

12. ADR AS AN ALTERNATIVE TO MEDICAL MALPRACTICE LITIGATION

Alternate Dispute Resolution (ADR), Mediation, and Other Options for the Defendant Physician.

“A clever counsel would tear it all to rags”. Sherlock Holmes-Silver Blaze



LITIGATION

[ADR] MEDIATION



YOUR OPTIONS AS A PHYSICIAN DEFENDANT

You should know at least something about alternate dispute resolution rather than go the full length of medical malpractice litigation without knowing of this possible option.

If you feel not up to the rigors, stress and strain of litigation you might suggest, another option to your attorney -whether he can look into ADR and mediation- and whether it is feasible in your state or locality. Sometimes when the patient really wants an apology and/or to find out what really happened to him or his relative, this may work.

There are states which run a very successful program with ADR as an alternative to medical malpractice litigation.

One such state is Wisconsin. Also Colorado and other states are trying to get into this position to decrease the load on the courts.

In this chapter, we will discuss various options and substitutes for medical malpractice litigation as well as ADR terms and definitions you need to know. You should not be unaware of this process- especially the Two Track system in which 2 tracks mediation and litigation i.e. start off at the same time with one ultimately taking preference over the other. It's not as difficult or expensive as it sounds; in fact costs are lower when you take into consideration that 50% of the money paid on a liability claims goes to attorney fees alone.[K.A.Slaikeu "ADR in Health Care" Austin: Chorda Conflict Mgmt.1988]

Prior to making any decision as to whether you should opt for ADR you must know thyself first. Are you selecting ADR out of your anxiety and fear of the stress of litigation. If that's so you don't need another reason. Your peace of mind is worth a lot. However, this is not a decision to be made unilaterally. It may be preferable to review with your private attorney-not the insurance attorney- the pros and cons. Perhaps to calm your anxiety, you might ask for further study of your case with a focus group and check out other options you many not know about till now.

LITIGATION FOCUS GROUPS

Litigation focus groups use -paid "jurors" to sit in for the real ones in a "mock" rehearsal of the medical malpractice trial. This method may allow a testing of your attorney's potential theory and themes of your defense and how it would go over with the jury.



MOCK TRIALS

Mock trials-both adversarial, in which "opposing" lawyers are present. and non adversarial without opposing attorneys. In the former, lawyers for both sides of the issues render only their concise summaries of their positions; sometimes with additional real witnesses to rehearse their testimony. An advantage of Mock trials is it prepares you and your witnesses to testify in court along the basic theme of your trial strategy with a reduction of anxiety. The "focus group-jury" can give some information as to the effectiveness of you and your expert's exhibits and perhaps ideas on how to modify them

THE MOCK JURY: The Mock Jury Graduates From Law School

Mock trials are no longer classroom-only exercises. They are increasingly being used, sometimes well in advance of an actual trial, to help parties assess strategy, determine the manner of presentation of the cases, and evaluate settlement as an alternative to litigation. Real attorneys watch the mock jury deliberations through one-way mirrors or on live-feed monitors or videotape. The mock jury's members often are asked to complete questionnaires about each witness so that the lawyers can gain insight as to how real jurors at an actual trial may react.

How can a mock jury help lawyers and experts? By answering questions such as:

- Does the jury comprehend what the expert witness is saying?
- How does the jury perceive the expert witness – knowledgeable? believable? fair? pompous? candid? nice? biased? defensive?
- Does the expert's testimony help the jury come to the right conclusion?

- Should the expert also use some demonstrative evidence? Or would it distract from the expert's explanation?
- What else would be helpful to better convey an understanding of the case to the jury?

A Mock jury carries more weight with you –the medical expert witness than all the words and warnings that the attorney can give. For example, if the jurors don't understand the "big words" the expert is using, the expert can try to "dumb it down" at trial. If the mock jury reads the expert's ongoing referring to her notes as "reading from a script", the lawyer sometimes can blow the notes up as an exhibit, so the jury sees there is nothing to hide. If the expert takes undue pains to carefully qualify his answers, yet the jurors see that as "evasive", the expert can adjust his trial presentation.

If you are to be an expert, you should welcome the opportunity to participate in a mock trial. The experience provides guidance and suggestions for improving and clarifying your testimony and delivery in order to become a more effective expert witness. Watching your own testimony on videotape, and hearing and seeing how jurors react to your testimony, and how they reach their decisions, can be invaluable to you as a witness. It often helps you to present a clearer, more focused picture during the actual trial, and in the future.



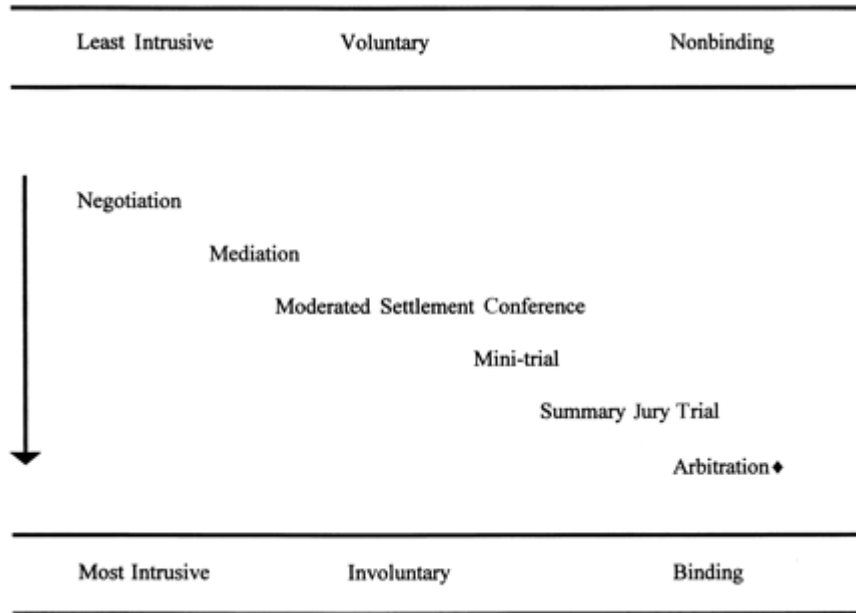
TORT REFORMS

Various solutions have been proposed to reform the tort system and thereby reduce the rippling effects of the malpractice crises on the cost and delivery of health care. The impetus for tort reforms come from the heavy costs of litigation to the U.S. health care system. According to *2006 AHA Hospital Statistics, 2004 Aon Hospital Professional Liability and Physician Benchmark analysis, 2004 Best's Aggregates & Averages, & Price WaterhouseCoopers 2006*] the numbers are staggering.

- 10% of all US annual expenditures for health care goes to medical liability and defensive medicine
- \$32.6 Billion is spent annually for professional liability claims and expenses for hospitals, long term care facilities[LTCF] and physicians' malpractice awards.
- Total annual allocation to the Legal Industry is \$246 Billion per year.
- Medical Malpractice litigation costs are growing 7.5% annually.
- 50% to 80% of payouts by self insured hospitals, LTCFs, and medical malpractice insurance companies go directly to attorney' fees both defense and plaintiff and their "administrative costs".

- 25% goes to Adjusted Loss Allocation expenses [ALAE PAID]
- Of the amount awarded to the injured patient [the plaintiff] 35-50% goes to the plaintiff's attorney as a contingency fee award.
- While tort reform in several states may keep some cases from entering the pipeline, for any case that does enter the pipeline more than 50% goes to the plaintiff's and defendants' attorney fees.

These tort reform strategies are best understood when these reforms are considered as first-generation and second-generation .



Early interventions, first-generation tort reforms, attempted to reduce the frequency and severity of malpractice claims. Later efforts, second-generation tort reforms, were aimed at streamlining adjudication and compensation systems.

It is important to note that the 50% of the award payout still goes to attorney fees even if mediation/arbitration is chosen. That's because plaintiffs and defendants are still represented by trial attorneys whose revenues go up with either the contingency fee in the former and billable hours of preparation by the latter- especially if ADR occurs downstream i.e.late in the process, after the lions' share of the money has already been spent on adversarial discovery, depositions, medical experts and other trial preparation.

ALTERNATIVE DISPUTE RESOLUTION (ADR)

ADR refers to a group of processes through which a dispute can be resolved short of litigation and to procedures for settling disputes by means other than litigation. ADR is increasingly being used in commercial and labor disputes, divorce actions, motor vehicle claims, and more recently, medical malpractice tort claims.

Various ADR methods are available to resolve medical malpractice claims.

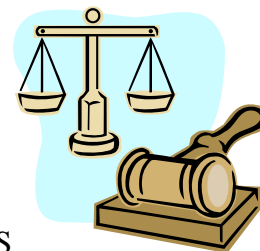
Terms in use in ADR

Arbitration: A form of ADR in which the parties agree to have one or more trained arbitrators hear the evidence of the case and make a determination on liability or damages. The disputing parties may specify the rules of evidence and other procedural matters. Arbitration can be binding (ie, subject to limited judicial review) or nonbinding (ie, the parties may proceed to trials if not satisfied with the outcome of the arbitration).

In arbitration the parties agree to submit their dispute to a neutral third party, usually an arbitrator or an arbitration panel. The arbitrator conducts a hearing in which each side presents evidence. The arbitrator then makes a determination on liability and/or renders a decision of award. Often the parties agree in advance whether the arbitrator's decision will be binding. However, the decision of the arbitrator is subject to limited appellate review for procedural error, arbitrator bias, or fraud. Arbitration can be private, arising from the terms of a contract between the parties, or judicially mandated (court-annexed) by statute or rule.

Potential advantages of arbitration over judicial trials for resolving malpractice claims are: speed (arbitration can be initiated as soon as the dispute arises), simpler and less expensive proceedings (in arbitration the rules of evidence are less stringent and the processes are often more streamlined than court proceedings), and privacy (arbitration hearings are more private than judicial trials, which can become media events).

An advantage not to be overlooked is the opportunity to use a uniquely skilled arbitrator. Unlike a judge, the arbitrator may possess technical skills or scientific knowledge directly related to the subject of the dispute; this could be a distinct advantage when the dispute is enmeshed in an extremely complex or esoteric content area such as medicine. However, by choosing an arbitration panel over a court trial, the defendant physician sets aside certain rights. For example, in arbitration there is no right to a trial by jury and no judicial instruction on the law. Similarly, documents from arbitration proceedings are not as complete as court proceedings. This can become problematic, as arbitration panels need not explain the basis of their decisions.



ALTERNATE DISPUTE RESOLUTION [ADR] DEFINITIONS

Arbitration has been applied in medical malpractice for more than 20 years. In the state of Michigan it is required by statute and in California by contract between managed care organizations and enrollees. Challenges to medical malpractice arbitration awards in both states have been upheld by their highest courts. Despite this, arbitration remains an underutilized ADR method in medical malpractice cases across the country.

Caps on damages: Legislative limitations on the amount of money that can be awarded to the plaintiff for economic or noneconomic damages in a personal injury claims, such as medical malpractice. The limit is imposed regardless of the actual amount of economic and noneconomic damages.

Damages: The sum of money a court or jury awards as compensation for a tort or breach of contract. The law recognizes several categories of damages. General damages: typically intangible damages, such as pain and suffering, disfigurement, interference with ordinary enjoyment of life, or loss of consortium. Special damages: out-of-pocket damages that can be quantified, such as medical expenses, lost wages, or rehabilitation costs.

Punitive/exemplary damages: damages awarded to the plaintiff in cases of intentional tort or gross negligence to punish the defendant or act as a deterrent to others.

Defensive medicine: Physician behavior intended to prevent patients from filing medical malpractice claims. Attempts to make more accurate diagnosis by ordering extra laboratory tests, medical procedures, and visits. The term can also be used to describe physician avoidance of high-risk patients or procedures primarily to reduce the risk of malpractice claims being filed against the physician. The performance of extra procedures for defensive purposes is sometimes called positive defensive medicine. The avoidance of high-risk patients or procedures can be referred to as negative defensive medicine.

Early neutral evaluation: A panel of 1 to 3 neutral advisors hears a presentation of the disputants' positions. The panel reports its evaluation of the merits of each side's case, then facilitates further settlement discussions. This term is synonymous with the term moderated settlement conference when lawyers are the neutrals.

Early neutral evaluation. Example of how it works in 1 state [Wisconsin] Medical Mediation Panels in Wisconsin provide an objective assessment of the strengths and weaknesses of a medical malpractice claim. By law, all medical malpractice claims must go through this process before they can proceed to court. Each panel consists of a lawyer, a health care provider, and a layperson. The early neutral evaluation they provide can reduce litigation costs by identifying claims without merit as early as possible and by expediting the resolution of those claims that do have merit. The Medical Mediation Panels were created by the Legislature in 1986 in an effort to provide "an informal, inexpensive and expedient means for resolving medical malpractice disputes without litigation," Wis. Stat. § 655.42(1). Although referred to in the legislation as "mediation," the work of the panels is more accurately described as "early neutral evaluation."

Enterprise liability: A system under which a health care institution or health insurance plan assumes full legal liability for the actions of physicians acting as their agents, and individual physicians cannot be named as defendants.

Malpractice: Professional negligence resulting from improper discharge of professional duties or failure to meet the standard of care of a professional, resulting in harm to another. The legal standard for malpractice requires (a) a physician/patient relationship that establishes the duty of care, (b) an adverse outcome with actual injury or harm, (c) negligence by the provider (often interpreted as failure to provide the standard of care), and (d) direct causality between negligence and outcome.

Mediation: is really an extension of direct negotiation between the parties, using a neutral third party to facilitate the negotiation process. As a facilitator, the mediator has no authority to impose a solution on the parties nor are the results of the process binding on the disputing parties. The mediator acts by identifying issues, proposing solutions, and encouraging accommodation on both sides. Mediation can be effective in medical malpractice cases in which the patient and physician want to preserve their relationship or in which poor communications has led to the dispute.



The advantages of mediation over litigation are its decreased costs, more confidential proceedings, and the degree of control enjoyed by the disputing parties over the process and outcome. In resolving allegations of medical negligence, patients tend to favor mediation because it provides a forum in which they can express their concerns and may lead to an acknowledgment of the problem sometimes in the form of an apology

Mediation, however, has its limitations. In many jurisdictions mediation is voluntary and can only be pursued if both parties agree to it. Mediators do not have the same authority as judges and therefore cannot compel the release of information nor can their decisions be imposed. The mediator has only as much power as the disputing parties permit and as such can go no further than the disputants themselves are willing to go.



***The Two Track System-upstream i.e. in the early phases of the impending malpractice suit may save you a lot of time and stress and is not as expensive if done early.**

Track 1 = Negotiation or Mediation by separate attorneys paid on an hourly basis.

Track 2 = The traditional method of litigation with contingency fees for the plaintiff's attorney and the same hourly reimbursement for the defendant's attorney only if Track 1 fails.

How Mediation/ADR Works & Saves Time and Money:

** Discussion below from Slaikeu K.A. "When Push comes to Shove" San Francisco: Jossey-Bass Pub.1996; Controlling the costs of Conflict" San Francisco: Jossey-Bass Pub.1998; Two Track Model for Attorney Representation in Dispute Resolution" Austin Tx: CHORDA Conflict Management, 2004.*

Of the many models of mediation, some emphasize shuttle diplomacy, others joint talk, and yet others an integration of the two. Any mediation, however, stands to save money by helping in the following ways:

1. Overall, the mediator serves as a buffer and helps control adversarial posturing. In litigation, mediation can control discovery costs (depositions of key witnesses, exchange of records, assessments of damages etc.) by providing a forum for collaborative resolution of issues along the way to court.
2. After an opening meeting, the mediator might meet with the parties privately to hear interests and "matters of the heart" that they and their attorneys may be unwilling to disclose to the other side. To the extent that the mediator uses private caucuses, the mediator will have a greater data set (private in-formation from each party) than the parties themselves had when the mediation began. The mediator uses this information very carefully and does not disclose what the parties do not want disclosed to the other side.
3. In joint meetings, the mediator can assist the parties as they discuss problems and underlying interests, and as they create solutions. Both parties are assisted by having a monitoring process that allows them to get back to the table should there be any difficulties in implementing the agreement.
4. The mediator can float options for resolution that the parties are unwilling to declare or even discuss with the other side for fear of sending the wrong signal. The private caucus gives both the mediator and the party more freedom to explore options than arbitration or litigation ever does.
5. Mediation takes fewer person hours than a hearing, as the primary players are the conflicting parties.
6. They might consult with attorneys in the early stages; attorneys might even be present in mediation in certain cases. Still, two parties, two attorneys, and one mediator are considerably fewer people than a full-scale hearing. The savings in attorney time (a key

indication of expense) using this approach are significant. The reduction in legal expenses usually falls in the range of 50-80%.

***Who decides on ADR?**

Attorneys on both sides can argue forever with one another –“a game without end” as someone once put it – about whether a case is “right for ADR.” Can you imagine that attorneys who do not agree over the facts of the case, liability, and damages will somehow reach agreement on whether or not to take a case to mediation or ADR? Especially when, by going to mediation or arbitration, they fear showing “weakness,” and their fees as litigation counsel may be 1/5 or less of what they would be if the case went to trial or settled on the courthouse steps? The decision should be up to you the physician defendant who must make the decision to undergo a very rigorous court room litigation battle vs. a quieter medication session with the patient along with the medication attorneys.

In **litigation**, the idea is to convince a judge or jury of the rightness of one’s argument according to a point of law. There is no interest in getting cooperation from the other side. Litigation is a battle. Litigation takes more money.

Mediation, on the other hand, is just the opposite. Instead of using the adversary model to try to convince somebody else that one is right or wrong, the mediation model helps the parties and their advocates to understand and appreciate one another’s points of view and key interests, acknowledge any mistakes or wrongdoing, and then fashion solutions that can be accepted by both sides. How the parties will relate (or not) to each other at the end is very important.

When **mediation** is done well, the parties may settle their dispute with appropriate restitution, and, in some cases, even reconcile with one another through acknowledgements, apologies, and by making mutually agreeable changes in a possible doctor patient working relationship in the future.

***Why litigate the case in Court?**

There are really only two reasons to be in court these days:

- (1) to establish a legal precedent (case law), and
- (2) to send a message to the world (very public dispute resolution).
- (3) and also a very important one for the physician defendant. **If you win the case there is no settlement or transfer of money to the plaintiff. This saves your insurance carrier the award to the plaintiff [minus of course the legal fees of discovery, expert witnesses, attorney billable hours, legal research etc], but more important to you it saves you from being reported to the National Practitioner Data Bank which will be kept in your record during your entire professional life. This has to be weighed very carefully by you in this decision.** But remember this-
- (4) over 90% of malpractice cases get settled before trial and literally on the courthouse steps. Even that settlement after all your stress and preparation for the trial still means a report to the Data Bank. You should know and at least ask whether you have the right to block any settlement decided by the malpractice insurance company without your permission. Otherwise all that time in discovery and stress all the way up to the trial date will be for naught and out of your control.

But there is an advantage, where insurance carriers allow it of maximizing the benefits of mediation by adopting the “two-track” model for attorney representation in dispute resolution.

***Should your malpractice attorney suggest or decide on ADR?**

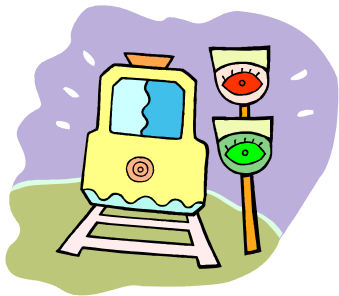
Litigation and mediation are very different processes, and the attorney role in each is very different. If you send in the litigation attorney whose main talent is the adversary model, and who will make more in legal fees if the case goes to court rather than if it is resolved earlier in mediation, you shoot ourselves in the foot in at least two ways. First, with few exceptions, this type of advocate won’t be as good in the “work together to work it out” part as would an advocate who is trained and paid only to “work it out.” Second, if you follow the money, the old model effectively allows a financial conflict of interest to run freely in the mediation, since the financial compensation for the attorney advocate is always greater in litigation (or settling on the courthouse steps) than in mediation, which typically entails fewer billable hours per case for attorneys.

This is not lawyer bashing. What’s being bashed is the use of the litigation model when you may not need it. Here is another way to put it. In our culture the lawyer jokes are actually grounded in disgust at the litigation/adversary model wreaking havoc to relationships-the divorce; the partnership split, the personal injury case, and even the medical malpractice case- after which the two “adversaries” go out for a drink and a talk about their golf scores.

The traditional view of lawyers, are as spoilers who say no because of legal liability issues, or who inflame a case by escalating it with their adversarial/litigation tools, which are used in relating to the other side as an “opponent.”

A far better approach perhaps in your case is to appropriately use one set of attorneys (to maximize the counselor at law role) for the “work it out,” mediation, or settlement phase, and then hand it to true litigators for going to court, if necessary.

Indeed, there will be many lawyers who will be equipped to do both services, **although not both services for the same client.** As a bonus, you can tell your malpractice insurance carrier that if their litigation expenses go down with ADR, then so will your insurance costs and malpractice premiums, since the insurance rates are influenced heavily by the litigation expenses.



***The two track model.**

As a solution to this problem, the “two track” model uses separate attorneys for the 2 tracks.

If you get into mediation, you or your insurance carrier will hire one attorney to represent you in the mediation, and use an attorney from another law firm to pick up the case for

litigation, if necessary. “This is not as inefficient as it may at first sound, i.e., two attorneys instead of one,” claims Slaikeu*. “You can build in an appropriate transfer of the case if you need it. And, even more important, you can actually have the litigation counsel give a private opinion to you and the insurance carrier, and your mediation counsel, regarding your chances in court, so a comparison can be made of a potential mediation settlement with your chances of success in court. The difference is that the one predicting the success of the court path will not be allowed to represent you in the bridge-building, talk-it-out for resolution phase of mediation. As a client, you will then have the best of both worlds: a highly skilled collaborative type to reach a win/win agreement if at all possible (sometimes called “the last nice person you will talk to on this matter”) vs. the aggressive litigator”.

***Attorney fees in the Two Track System:**

How about the plaintiff’s side? The plaintiff’s side takes a percentage of whatever the settlement is, however they get it, whether through direct negotiations or mediation, or failing that, a court award. It is actually to their advantage to get many of these cases resolved earlier to reduce their upfront expenses on contingency fee cases. Some plaintiffs’ attorneys may also see the value in representing clients in negotiations and mediations on an hourly fee basis.

In summary claims Slaikeu “Instead of continuing the tort reform battle why not move upstream and implement solutions that will reduce to a trickle the number of [medical malpractice] cases that will end up in litigation. Thinking of the interests of patients, physician, and [medical] provider institutions for solutions that allow them to continue as partners even in the face of unanticipated outcomes. Why not invest in systems that address human needs and professional interests while also reducing the inordinately high litigation expense component of medical malpractice insurance?”

Where is ADR/mediation working now?

The University of Pittsburgh Medical Center's [UPMC] pioneering formal mediation process not only helps settle malpractice claims before they go to court, but it also allows both sides to think about creative ways to work things out. Besides monetary awards, patients have had plaques, monuments or hospital rooms named in their honor. From late 2004 through mid-January,2007, UPMC mediated 77 cases and settled 68 of them, said a national expert in hospital mediation who developed a mediation program for the Johns Hopkins Medical Institutions in Baltimore prior to coming to UPMC. Other hospitals using this mediation program in addition to UPMC & Johns Hopkins, include Drexel University and the University of Michigan. At these hospitals patients sign an agreement prior to treatment saying that if they later pursue a claim against the facility, they must attempt to resolve it through mediation before filing a lawsuit. The patients do not waive their rights to a jury trial if mediation fails. The process is voluntary and confidential.

According to Jury Verdict Research the median medical malpractice settlement was \$1 million in 2004, the latest year for which it had data, compared with a median jury award

of \$1.045 million. The latest estimates an average \$50,000 in legal expenses is saved in each case that is mediated rather than tried in court.

Pittsburgh attorneys who specializes in medical malpractice and personal injury, have settled a number of cases through mediation with UPMC, because it's beneficial for the patient and the hospital since litigation is very, very expensive. Also, many patients are seeking an apology and get it through mediation. In some instances patients are invited to come to the medical center and speak to a new influx of medical residents about what happened to her so they would learn. This accomplishes a goal most patients have to make sure this wouldn't happen again. For the hospital, it provides a setting to discuss what happened, why it happened and how the institution can implement changes. Mediation also allows the hospital to apologize for errors, "something a hospital can't do in court. "Mediation is growing but not nearly as fast as it should be," she said. "In general, it's a better way to solve conflicts."

UPMC's mediation system involves one mediator who listens to statements from plaintiffs, defendants and their attorneys in a joint session prior to working with each side individually to reach a resolution and also to "give the patient his day in court".

Since 2006, UPMC also has provided "intermediation" as a step toward early resolution of disputes. If a patient files a complaint while still in the hospital, it typically goes to the patient relations department. If the patient isn't satisfied with the staff's initial response, the hospital will provide early mediation, which has up to 2007 resolved nine cases to date.

When there are times the process doesn't work if there is an inflexible difference of opinion regarding the liability of the claim and the value of a claim and when there is no of the minds, you simply go to court and try the case before a jury.

The mediation system doesn't keep UPMC out of the courtroom if either party including the hospital insist on a trial where the hospital thinks the complaint or suit is frivolous.

Medical-arbitration: This is a hybrid form of dispute resolution. It starts with mediation, which if unsuccessful, is followed by arbitration.

In Florida the major Medical malpractice insurance carrier First Professional Insurance co. offers an arbitration program to its policyholders. Like mediation the objectives of arbitration are to reduce legal costs and facilitate earlier resolution of claims. This program differs from mediation because it is a binding arbitration program which means that the physicians and patients agree to present any claims and patients agree [prior to medical services]to present any claims before an arbitration panel outside the court system. The panel's decision is binding on the parties. Patients and physicians may also use the mediation process only after a claim has been made and Notice of Intent to Pursue Litigation has been given. While mediation needs mutual agreement by both parties reduced to writing. in arbitration the panel is binding on both parties whether or not they agree with the results.

Mini-trial: Senior officials of corporate entities in the dispute meet with a neutral advisor and after hearing each party's presentation, proceed to develop a voluntary settlement.

Moderated settlement conference: Sometimes referred to as "early neutral evaluation" or "advisory opinions," this procedure is similar to nonbinding arbitration with certain exceptions: no rules of evidence, no cross-examination, and no formality in how the neutral entity communicates the outcome. This venue is often used in cases with heavy application-of-law content.

Negotiation, the most frequently used method of ADR, is defined as the process whereby 2 or more disputing parties confer together in good faith so as to settle a matter of mutual concern. The approach to negotiation may be positional or principled. In positional negotiation, divergent parties incrementally concede their position until a compromise is reached. In principled negotiation, the parties generate options focused on their interests to arrive at an agreement based on objective criteria. Negotiation serves as the basis for mediation, an important ADR method used in medical malpractice cases.



Negotiation has its advantages. The disputants remain in control of the process. Negotiated resolutions tend to have greater durability than agreements reached by other methods. The process of negotiation can be educational for both parties and therefore may prevent subsequent discord in the relationship. However, sometimes negotiation alone is not enough to resolve medical malpractice actions.

Neutral fact finder: A neutral entity with expertise in the disputed subject matter examines critical facts in the dispute and renders an advisory opinion on the matter.

No-fault compensation: A method for compensating persons injured during the course of medical treatment, regardless of whether the injury was caused by the negligence or fault of a health care provider.

National Practitioner Data Bank

A major impediment to physician use of ADR in medical malpractice is the mandatory reporting of all malpractice payments to the National Practitioner Data Bank (NPDB). It is important that physicians understand that any malpractice payment (eg, settlement or award) made on their behalf, even those derived from an ADR process, must be reported to the NPDB. Entries in the NPDB are specific to the physician on whose behalf the payment was made and are permanent. Every time a physician seeks or renews clinical

privileges at a hospitals or new employment his or her NPDB may be queried by authorized entities. Although physicians can furnish a note of explanation in their NPDB files, many prefer to take the odds of litigation, which tends to favor the physician defendant. Repeated efforts to open the NPDB to the public have not succeeded thus far. This could change as patient rights initiatives continue to gain momentum and other databanks of disciplinary actions taken against health care practitioners that are already open to the public (eg, Medicare/Medicaid programs exclusions, Occupational Safety and Health Act/Clinical Laboratories Improvement Act sanctions, adverse actions taken by state medical licensing boards) continue to proliferate.

Ombudsman: A neutral third party investigates facts involved in a complaint or grievance within an institution and makes a nonbinding advisory recommendation to senior managers regarding resolution of the problem.

Practice guidelines: Generally refers to clinical practice guidelines [CPGs], which is defined by the Institute of Medicine as systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.

Pretrial screening panel: An ADR procedure in which a screening panel hears the evidence of a malpractice claim including expert testimony, and determines liability before the plaintiff files a malpractice suit. In some instances the pretrial screening panel also determines damages in the claim. The pretrial screening panel may be composed of health care professionals, legal experts, and/or health care consumers. The use of the screening panel and its method of operation are determined legislatively, thus it may be mandatory or voluntary depending on the law. However, the decision of the pretrial screening panels is not binding. Therefore, the parties may subsequently pursue the claim through the legal system.

The pretrial screening panel is an ADR method that was uniquely developed for medical malpractice cases. About half of the states have statutes establishing pretrial screening panels that review malpractice claims and render a nonbinding advisory opinion on the merits of the claim before a suit being filed. Panel composition varies considerably from state to state. In some states only physicians sit on pretrial screening panels. Other states restrict panels to attorneys. Other states require that the members of a pretrial screening panel include physicians, attorneys, judges, and/or laypersons. The panel reviews the merits of the malpractice case and offers an opinion on the physician's liability. In some states the panel reviews the claim before legal action is taken. In other states the suit must be filed in court before it is sent to the panel. States also vary on whether the panel renders an opinion on damages. Furthermore, state law determines whether the findings of the pretrial screening panel can be admitted as evidence should the claim go to trial, and if so, how much weight the panel's findings should be given.

The purpose of the pretrial screening process is twofold:

1. to eliminate nonmeritorious claims and to

²encourage settlement of meritorious claims before litigation.

The earliest malpractice pretrial screening panels date back to the 1960s. In New Mexico a 1962 statute introduced a voluntary pretrial review panel; in the mid 1970s, during the malpractice litigation crisis, the statute was revised to make pretrial screening mandatory. Consequently, from 1976 to 1996 New Mexico panels have heard more than 2100 medical malpractice cases; nearly three-quarters of those cases were resolved without trial.

A major disadvantage of pretrial screening panels is the nonbinding nature of most ADR methods. In many states the plaintiff can still litigate after the pretrial screening panel decision is made. Thus, the pretrial screening panel may, in effect, further delay final resolution of the claim. Although there is some evidence that screening panels are effective in eliminating low-merit cases others contend that panels are victims of their own existence, as they can become clogged with frivolous claims that otherwise would not be pursued.



Private judging: Also known as "rent-a-judge," parties hire a retired judge to hear the case, following court-like procedures. The judge's decision is as enforceable as a regular court decision would be.

Statute of limitations: The time period established by law during which a plaintiff may file a lawsuit; the period for reporting malpractice is longer for minor patients than adults. Once this period expires, the plaintiff's lawsuit can be barred. In some states, the time period does not begin until the injury is discovered. The discovery rule states that the date of the injury, from which the time period is measured, is the date that it was reasonable for the plaintiff to have discovered the injury rather than the actual date of injury. Injuries may be discovered years after the treatment was provided. Therefore, the time period for filing actions may be extensive and difficult to verify. The long tail associated with pediatric care is an important consideration in resolving malpractice allegations. The more time that has passed, the more difficult it is to obtain pertinent evidence and available witnesses.

Summary jury trial: The parties' lawyers present summaries of evidence and arguments to a jury in a 1-day hearing. After a nonbinding jury verdict is rendered, the parties may interview jurors about how they perceived the merits of each side's position. A regular trial may follow if the parties do not subsequently settle based on the information received.

Tort: A civil wrong for which an action can be filed in court to recover damages for personal injury or property damage resulting from negligent acts of intentional misconduct.

Tort law: A body of law that provides citizens a private, judicially-enforced remedy for injuries caused by another person. Legal actions based in tort have 3 elements: 1) existence of a legal duty from the defendant to the plaintiff; 2) breach of that duty; and 3) injury to the plaintiff as a result of that breach.

Tort reform: A term used to describe collectively a number of legislative and judicial modifications to traditional tort law.



SUMMARY OF POINTS MADE IN THE PEER REVIEWED LITERATURE:[see Appendix for other references and readings.]

1. ADR techniques are often described as bilateral tort reforms because they can make it cheaper for physicians to defend unfounded claims and easier for plaintiffs to prevail on meritorious claims. Given the persistent problems in medical malpractice litigation for both sides it is surprising that ADR methods remain underutilized, especially when reforms based on ADR potentially make the tort system more equitable and affordable to both plaintiffs and defendants. See [*Committee on Medical Liability, 1999-2000 J.J. Fraser MD. Technical Report: Alternative Dispute Resolution in Medical Malpractice PEDIATRICS Vol. 107 No. 3 March 2001, pp. 602-607*]

2. The use of arbitration in the commercial arena has increased tremendously in recent years, yet there has been a reluctance to adopt arbitration of medical malpractice claims in place of litigation. After discussing the benefits of arbitration in medical malpractice cases, Professor Metzloff examines why the use of arbitration has not become predominant, discussing such factors as judicial hostility, failure of state statutes designed to encourage arbitration, and lack of hard evidence that arbitration works. Professor Metzloff then explores the future of arbitration in medical malpractice cases, citing examples from his own work experience with Duke Law School's Private Adjudication Center, and discusses attributes which would make malpractice arbitration successful in the future.
Spec Law Dig Health Care Law. 1997 Jan;(215):9-36.
The unrealized potential of malpractice arbitration.
Metzloff TB. of Duke University School of Law, USA.

3. Dr. J.J.Fraser from the Department of Emergency Medicine, University of Texas-[Houston] Medical School, compares the different ADR systems in this summary article. The medical malpractice crises and ensuing tort reform efforts, including methods of alternative dispute resolution (ADR), are generally reviewed. Arbitration in the context of medical malpractice is examined from the perspective of other states' experiences. Fraser reports that Michigan has one of the nation's oldest medical malpractice arbitration programs, but it suffers from underutilization. California's experience derives from the use of arbitration in the managed care setting. While Texas has statutory provisions for medical malpractice arbitration, in light of public policy favoring ADR, the statute could be perceived as antipublic policy, resulting in underuse.

Fraser also believes that The National Practitioner Data Bank also serves to discourage physician participation. *Fraser JJ Jr. Medical malpractice arbitration: a primer for Texas physicians. Tex Med. 1997 Jan;93(1):76-80.*

4.

In the 1970's, Michigan and other states were confronted with a medical malpractice crisis. The escalating number of medical malpractice lawsuits and concomitant increase in malpractice premiums for health care providers fostered a divisive climate among doctors, lawyers and patients. In response to this crisis, the Michigan legislature enacted the Medical Malpractice Arbitration Act. The Act establishes a process whereby patients may agree to arbitrate any claims rather than pursue them through the courts. Bedekian believes that as the law respecting arbitration becomes less vulnerable to judicial perforation, that other jurisdictions will treat the Michigan Medical Arbitration Program as an archetype, susceptible to replication. *Bedikian M. Medical Malpractice Arbitration Act: Michigan's experience with arbitration. Am J Law Med. 1984 Fall;10(3):287-306*

5. Lehrman TD. proposes a two-pronged legislative response to the current debate over medical malpractice insurance. The author does not advocate mandatory caps on malpractice damages, nor the imposition of a uniform regime on the field of medicine. Rather, he articulates some of the important legal, medical, and societal benefits that would come from embracing arbitration in the non-emergent medical malpractice context. The author also calls for the reformulation of the National Practitioner Data Bank

J Health Law. 2003 Summer;36(3):475-506.

Reconsidering medical malpractice reform: the case for arbitration and transparency in non-emergent contexts.

6. The wide variety of economic cooperative arrangements in which hospitals and physicians engage can lead to disputes. As methods of dispute resolution, litigation and arbitration are costly and time-consuming and can have long-lasting adverse effects on relationships between the disputing parties. An alternative method of dispute resolution is mediation, the process of voluntarily negotiating a settlement with the help of a mediator. Mediation generally is quicker, less costly, and less likely to be adversarial than litigation or arbitration. In addition, mediation offers privacy regarding the nature of the dispute,

thus preserving valuable reputations. *Healthc Financ Manage.* 1999 Jun;53(6):78-9. Using mediation to resolve disputes among hospitals and physicians. Duncheon MA

7. An increasingly complex health care system undergoing rapid changes is an ideal set-up for frequent conflicts among the numerous participants. While conflict is inevitable, the manner in which it is handled can markedly affect the outcome of the dispute and the future relationship of the parties, as well as the emotional and financial cost of the dispute. This article presents an overview of the principles and processes of alternative dispute resolution (ADR), and describes how these processes are currently being used to resolve health care disputes. *Physician Exec.* 1995 Nov;21(11):26-30 The role of health care ADR (alternative dispute resolution) in reducing legal fees. Joseph DM.

8. Provider-patient disputes are inevitable in the healthcare sector. Healthcare providers and regulators should recognize this and plan opportunities to enforce alternative dispute resolution (ADR) as early as possible in the care delivery process. Negotiation is often the main dispute resolution method used by local healthcare providers, failing which litigation would usually follow. The role of mediation in resolving malpractice disputes has been minimal. Healthcare providers, administrators, and regulators should therefore look toward a post-event communication-cum-mediation framework as the key national strategy to resolving malpractice disputes. *J Med Pract Manage.* 2006 Mar-Apr;21(5):257-61. Minimizing medical litigation. Harold TK.

9. The wide variety of economic cooperative arrangements in which hospitals and physicians engage can lead to disputes. As methods of dispute resolution, litigation and arbitration are costly and time-consuming and can have long-lasting adverse effects on relationships between the disputing parties. An alternative method of dispute resolution is mediation, the process of voluntarily negotiating a settlement with the help of a mediator. Mediation generally is quicker, less costly, and less likely to be adversarial than litigation or arbitration. In addition, mediation offers privacy regarding the nature of the dispute, thus preserving valuable reputations. *Physician Exec.* 2005 Jul-Aug;31(4):34-7. Using mediation to resolve disputes in health care. Gorton C. Johns Hopkins University .

10. Malpractice litigation is felt to provide a standard for practice. It can be costly both in terms of settlement awards and detrimental impact on the physician. Mediation offers opportunities to bypass that stringent legal process yet allows a resolution of disputes and allows proper redress of grievances. *Mediation sans litigation in malpractice.* Buckner F. University of Washington School of Medicine,

11. Conflict thrives and grows in the increasingly competitive and uncertain health care environment. Conflict impacts health care organizations' performance in several areas: (1) patient grievances and health plan member disputes; (2) internal employee and management disputes; and (3) payer, provider, and vendor disputes. "Grief Budgets," the hard costs and soft costs due to disputes that are poorly handled and conflicts that are ignored, detract from an organizations health mission and erode its bottom line. This article offers a strategy to solve conflict at an early stage in all three areas, with measurable results that strengthen profits and improve customer service by instilling a

mediation-based conflict resolution culture throughout the organization. Mediation is non-adversarial, neutral, proactive, and collaborative. It is also confidential and always protects the future relationship between the parties. The challenge, therefore, is to strategically implant mediation into the health care organization's structure, to intercept and solve conflict early on. The article provides an overview of the steps needed to install a dispute resolution program. *Qual Health Care*. 1995 Jun;4(2):151-8.
Alternative dispute resolution and mediation. Brown H et al.