbitration agreements, and observing that, "arbitration agreements in patient contracts are neither voluntary nor knowing. In addition, the process of arbitration as it is currently practiced is controlled and designed to benefit the insurer and/or physician."); Nicole L. Kaufman, The Demise of Medical Malpractice Screening Panels and Alternative Solutions Based on Trust and Honesty, 28 J. Leg. Med. 247, 249 (2007) (concluding that "screening panels are not serving the public interest as a form of non-litigation resolution").

[FN108]. Dauer & Marcus, supra note 93, at 198-215 (discussing potential of mediation to improve quality of patient care); Dauer, Thereapeutic Jurisprudence, supra note 82, at 47-50 (2003) (proposing a model of early-intervention mediation); Rita Lowery Gitchell & Andrew Plattner, Mediation: A Viable Alternative to Litigation for Medical Malpractice Cases, 2 DePaul J. Health Care L. 421 (1999) (discussing formal mediation process); Sheea Sybblis, Mediation in the Health Care System: Creative Problem Solving, 6 Pepp. Disp. Resol. L.J. 493 (2006) (discussing formal mediation process); Douglas W. Taylor, Assessment and Plan for Medical Malpractice: Quality Improvement Through Mediation, 6 DePaul J. Health Care L. 343 (2003) (discussing formal mediation process); Florence Yee, Mandatory Mediation: The Extra Dose Needed to Cure the Medical Malpractice Crisis, 7 Cardozo J. Conflict Resol. 393 (2006) (discussing benefits of malpractice mediation and proposing that states make it mandatory before a lawsuit could be filed). But see Thomas B. Metzloff et al., Empirical Perspectives on Mediation and Malpractice, 60 Law & Contemp. Probs. 107, 151 (1997) (expressing concern that one court-ordered mediation program had evolved simply into "a structured, traditional settlement conference con-

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ducted by a neutral third party. The parties themselves participate only infrequently and creative solutions are rarely considered. Lawyers talking about money is the norm. There remains much opportunity to consider how more creative forms of mediation could be employed in the malpractice context."); Ralph Peeples et al., Following the Script: An Empirical Analysis of Court-Ordered Mediation of Medical Malpractice Cases, 2007 J. Disp. Resol. 101, 117-18 (noting that court-ordered mediation differs from mediation outside the courts, and suggesting that "a sort of predestination was at work in these sessions" and that "the presence of attorneys, pursuant to a court order, makes the process more like settlement and less like mediation"). See also infra notes 114 and 116 and accompanying text (discussing mediation in patient care disputes over end-of-life care).

[FN109]. Dauer, Postscript, supra note 94, at 1034-35 (2005):

Living alongside ADR, in its shadow though antedating it, is a field of practice [preventive law] that attends to the kinds of not-yet-dispute conflicts which ADR fails to address.... The combination of these two fields - preventive law and ADR--is the core characteristic of conflict management.... The emergence of the new understanding of dispute resolution in health care, while not yet traveling under that name, portends exactly that combination.;

Slaikeu & Slaikeu, supra note 100, at 340-46, 350-51(2002) (discussing collaborative methods for channeling conflicts prior to formal ADR and litigation forums, such as fostering individual initiative, negotiation, and mediation with a neutral; and suggesting a two-track model for attorney representation in dispute resolution: one to represent hospital in mediation ("the last nice person you will talk to on this matter"), and another to litigate thereafter if necessary ("a 'take no prisoners' litigator type")).

[FN110]. Supra notes 74-76 and accompanying text (reform proposals) and notes 95-100 (recent disclosure programs).

[FN111]. See Liebman & Hyman, supra note 75 (providing an excellent model of communication skills and processes to be used both during and after the disclosure conversation, and recommending early, informal, interest-based mediation process after a claim is filed to resolve it before costly and extensive litigation processes are undertaken).

[FN112]. Kathleen Clark, The Use of Collaborative Law in Medical Error Situations, 19 No. 6 Health Law. 19 (2007); Karen Fasler, Show Me the Money!! The Potential for Cost Savings Associated with a Parallel Program and Collaborative Law, 20 No. 2 Health Law. 15 (2007).

[FN113]. Roger Fisher & William Ury, Getting to Yes: Negotiating Agreement Without Giving In, 17-94 (2d ed. 1991).

[FN114]. Hetzler, supra note 95. See also Morrison, supra note 100, at 936-38 (discussing other health care organizations' training programs to promote interest-based conflict resolution skills among health care professionals).

[FN115]. Burns & Truog, supra note 3, at 1993 (concluding that providers should work at "finding better ways to support the patient's family and each other in providing that care than in seeking to overrule the requests for care that we regard as unreasonable").

[FN116]. See generally Nancy N. Dubler & Carol B. Liebman, Bioethics Mediation: A Guide to Shaping Shared Solutions (2004). See also M. Gregg Bloche, Managing Conflict at the End of Life, 352 New Eng. J. Med. 2371, 2372-73 (2005), recommending that:

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At the first sign of tension, physicians, nurses, and social workers should become active listeners in search of smoldering feelings that might give rise to conflict. If and when conflict erupts, end-of-life choices shouldn't be treated as purely ethical questions, divorced from the regrets and resentments involved. Psychiatric and social-work consultation should be part of the management plan, and mediation merits study as an approach.;

Robert Gatter, Unnecessary Adversaries at the End of Life: Mediating End-of-Life Treatment Disputes to Prevent Erosion of Physician-Patient Relationships, 79 B.U. L. Rev. 1091 (1999) (recommending mediation to foster communication and promote trust in patient-physician relationship); Thomas L. Hafemeister, End-of-Life Decision Making, Therapeutic Jurisprudence, and Preventive Law: Hierarchical v. Consensus-Based Decision-Making Model, 41 Ariz. L. Rev. 329 (1999) (proposing that therapeutic jurisprudence and preventive law principles be integrated and applied to end-of-life decision-making); Kimberlee K. Kovach, Neonatology Life and Death Decisions: Can Mediation Help? 28 Cap. U.L. Rev. 251, 253 (2000) (proposing that “the NICU situation is one for which mediation holds promise, particularly as it has been found that many life and death decisions arise from negotiations between the decision-makers, and mediation is, in essence, facilitated negotiation”). But see Robert Gatter, Institutionally Sponsored Mediation and the Emerging Medical Trust Movement in the U.S., 23 Med. & L. 201 (2004) (cautioning that bias in institution-sponsored medical mediation programs may undermine patient trust); Thaddeus M. Pope & Ellen A. Waldman, Mediation at the End of Life: Getting Beyond the Limits of the Talking Cure, 22 Ohio St. J. Disp. Resol. 1 (2007) (discussing failure of mediation to resolve intractable futility disputes for variety of reasons, including surrogate intransigence and legal uncertainty, which cause providers simply to back down from conflict and provide treatment); Liza T. Watkins et al., The Role of the Bioethicist in Family Meetings about End of Life Care, 65 Soc. Sci. & Med. 2328, 2340 (2007), commenting that:

In order to negotiate the difficult terrain of end of life decision making, our data show that bioethicists often add persuasion to the official goals of mediation and consultation.. .. The “mediation” model is limited by the bioethicists' obligation to ... ensure that decisions reflect the basic ethical principles of medicine that require practitioners to “do no harm” .

[FN117]. Dauer, Postscript, supra note 94, at 1045, 1049-54 (discussing the transformative potential for ADR to help change the culture of health care); Morrison, supra note 100, at 951-56 (discussing a variety of recent initiatives and programs to foster collaboration and conflict resolution in health care).

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