

MANDATORY MEDIATION: THE EXTRA DOSE NEEDED TO CURE THE MEDICAL MALPRACTICE CRISIS

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I. INTRODUCTION

Physicians today are not just aggressively striving to find a cure for life-threatening diseases, doctors are also struggling to find a cure for the medical malpractice crisis. From rallies on the statehouse steps of their state capitols¹ to lobbying Congress for medical malpractice legislation,² physicians are wielding their clout to bring about medical liability reform with their grassroots efforts³

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¹ On January 26, 2005, hundreds of lab-coat clad South Carolina physicians, with the support of the American Medical Association, gathered at the statehouse in Columbia to “urge passage of medical liability reform legislation that would protect patients’ access to the medical care they need.” AMA Member Communications, *South Carolina Docs Rally to Protect Patient Access*, Jan. 26, 2005, <http://www.ama-assn-org/ama/pub/category/14590.html> [hereinafter *South Carolina Docs Rally*]. (stating that South Carolina has been showing signs of a potential medical liability crisis in recent years, as several trauma and specialty health care centers have closed due to the state’s deteriorating liability climate). The South Carolina Medical Association said that 25% of OB/GYNs in one county and that family-practice physicians in ten other counties no longer perform baby deliveries. See American Political Network, Vol. 10 No. 9 AM. HEALTH LINE, Jan. 28, 2005. High-risk specialties such as neurosurgery have also been forced to limit services—“patients in Horry County only have trauma coverage ten days out of the month for emergencies such as head injuries and cerebral hemorrhages.” *South Carolina Docs Rally*, *supra*.

² See *infra* text accompanying note 15.

³ In one of the most unique approaches in the fight against rising medical liability insurance rates, physicians in Madison County, Illinois were adorning wristbands resembling the yellow ones worn by supporters of the Lance Armstrong Foundation. See Damon Adams, *Tort Reform Gets Own Bracelet Campaign: Physicians Hope to Spread Awareness Next Through Green T-shirts*, AMEDNEWS, Dec. 6, 2004, <http://www.ama-assn.org/amednews/2004/12/06/pr121206.htm>. Doctors in southern Illinois wore the lime-green wristbands as “a sign of solidarity, a tiny billboard that urges ‘Keep Doctors in Illinois.’” The bracelet idea was the creation of Lynne Willett Nowak, M.D., an internal medicine specialist at Memorial Hospital in Belleville, Ill., who was inspired after watching the Olympics and seeing people sporting yellow wristbands from the Lance Armstrong Foundation to raise cancer awareness. For the past two years, the American Tort Reform Association has labeled Madison County, Illinois, the nation’s No. 1 “judicial hel-

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netting accomplishments. Consider, for instance, what happened in Texas. In 2002, there were murmurs of a state-wide doctors' strike.⁴ But instead,

[a]rmed with bumper stickers and buttons, pamphlets to distribute in their waiting rooms and yard posts to post on the lawns of their homes, medical professionals affiliated with the 50,000-member Texas Medical Association joined others in a rally for change. In [Corpus Christi], 200 doctors, with busloads of supporters and friendly legislators in tow, began an awareness day at the Nueces County Courthouse. . . . [I]n Austin, doctors began showing up on the first Tuesday of each month, donning white coats and meeting with policymakers to state their cause.⁵

The rallies and lobbying worked.⁶ In 2003, the Texas legislature enacted H.B. 4, which contained sweeping medical liability reforms.⁷ Then during election time, Texas voters showed their support for their state's doctors when they approved Proposition

hole" because of its high lawsuit rate. See Tanya Albert, *Bush Stumping for Liability Reform in "Judicial Hellhole": The President Stresses the Need for a \$250,000 Cap on Noneconomic Damages*, AMEDNEWS, Jan. 24, 2005, <http://www.ama-assn.org/amenews/2005/01/24/gvsb0124.htm>. Madison County is a favored venue for lawyers filing class-action lawsuits. In 2004, a county judge awarded \$10.1 billion in damages to plaintiffs in a class-action case involving Philip Morris. See Dave McKinney, *Bush in State to Push Tort Reform; In Madison County, President Says Voters Expect Changes*, CHI. SUN-TIMES, Jan. 6, 2005, at 19.

⁴ Eleanor Barrett, *Doctors' Orders: Physicians Have Wielded Their Clout to Bring About Medical-Liability Reform, But What Lied Beyond Caps on Damages?*, BEST'S REV., Sept. 2005, at 28.

⁵ *Id.*

⁶ Texas is not the only state where such rallies have produced results. In early 2004, thousands of doctors and members of the Medical Society of Virginia marched on Richmond in an unprecedented call for help from rising malpractice-insurance rates and lost medical care. See Bill McKelway, *New Caps Not Seen Happening*, RICH. TIMES-DISPATCH, Jan. 19, 2005, at A1 ("Chanting signs and carrying signs mocking trial lawyers and malpractice premiums, doctors and the Medical Society of Virginia pushed a powerful legislative agenda. . . that is still being promoted across the country by the American Medical Association."). The agenda included a \$250,000 cap on non-economic damages and strict limits on lawyers' fees and access to courts. The Medical Society of Virginia also wanted money paid by collateral sources to be introduced as evidence during trials, and it wanted to protect physicians from liability when a patient leaves care against medical advice. See Albert, *supra* note 3. In addition, doctors proposed "I'm sorry" language so that "a doctor would be able to apologize for a patient's outcome without fear that the apology would be later used in court as an admission of wrongdoing." McKelway, *supra*, at A1. However, not all reforms the Virginia physicians requested were enacted. The omnibus tort reform bill, Senate Bill 1173 and House Bill 2659, did not include the "centerpiece" of the physicians' campaign, a provision to cap non-economic damages. Nevertheless, the legislation would require certification for expert witnesses who testify in malpractice lawsuits, allow the "I'm sorry" language and necessitate the state Medical Review Board to evaluate physicians who have settled three or more malpractice lawsuits. See American Political Network, *supra* note 1.

⁷ Barrett, *supra* note 4. Such reforms included a \$250,000 limit on non-economic damages and a \$750,000 overall limit per case. *Id.*

12, permitting medical malpractice liability premiums to immediately decrease.⁸ The results? Access to care increased and claims decreased.⁹ Physician recruitment and retention increased, especially in high-risk specialties.¹⁰ Eleven new insurers entered the Texas medical liability market,¹¹ and all five of the largest insurers in that market announced rate cuts.¹² The American Medical Association, recognizing that significant improvements were occurring in Texas, removed Texas from its list of crisis states in 2005.¹³

The reforms have not just been isolated to Texas. Since 2002, physician politicking has stimulated medical malpractice legislative

⁸ *Id.* Proposition 12 allowed amending the state constitution to specifically empower the legislature to enact caps on non-economic damages in health care cases. American Medical Association, *America's Medical Liability Crisis Backgrounder on Texas*, <http://www.ama-assn.org/ama/pub/category/12397.html> (last visited Apr. 24, 2006) [hereinafter *America's Medical Liability Crisis Backgrounder on Texas*]. This effectively circumvented a possible 10-year wait for the state Supreme Court to determine whether the caps were constitutional. Barrett, *supra* note 4.

⁹ American Medical Association, *Rhode Island Joins States in Medical Liability Crisis; Texas Liability Reforms Halting Crisis There*, May 16, 2005, <http://www.ama-assn.org/ama/pub/category/15063.html> [hereinafter *Texas Liability Reforms Halting Crisis There*]. One year after Texas passed its medical liability reforms, the rate of malpractice filings had decreased at least 80% in most major Texas counties. *America's Medical Liability Crisis Backgrounder on Texas*, *supra* note 8. In addition, the Texas Medical Association reports that more doctors are providing high-risk services since the reforms have been passed. In April 2003, a survey noted that more than half the Texas doctors said they had stopped providing high-risk services to patients. Almost a year after the passage of the H.B. 4 and Proposition 12, the percentage of physicians with restrictions on high-risk cases dropped to just 13%. *America's Medical Liability Crisis Backgrounder on Texas*, *supra* note 8.

Dr. David Cantu, a family practice physician from Fredericksburg, said he and his partner had to quit practicing obstetrics because of the cost of insurance. "Our overhead was hitting 100 percent," Cantu said. "I had a three-month stretch of no pay." As soon as they stopped delivering babies, the practice saw an immediate decrease in insurance costs, but at the same time, their patients from Fredericksburg, Mason, Boerne, Rockspring and Johnson City had to go elsewhere to deliver babies. But with Proposition 12, Cantu and his partner now are able to deliver babies.

Id. (quoting from August 27, 2004's San Antonio Express-News).

¹⁰ *Texas Liability Reforms Halting Crisis There*, *supra* note 9. After years of little growth, Texas is gaining doctors in often-sued specialties such as obstetrics, anesthesiology and neurosurgery. *America's Medical Liability Crisis Backgrounder on Texas*, *supra* note 8. Notwithstanding the above statistics, the most compelling evidence lies in the anecdotes of Texas physicians.

¹¹ Barrett, *supra* note 4.

¹² *Texas Liability Reforms Halting Crisis*, *supra* note 9. Shortly after passage of its medical liability reforms, Texas Medical Liability Trust (TMLT), the largest medical liability insurer in Texas, reduced premiums 12%. In Sept. 2004, TMLT reduced premiums an additional 5%. The total rate reduction of 17% represents a \$34 million savings to physicians and patients in Texas. With the other four largest insurers in the Texas medical liability market reducing rates, Texans have been provided with an additional \$16 million in relief. *America's Medical Liability Crisis Backgrounder on Texas*, *supra* note 8.

¹³ *Texas Liability Reforms Halting Crisis There*, *supra* note 9.

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reform in Alaska, Arkansas, Connecticut, Florida, Georgia, Idaho, Illinois, Missouri, Nevada, Ohio, Oklahoma, South Carolina and West Virginia.¹⁴ In addition, in July 2005, the House of Representatives passed H.R. 5, a comprehensive medical malpractice liability reform bill.¹⁵

Now, physicians are turning their attention to altering risk-management techniques to avoid the entanglement of the court system.¹⁶ But these initiatives are not exactly new. Doctors have long insisted on alternatives to the traditional litigation system for handling medical malpractice disputes.¹⁷ In response to the medical malpractice crisis of the 1970's, many states enacted statutes to facilitate the use of binding arbitration in these disputes.¹⁸ However, such measures failed,¹⁹ and the residual voluntary arbitration

¹⁴ Barrett, *supra* note 4.

¹⁵ The American Medical Association declares that H.R. 5 is a comprehensive set of proven reforms that will bring common sense to the country's out of control medical liability system. American Medical Association, *AMA Celebrates House Passage of H.R. 5*, July 28, 2005, <http://www.ama-assn.org/ama/pub/category/15373.html>. H.R. 5 will cap non-economic damages at \$250,000; limit punitive damages to \$250,000 or two times the amount of economic damages; allow periodic payout of damage awards over \$50,000; protect an uninsured, underinsured, or bankrupt defendant so that it may not have to pay its share of damages if it is unable to; limit attorneys' contingency fees based on the amount awarded; and set the statute of limitations to three years after the manifestation of the injury or one year after the claimant discovers the injury, unless tolled. See Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2005, H.R. 5, 109th Cong. (2005); *GovTrack: H.R. 5: Text of Legislation*, <http://www.govtrack.us/congress/billtext.xpd?bill=h109-5> (last visited Apr. 24, 2005). As this Note went into publication, the legislation has stalled in the U.S. Senate. During "Health Week" in early May of 2006, the U.S. Senate is expected to discuss and vote on S. 22, the Medical Care Access Protection Act of 2006, a comprehensive bill to alleviate the medical liability crisis. See American Medical Association, *AMA Launches Ad Campaign Calling for National Medical Liability Reform*, Apr. 25, 2006, <http://www.ama-assn.org/ama/pub/category/16213.html>.

¹⁶ Meg Green, *Doctors Say "I'm Sorry"*, *BEST'S REV.*, Sept. 2005, at 28 (stating that a major component of risk management for doctors is addressing potential medical malpractice claims early on).

¹⁷ Thomas B. Metzloff et al., *Empirical Perspectives on Mediation and Malpractice*, 60 *LAW & CONTEMP. PROBS.* 107, 107 (1997); see, e.g., Kirk B. Johnson et al., *A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims*, 42 *VAND. L. REV.* 1365 (1989).

¹⁸ See Michael H. Moore, *Constitutional Standards of Review for Medical Malpractice Mediation Panels*, 1 *J. DISP. RESOL.* 183, 183 (1985). Along with mandatory "mediation" or screening panels, which will be discussed *infra* in Part VI.A, mandatory arbitration panels constituted the major focus of reform. In early 2005, twenty-six states had enacted legislation establishing "mediation" or arbitration panels to review malpractice claims. By 2006, only nineteen of those states maintain statutory provisions mandating submission of medical malpractice claims to these pre-trial panels.

¹⁹ Today, mandatory arbitration has been abolished in all states in the face of constitutional concerns. See *infra* discussion Part IV.A.

provisions are largely ignored.²⁰ It has not been until recently that health care professionals have considered the unrealized potential of mediation in the malpractice context.²¹

This Note discusses the advantages and drawbacks of mandating participation in mediation in medical malpractice disputes. Part II of this Note reviews the extent of the current medical malpractice crisis. Part III examines litigation as the traditional means of resolving medical malpractice disputes and suggests that litigation's weaknesses eclipse any of its strengths. Part IV evaluates the lingering challenges to arbitration, accounting for its ineffectiveness in resolving medical malpractice disputes. Part V analyzes why mediation may be the better alternative to both litigation and arbitration in resolving such disputes, and how its hurdles can be best surmounted by mandatory mediation. Part VI reviews lessons that can be learned from mediation in practice, from mandatory "mediation" panels to the Chicago Rush Hospital apology-based mediation model. Finally, Part VII concludes that mandating mediation may be the radical overhaul that the traditional system requires to emerge from the current medical malpractice crisis.

II. THE CURRENT MEDICAL MALPRACTICE CRISIS

A. Medical Malpractice Insurance Rates and Health Care Costs Continue to Soar

The medical malpractice crisis did not appear overnight, and is not the first of its kind.²² Previous crises occurred in the early 1970's and the 1980's.²³ However, the crisis has not waned—it has

²⁰ See Fillmore Buckner, *A Physician's Perspective on Mediation Arbitration Clauses in Physician-Patient Contracts*, 29 *CAP. U.L. REV.* 307, 315 (2000) (expressing the view of Mr. Fillmore Buckner, who is a M.D., J.D. and Clinical Professor of Obstetrics & Gynecology at the University of Washington School of Medicine in Seattle. His article is an extension of his membership on a panel voicing the physician's perspective on mediation in medical professional liability cases).

²¹ See Metzloff et al., *supra* note 17, at 170.

²² Robert P. Hartwig & Claire Wilkinson, *Medical Malpractice Insurance*, 1 *INS. INFO. INST.* 2 (2003), available at <http://www.iii.org/media/hottopics/insurance/medicalmal/whitepaper/>.

²³ See *INS. INFO. INST.*, *Medical Malpractice*, <http://iiidev.iii.org/media/hottopics/insurance/medicalmal/?printerfriendly=yes> (last visited Jan. 29, 2005). As a result of the rising claims and inadequate rates of the 1970's and 1980's crises, several private insurers left the market. The exodus of capacity resulted in an availability crisis. Various attempts were made to ease the explosion in claims costs—tort reform, increased diagnostic testing, improved peer review, and

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worsened. Escalating jury awards and the high cost of defending against lawsuits have caused medical liability premiums to skyrocket in the last several years, making it difficult or impossible for physicians to find or afford insurance.²⁴ Some malpractice insurance carriers—such as St. Paul,²⁵ a company that formerly wrote approximately 9% of the country's malpractice insurance policies—have pulled out of the industry as a result.²⁶ Those insurance companies that still write malpractice policies have sharply increased rates.²⁷ According to data on medical liability insurance rate filings,²⁸ at least one company raised liability premiums 40%

increased communication between doctors and patients. Those efforts appeared to have had a positive impact. The number of claims has remained more or less constant. However, the size of claims—the dollar amount—has continued to grow.

²⁴ Andrea D. Stailey, *The Health Act's Same Old Story, Different Congress Dilemma: Overhauling the Health Act and Unifying Congress as a Remedy for Tort Reform*, 40 *TULSA L. REV.* 187, 190-91 (2004); see also *Assessing the Need to Enact Medical Liability Reform, Hearing Before the Subcomm. on Health of the Comm. on Energy and Com.*, 108th Cong. 120 (Feb. 27, 2003) [hereinafter *Medical Liability Reform Hearings*] (testimony of Donald J. Palmisano, M.D., J.D., Immediate Past President of the AMA).

[P]hysicians have been hit with medical liability premium increases of 25 to 400 percent as reports show the average jury award reaching [\$6.25] million. As medical liability insurance becomes unaffordable or unavailable, physicians are forced to close their practices or drop vital services seriously affecting patient access to care. . . . Several recent government and private sector reports confirm that the cause of the liability crisis is the unrestrained escalation of jury awards. Opponents claim that the soaring medical liability insurance premiums are the result of declining investments in the insurance industry, and that liability reforms do not stabilize the insurance markets. These claims are misleading, based on flawed analysis and are contrary to the facts.

Medical Liability Reform Hearings, supra (quoting from testimony from Donald J. Palmisano, M.D., J.D., Immediate Past President of the AMA); see also *infra* note 61 (incorporating the most recent statistics).

²⁵ See U.S. DEPT. HEALTH & HUMAN SERVS., *CONFRONTING THE NEW HEALTH CARE CRISIS: IMPROVING HEALTH CARE QUALITY AND LOWERING COSTS BY FIXING OUR MEDICAL LIABILITY SYSTEM* (2002), available at <http://aspe.hhs.gov/daltcp/reports/litrefm.htm>; see also Tanya Albert & Jessica Diehl, *Liability Premium Shock is Spreading; An AMNews Exclusive Survey Shows*, *AMEDNEWS*, Jan. 31, 2005, <http://www.ama-assn.org/amednews/2005/01/31/pr110131.htm> (reporting that the medical liability problem escalated in December 2001 when the St. Paul Companies announced that it was pulling out of the medical liability insurance market).

²⁶ See Stailey, *supra* note 24, at 191; U.S. DEPT. HEALTH & HUMAN SERVS., *supra* note 25. The U.S. Department of Health and Human Services report also notes that other insurers have withdrawn from the medical malpractice insurance market, including MIXX, PHICO, Frontier Insurance Group, and Doctors Insurance Reciprocal.

²⁷ See U.S. DEPT. HEALTH & HUMAN SERVS., *supra* note 25.

²⁸ In 2001 and again in 2004, *AMNews*, a publication from the American Physicians Association, asked state insurance departments for data on medical liability insurance rate filings for the year. In the few instances in which the state could not provide information, the state medical and individual insurance companies provided the information.

or more in nineteen states in 2004.²⁹ In 2001, only twelve states experienced increases of that magnitude.³⁰ Furthermore, at least one company in thirty-four states raised rates 25% or more in 2004.³¹ That is nearly double the eighteen states with similar increases in 2001.³²

Physicians in high-risk practice areas pay the highest yearly premiums, sometimes in the range of six figures.³³ For example, obstetricians and gynecologists pay premiums as high as \$170,000 a year in Illinois³⁴ and \$250,000 a year in Florida.³⁵ In 2004, Illinois neurosurgeons paid \$300,000,³⁶ an increase of \$132,000 from 2002

²⁹ See Albert & Diehl, *supra* note 25 (reporting that in 2004, the states with liability premium increases from 40% to 99.99% were Arizona, Colorado, Connecticut, Delaware, Florida, Iowa, Maryland, Michigan, New Jersey, North Carolina, Ohio, Oregon, South Dakota, Washington, Wisconsin and Wyoming). It is also interesting to note that Illinois, Mississippi, and Oklahoma experienced increases of more than 100%.

³⁰ See *id.* In 2001, the states with liability premium increases from 40% to 99.99% included Connecticut, Florida, Georgia, Michigan, Mississippi, Nevada, Pennsylvania, South Carolina and Texas. The states with increases of more than 100% were Arkansas, Illinois and Ohio.

³¹ See *id.* The states with medical malpractice premium increases from 25% to 39.9% were Alaska, Georgia, Hawaii, Idaho, Indiana, Louisiana, Maine, Massachusetts, Missouri, Montana, Nevada, New Hampshire, North Dakota, South Carolina and Tennessee.

³² See *id.* The states with increases from 25% to 39.9% in 2001 were Alaska, Kansas, Louisiana, Missouri, North Carolina and Virginia.

³³ This is dependent on the state. For example, a large insurer in Minnesota charged base premium rates of \$3,803 for the specialty of internal medicine, \$10,142 for general surgery, and \$17,431 for OB/GYN in 2002 across the entire state. In contrast, a larger insurer in Florida charged base premium rates in Dade County of \$56,153 for internal medicine, \$174,268 for general surgery, and \$201,376 for OB/GYN. However, the differentials should be contrasted against the background of the base liability premium rate increases. Between 1999 and 2002, the Minnesota insurer increased its premium rates by about 2% for each of the three specialties while the Florida insurer increased its rates by about 98%, 75%, and 43%, respectively, for the three specialties in Dade County. See U.S. GENERAL ACCOUNTING OFFICE, MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE, GAO-03-836, at 8-9 (2003) [hereinafter U.S. GAO: IMPLICATIONS OF RISING PREMIUMS].

³⁴ American Medical Association, *America's Medical Liability Crisis Backgrounder on Illinois*, <http://www.ama-assn.org/ama/pub/category/12384.html> (last visited Apr. 20, 2006) [hereinafter *America's Medical Liability Crisis Backgrounder on Illinois*] ("When three ob-gyns on staff at Advocate Lutheran General Hospital in Park Ridge learned that their 2004 liability insurance premiums would climb from \$345,000 to \$510,470, they decided to take their practice to Kenosha, where . . . their combined insurance will cost \$50,018.").

³⁵ American Medical Association, *America's Medical Liability Crisis Backgrounder on Florida*, <http://www.ama-assn.org/ama/pub/category/12384.html> (last visited Apr. 20, 2006) [hereinafter *America's Medical Liability Crisis Backgrounder on Florida*].

³⁶ *America's Medical Liability Crisis Backgrounder on Illinois*, *supra* note 34 (reporting that the last neurosurgeons in Southern Illinois, B. Theo Mellion and Sumeer Lal of Neurological Associates of Southern Illinois, resigned due to the cost of premiums).

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rates.³⁷ General surgeons do not lag far behind, with at least one Mississippi and one Florida insurance carrier charging rates of \$170,000³⁸ and \$226,000,³⁹ respectively. The percentage increases in premiums are also dramatic. In Mississippi, Pennsylvania and Texas, several insurers increased medical malpractice liability rates for general surgeons over 100% from 1999 to 2002.⁴⁰ During the same time period, comparable increases were seen in Florida, Pennsylvania and Texas for premiums charged to physicians specializing in internal medicine.⁴¹

The consequence of such high premiums is that “in many states it is getting difficult to find doctors who will deliver babies.”⁴² Reports abound of physicians who are limiting their practices to low-risk medical specialties or geographical areas with lower malpractice premiums, leaving the practice of medicine altogether, or even worse—practicing without insurance.⁴³ In addition, the fear of malpractice litigation has forced physicians to practice “defensive medicine.”⁴⁴ The resulting reduction or elimination of high-risk services have contributed to reduced access to specific services, such as trauma care, complicated surgical procedures and baby deliveries.⁴⁵ The American Medical Association has pro-

³⁷ See Jennifer Nielsen, *America's Medical Liability Crisis Backgrounder on Illinois*, <http://www.ama-assn.org/ama/pub/category/print/12386.html> (last visited Dec. 12, 2004). In 2002, Chicago neurosurgeons paid \$168,000.

³⁸ American Medical Association, *America's Medical Liability Crisis Backgrounder on Mississippi*, <http://www.ama-assn.org/ama/pub/category/12388.html> (last visited Apr. 20, 2006). Dr. Paul Mace, a general surgeon in Gulfport, was forced to discontinue handling traumas and other high-risk procedures to counter the premium increase.

³⁹ *America's Medical Liability Crisis Backgrounder on Florida*, *supra* note 35.

⁴⁰ See U.S. GENERAL ACCOUNTING OFFICE, *MEDICAL MALPRACTICE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES*, GAO-03-702, at 12 (2003) [hereinafter U.S. GAO: MULTIPLE FACTORS].

⁴¹ See *id.* at 14. In Florida, the First Professionals Insurance Company and Medical Assurance increased their rates 98% during 1999 to 2002. The Pennsylvania Medical Society Liability Insurance Company increased its rates nearly 130%. The Texas Medical Liability Trust in both El Paso and Amarillo increased its rates 108% and 96%, respectively.

⁴² Stailey, *supra* note 24, at 191, citing William Tucker, *Legal Malpractice: Will Congress Side with the Lawyers or the Doctors?*, 8 WKLY. STAND. 18 (Mar. 24, 2003).

⁴³ Stailey, *supra* note 24, at 191; see also U.S. GAO: *IMPLICATIONS OF RISING PREMIUMS*, *supra* note 33, at 1.

⁴⁴ See U.S. GAO: *IMPLICATIONS OF RISING PREMIUMS*, *supra* note 33, at 11. Physicians may reduce or eliminate certain services that they believe place them at risk of malpractice litigation. Alternatively, physicians may overutilize certain diagnostic tests or procedures, which add to the cost of health care. Such practices are referred to as defensive medicine.

⁴⁵ See *id.* at 12. For example, in Jacksonville, Florida, at least nineteen general surgeons who served the city's hospitals took leaves of absences beginning in May 2003 when state legislation capping non-economic damages for malpractice cases at \$250,000 was not passed. See *id.* at 13. “[T]he loss of these surgeons reduced the general surgical capacity of Jacksonville's acute care

claimed that more than 26% of health care institutions have reacted to the liability crisis by cutting back on services, or even eliminating some units,⁴⁶ and there are now twenty-one states in a full-blown medical liability crisis—up from twelve in 2002.⁴⁷

community hospitals by one-third.” *Id.* In Mississippi, surgeons along the Gulf Coast who formerly provided on-call services at multiple hospitals restricted their coverage to a single ER and others eliminated coverage entirely in an effort to minimize their malpractice premiums and exposure to litigation. *See id.* at 14. Put this side by side against an incident in Clark County, Nevada. “To draw attention to their concerns about rising medical malpractice premiums, over [sixty] orthopedic surgeons in the county withdrew their contracts with the University of Nevada Medical Center, causing the state’s own Level I trauma center to close for [eleven] days in July 2002.” *Id.* Trauma centers are designated based on the level of service sophistication, with Level I trauma centers equipped to handle the most complex trauma cases. *Id.* It was only after a special arrangement was made for surgeons to temporarily obtain malpractice coverage through the Medical Center and the governor announced his support for tort reform, did the center reopen with the return of fifteen of its surgeons. *See id.* These are only a few examples of similar practices occurring in the twenty-one states in crisis.

⁴⁶ *Medical Liability Reform Hearings, supra* note 24 (testimony of Donald J. Palmisano, M.D., J.D., Immediate Past President of the AMA).

⁴⁷ *See* American Medical Association, *Medical Liability Crisis Map*, <http://www.ama-assn.org/ama/noindex/category/print/11871.html> (last visited Apr. 20, 2006). The twenty-one states in crisis are Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Massachusetts, Mississippi, Missouri, Nevada, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, Tennessee, Washington, West Virginia and Wyoming. Only California, Colorado, Indiana, Louisiana, New Mexico, and Wisconsin have been classified as “states currently okay.” *See* American Medical Association, *America’s Medical Liability Crisis: A National View*, http://www.ama-assn.org/ama1/upload/mm/~1/med_liab_19stat.pdf (last visited June 10, 2005); American Medical Association, *Medical Liability Reform – NOW!* (2005), available at <http://www.ama-assn.org/go/mlrnow>. For a primer on the twenty-one states’ backgrounds and current state tort law, *see, e.g., Arkansas*, <http://www.ama-assn.org/ama/pub/category/print/12382.html> (last visited Apr. 20, 2006) (stating that their premiums have increased 829% between 1976 and 2000 and now 90% of physicians say they are forced to practice defensive medicine); *Connecticut*, <http://www.ama-assn.org/ama/pub/category/print/12383.html> (last visited Apr. 20, 2006) (noting that despite strong support from the governor and a coalition of health and consumer groups, the Connecticut legislature refuses to support proven liability reforms); *Florida*, <http://www.ama-assn.org/ama/pub/category/print/12384.html> (last visited Apr. 20, 2006) (noting that 100% of South Florida neurosurgeons have been sued and North Florida Surgeons, a Jacksonville surgical group that has never lost a single case in court, was forced to close its doors in 2003 because of skyrocketing medical liability premiums, claims and losses); *Georgia*, <http://www.ama-assn.org/ama/pub/category/print/12385.html> (last visited Apr. 20, 2006) (discussing how Georgia’s crisis has affected women and children because there are only 7 pediatric neurosurgeons in the state and women in Statesboro often wait 6-9 months for a routine mammogram); *Illinois*, <http://www.ama-assn.org/ama/pub/category/print/12386.html> (last visited Apr. 20, 2006) (reporting that since 2003, in two counties alone (St. Clair and Madison), 160 physicians have left); *Kentucky*, <http://www.ama-assn.org/ama/pub/category/print/12387.html> (last visited Apr. 20, 2006) (noting that from 2000 to 2002, the state lost more than 1,200 physicians, nearly one-third to other states and one-third to retirement); *Massachusetts*, <http://www.ama-assn.org/ama/pub/category/print/12391.html> (last visited Apr. 20, 2006) (stating that 68% of emergency medicine specialists, 64% of neurosurgeons and 64% of OB-GYNs practice defensive medicine); *Mississippi*, <http://www.ama-assn.org/ama/pub/category/print/12388.html> (last visited Apr. 20, 2006) (“Missouri ranks 50 out of 51 states and the District of Columbia for the number

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The expense of defensive medicine has trickled down to consumers in increases in health care costs.⁴⁸ Last year marked the

of physicians (152) per 100,000 patients. The national average is 230.”); *Missouri*, <http://www.ama-assn.org/ama/pub/category/print/12389.html> (last visited Apr. 20, 2006) (noting that more than 30 insurance companies were licensed to write liability insurance for doctors two years ago but currently, only 3 are willing or able); *Nevada*, <http://www.ama-assn.org/ama/pub/category/print/12390.html> (last visited Apr. 20, 2006) (“OB-GYNs in the Las Vegas area pay as much as \$141,000 per year in liability insurance premiums while an OB-GYN in Los Angeles can expect to pay about \$60,000.”); *New Jersey*, <http://www.ama-assn.org/ama/pub/category/print/12391.html> (last visited Apr. 20, 2006) (stating that liability insurance has increased 203% from 1999); *New York*, <http://www.ama-assn.org/ama/pub/category/print/12392.html> (last visited Apr. 20, 2006) (“New York is considered a ‘Red Alert’ state by the American College of Obstetricians and Gynecologists, which found that 67% of OB-GYNs have been forced to restrict their practice (including no longer delivering babies or performing gynecological surgery), retire or relocate to another state.”); *North Carolina*, <http://www.ama-assn.org/ama/pub/category/print/12393.html> (last visited Apr. 20, 2006) (noting that hospitals have had insurance premiums increase 400% to 500% in the past three years); *Ohio*, <http://www.ama-assn.org/ama/pub/category/print/12394.html> (last visited Apr. 20, 2006) (“Ohio ranked among the top five states for premium increases in 2002.”); *Oregon*, <http://www.ama-assn.org/ama/pub/category/print/12395.html> (last visited Apr. 20, 2006) (noting that 43.4% neurosurgeons, 27.1% orthopedic surgeons and 23.5% of OB-GYNs are practicing defensive medicine); *Pennsylvania*, <http://www.ama-assn.org/ama/pub/category/print/12396.html> (last visited Apr. 20, 2006) (“A good example of Pennsylvania’s lawsuit culture came in early 2004 when juries returned \$15 million and \$20 million verdicts on the same day.”); *Rhode Island*, <http://www.ama-assn.org/ama/pub/category/15061.html> (last visited Apr. 20, 2006) (“Forty-nine percent of Rhode Island physicians say that increasing medical professional liability costs have caused them to discontinue or consider discontinuing certain services. Forty-eight percent of the physicians responding to the same survey said liability costs forced them to consider leaving Rhode Island or clinical practice”); *Tennessee*, <http://www.ama-assn.org/ama/pub/category/print/15981.html> (last visited Apr. 20, 2006) (stating that of Tennessee’s 95 counties: 81 counties have no residing neurosurgeon, 49 counties have no residing orthopedic surgeon, 47 counties have no residing emergency physician and 42 counties have no residing OB-GYN); *Washington*, <http://www.ama-assn.org/ama/pub/category/print/12398.html> (last visited Apr. 20, 2006) (noting that the Washington Supreme Court recently overturned the cap on the non-economic damages portion of the state’s tort reform law. As a result, in 47 cases where the total amount awarded by juries was \$80.1 million and \$61.1 million represented non-economic damages, \$53.5 million would have been saved if the invalidated \$250,000 cap on non-economic damages were applied); *West Virginia*, <http://www.ama-assn.org/ama/pub/category/print/12399.html> (last visited Apr. 20, 2006) (noting that 94% of West Virginia doctors have changed the way they practice medicine because of litigation concerns); *Wyoming*, <http://www.ama-assn.org/ama/pub/category/print/12400.html> (last visited Apr. 20, 2006) (“Wyoming’s physician/population ratio ranks 47th out of 50 states, which makes every physician incredibly valuable.”). It is interesting to note that California is consistently noted as having the lowest insurance premium rates, even in high-risk practice areas. However, even though many scholars attribute such rates to California’s medical malpractice legislation providing caps on non-economic damage awards, premiums did not fall and stabilize until the state’s regulation of the insurance industry. See Adam D. Glassman, *The Imposition of Federal Caps in Medical Malpractice Liability Actions: Will They Cure the Current Crisis in Health Care?*, 37 AKRON L. REV. 417, 459 (2004).

⁴⁸ See U.S. GAO: IMPLICATIONS OF RISING PREMIUMS, *supra* note 33, at 11. Practices including the utilization by physicians of certain diagnostic tests or procedures primarily to reduce their exposure to malpractice liability add to the costs of health care.

seventh consecutive year that premiums increased faster than overall inflation and wage gains.⁴⁹ According to the Kaiser Family Foundation and the Health Research and Educational Trust,⁵⁰ premiums for employer-sponsored health insurance rose by 9.2% in 2005—about three times inflation and growth in workers' earnings.⁵¹ In 2005, average annual premiums for employer-sponsored coverage reached \$10,880 for family coverage and \$4,024 for individual coverage.⁵² Since 2000, premiums for family coverage have increased by 73%, compared with inflation growth of 14% and wage growth of 15%.⁵³

B. The Cause of the Crisis

What factors are responsible for skyrocketing health costs? Doctors and insurance companies allege that the single most important factor behind the increase in insurance rates and the general increase in health care⁵⁴ is the medical malpractice tort infrastructure—what has been described as “a rapidly growing in-

⁴⁹ KAISER FAMILY FOUNDATION AND HEALTH RESOURCE AND EDUCATIONAL TRUST, EMPLOYER HEALTH BENEFITS 2005 ANNUAL SURVEY (2005), <http://www.kff.org/insurance/7315/upload/7315.pdf>. In 1999, premiums for employer-sponsored health insurance rose 5.3%, faster than overall inflation (2.3%) and wage gains (3.6%). In 2000, premiums increased 8.2%, faster than overall inflation (3.1%) and wage gains (3.9%). In 2001, the first year of double-digit increases, premiums increased 10.9%, faster than overall inflation (3.3%) and wage gains (4.0%). In 2002, premiums rose by 12.9%, much faster than overall inflation (1.6%) and wage gains (2.6%). In 2003, premiums increased by 13.9%, which once again was much faster than overall inflation (2.2%) and wage gains (2.9%). In 2004, premiums increased by 11.2%, which was lower than the increase in 2002, but still a double-digit increase, and faster than overall inflation (2.3%) and wage gains (2.2%). *See id.* Whereas employer-sponsored health insurance provides coverage for 160 million Americans, reaching nearly three of every five of the nonelderly, nearly 46 million Americans are still uninsured. *See id.*; National Coalition on Health Care, *Facts on the Cost of Health Care*, <http://www.nchc.org/facts/cost.shtml> (last visited Apr. 19, 2006).

⁵⁰ The Henry J. Kaiser Family Foundation is a non-profit, private operating foundation focusing on the major health care issues facing the nation. The Kaiser Family Foundation is not associated with Kaiser Permanente or Kaiser Industries, a major supplier of insurance in California, Colorado, Georgia, Hawaii, Maryland, Virginia, Washington, DC, Ohio, Oregon and Washington state. The Foundation develops and runs its own research and communications programs to provide reliable information in a complex health care system to policymakers, the media, the health care community, and the general public.

⁵¹ *See* KAISER FAMILY FOUNDATION AND HEALTH RESOURCE AND EDUCATIONAL TRUST, *supra* note 49. Premiums rose by 9.2%, lower than in previous years, but nevertheless, faster than overall inflation (3.5%) and wage gains (2.7%).

⁵² *See id.*

⁵³ *See id.*

⁵⁴ A U.S. Department of Health and Human Services report says that medical liability adds billions to the cost of health care each year. U.S. DEPT HEALTH AND HUMAN SERVS., ADDRESS-

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come-transfer system from doctors to lawyers.”⁵⁵ The American Medical Association has referred to the tort litigation system as a “‘lawsuit lottery,’ where a few patients and their lawyers receive astronomical awards and the rest of society pays the price.”⁵⁶ The average cost of defending a medical malpractice claim can range from \$25,000 to \$250,000 and about 70% of claims end with no payment to the plaintiff, which shows “the degree to which substantial economic resources are being squandered on fruitless legal wrangling—resources that could be used to reduce health costs so that more Americans could find health insurance.”⁵⁷

A recently released study found that over twenty-eight years since 1975, when they were first identified separately, medical malpractice cost increases have outpaced other tort areas, rising at an average of 11.8% a year, compared to 9.2% for all other tort costs.⁵⁸ In terms of monetary awards, medical malpractice jury awards increased 300% between 1994 and 2001.⁵⁹ In 1994, the median jury award was \$1 million.⁶⁰ By 2001-2002, 52% of all awards for medical negligence cases were for \$1 million or more,⁶¹ with the average award reaching \$6.25 million.⁶² Furthermore, seven of the top twenty jury awards given in 2001 and 2002 were related to

ING THE NEW HEALTH CARE CRISIS: REFORMING THE MEDICAL LITIGATION SYSTEM TO IMPROVE THE QUALITY OF HEALTH CARE 11 (2003).

⁵⁵ Stailey, *supra* note 24, at 193, *citing* Devra Marcus, *I'm a Doctor, Not an Adversarial Unit of the Health Care Industry*, WASH. POST, Mar. 16, 2003, at B2.

⁵⁶ *Medical Liability Reform Hearings*, *supra* note 24 (testimony of Donald J. Palmisano, M.D., J.D., Immediate Past President of the AMA).

⁵⁷ *Id.*; *see also infra* text accompanying note 80. *But see* Douglas W. Taylor, *Assessment and Plan for Medical Malpractice: Quality Improvement Through Mediation*, 6 DEPAUL J. HEALTH L. 343, 348 (2003).

⁵⁸ *See* INS. INFO. INST., *supra* note 23 (contrasting data from the study released in early January 2005 by Towers Perrin, named “US Tort Costs: 2004 Update”). The study also noted that in 2003, medical malpractice costs, at almost \$27 billion, cost each American an average \$91 a year. This compares with \$5 a year in 1975.

⁵⁹ Dr. Robert P. Hartwig, *Trends in Medical Malpractice Insurance: Behind the Chaos*, INS. INFO. INST., Apr. 23, 2003, <http://www.iii.org/media/presentations/medmal/> (citing from a presentation given by Dr. Hartwig, Ph.D., CPCU, Senior Vice President and Chief Economist at the Insurance Information Institute to American Academy of Orthopedic Surgeons in Washington, DC on April 23, 2003. Dr. Hartwig cites data from Jury Verdict Research and the Insurance Information Institute).

⁶⁰ Stailey, *supra* note 24, at 194, *citing* Grace Vandecruze, *Has the Tide Begun to Turn for Medical Malpractice?* 15 HEALTH LAW. 15 (Dec. 2002).

⁶¹ Donald J. Palmisano, M.D., J.D., *Health Care in Crisis: The Need for Medical Liability Reform*, 5 YALE J. HEALTH POL'Y L. & ETHICS 371, 372-73 (2005) (citing statistics from JURY VERDICT RESEARCH, CURRENT AWARD TRENDS IN PERSONAL INJURY 18, 43 (43d ed. 2004)).

⁶² *See* INS. INFO. INST., *supra* note 23 (citing data from research done by Jury Verdict Research).

medical liability and totaled a cost of \$3 billion.⁶³ It is this by-product of the litigation system that the American Medical Association, other doctors' groups, and insurance companies argue is the most important factor contributing to the medical malpractice crisis.⁶⁴

III. LITIGATION: THE TRADITIONAL FORUM

"Litigation is the traditional means of resolving medical malpractice disputes."⁶⁵ "As such, it is the standard against which all other forms of dispute resolution must be measured."⁶⁶

A. Strengths of Litigation

One of the strengths commonly associated with litigation is that litigation fulfills an important role in the emotional aspect of dispute resolution.⁶⁷ Specifically, litigation satisfies the plaintiff's need for vindication because he/she feels that he/she has been wronged.⁶⁸

⁶³ Hartwig, *supra* note 59. The awards are as follows: in 2001, a \$312.8 million award where the issue concerned a Texas nursing home, a \$114.9 million and a \$107.8 million award in medical malpractice suits in New York; and in 2002, a \$2.4 billion award in a pharmacy malpractice suit in Missouri, a \$95.2 million and a \$80 million award involving baby injuries in New York, and another \$91 million award in a medical malpractice suit in New York. Dr. Hartwig cites data from the January 2002 and January 2004 Lawyers Weekly USA.

⁶⁴ See *Medical Liability Reform Hearings*, *supra* note 24 (testimony of Donald J. Palmisano, M.D., J.D., Immediate Past President of the AMA).

⁶⁵ David T. Caldon, *Medical Malpractice Disputes in the Age of Managed Care*, <http://www.mediate.com/articles/caldon.cfm> (last visited Apr. 19, 2006); see also Catherine T. Struve, *Doctors, The Adversary System, and Procedural Reform in Medical Liability Litigation*, 72 *FORDHAM L. REV.* 943, 950 (2004) (explaining that the frequency of medical malpractice suits rose markedly beginning in the 1830's and 1840's due to a combination of medical and social factors, among them an increased tolerance for litigation).

⁶⁶ Caldon, *supra* note 65. Caldon also notes that "if, in fact, one cannot improve (either in terms of judicial fairness or fiscal economy) upon its tried and accepted methods of resolving disputes then there is no reason to proceed." *Id.*

⁶⁷ See *id.*

⁶⁸ See *id.*; see also Allen K. Hutkin, *Resolving The Medical Malpractice Crisis: Alternatives to Litigation*, 4 *J. L. & HEALTH*, 21, 30 (1990) (explaining that when medical complications or unexpected results occur, physicians generally make themselves unavailable. This often times angers patients and causes them to look elsewhere for answers. The patient may seek assistance from an attorney. As the physician-patient relationship falters, the attorney-client relationship strengthens). The wronged party would seek the public forum of litigation for two reasons. First, the more publicity the case receives, the more likely the negligent provider would be investigated by the proper authorities and the state medical review board. Secondly, the attention

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When one has been injured, it is not uncommon to hear expressions such as “I’m going to slap him with a lawsuit,” or “I’m going to drag her into court and take her for everything she is worth.” While it may be more desirable, it would not be natural for a person who has been wronged to respond by saying: “I can’t wait to arbitrate or mediate this dispute.” Whether or not it is right, litigation certainly fulfills a basic human need to be heard.⁶⁹

There are also real pragmatic benefits derived from litigating a medical malpractice dispute.⁷⁰ One benefit is that litigation permits for the development of binding precedent.⁷¹ HMOs limit treatment options to those considered “standard.” Therefore, it is common that new therapies, labeled “experimental,” will be denied HMO coverage.⁷² If all disputes are resolved through the use of a private venue such as arbitration and mediation,⁷³ unprecedented decisions compelling an HMO to pay for experimental medical treatment cannot become the standard, or generally accepted, practice of tomorrow.⁷⁴

Lastly, while the procedural aspects of litigation are often cited as being time-consuming and expensive, litigation may offer protection to disempowered parties.⁷⁵ When there exists a dispar-

generated by the publicity of large trials will serve to alert the public at larger the potential danger of a repeat offender. See Caldon, *supra* note 65.

⁶⁹ Caldon, *supra* note 65. This is not just based on anecdotal evidence. Edward A. Dauer, *Apology in the Aftermath of Injury: Colorado’s “I’m Sorry” Law*, 34 *COLO. LAW* 47, 48 (2006). This is why the use of apology in mediation programs such as Chicago’s Rush-Presbyterian-St. Luke’s Medical Center and Philadelphia’s Drexel University are successful. The focus of their programs is an apology. See *infra* discussion Part VI.C.

⁷⁰ See Caldon, *supra* note 65.

⁷¹ See *id.*; see also Lee Korland, *What an Arbitrator Should Investigate and Disclose: Proposing a New Test for Evident Partiality Under the Federal Arbitration Act*, 53 *CASE W. RES.* 815, 818 (2003) (noting that a disadvantage of arbitration, and alternative dispute resolution in general, is the lack of binding precedent).

⁷² See American Private Physicians Association, *Ten Questions You Should Answer Before Joining an HMO*, <http://www.privatemd.com/10qhmo.htm> (last visited Feb. 6, 2004) (explaining that experimental treatments are usually not available until they are used elsewhere routinely. “Cutting-edge” technology requires the patient to pay out of pocket).

⁷³ See, e.g., Korland, *supra* note 71, at 818. For some parties, a private dispute resolution forum may be preferable to a public form.

⁷⁴ See Caldon, *supra* note 65. Legal precedent governing what treatments must be covered by insurance contracts assist the consumer. Thus, each time an insured requires a new or costly procedure, they won’t be forced to arbitrate or mediate the matter in a jurisdiction devoid of ruling precedent. When the law is developed with binding precedent from previous decisions, the insurer might simply provide the service rather than spend legal fees to litigate a matter it would certainly lose.

⁷⁵ See *id.*

ity of power among the parties, the weaker party may be disadvantaged by the insufficient opportunity for full discovery in conjunction with relaxed rules of evidence in alternative dispute resolution.⁷⁶ In such circumstances, the litigation forum would allow the parties to uncover certain records or other information that may not be made available in arbitration or mediation.⁷⁷

B. Weaknesses of Litigation

Notwithstanding the benefits of litigation, the general consensus today,⁷⁸ both within the legal community and within the public at large, is that litigation is often not the best forum to resolve medical malpractice disputes.⁷⁹ The most commonly cited problem with litigation is the high costs associated with the process. The average cost of medical malpractice litigation for both parties range from approximately \$25,000 to \$45,000 on the low end of the spectrum to as high as \$150,000 to \$250,000.⁸⁰ Additionally, as much as a decade may elapse by the time the trial is concluded.⁸¹ The accumulation of attorney contingent fees, court costs, expert witness costs, and other “overhead” costs, can consume as much as

⁷⁶ See generally Korland, *supra* note 71, at 818. Other procedural disadvantages include no written opinions regarding the resolution of the matter and no uniformity of decisions.

⁷⁷ See Caldon, *supra* note 65.

⁷⁸ See *id.*; Rita Lowery Gitchell & Andrew Plattner, *Mediation: A Viable Alternative to Litigation*, 2 DEPAUL J. HEALTH CARE L. 421, 423 (1999) (“Mediation is a win-win situation”); see also *infra* text accompanying notes 148, 157. See generally *infra* discussion Parts V.A, V.B.

⁷⁹ See Caldon, *supra* note 65.

⁸⁰ Kelly K. Meadows, *Resolving Medical Malpractice Disputes in Massachusetts: Statutory and Judicial Initiatives in Alternative Dispute Resolution*, 4 SUFFOLK J. TRIAL & APP. ADVOC. 165, 167 (1999) (citing the lower end of the range); Taylor, *supra* note 57, at 348 (highlighting information from the DePaul Journal of Health Care Law Symposium where Robert Clifford and E. Michael Kelly, both prominent figures in the practice of medical malpractice cases in Chicago as plaintiff’s counsel and defense counsel were panelists. Both counsel estimated the higher range to adequately represent a client in court for a medical malpractice claim. However, panelists at the symposium concluded that such a cost was certainly limiting the types of cases filed, such that only those cases that were more likely to be awarded large amounts of compensation were ever given the opportunity to be taken to trial; see also Thomas B. Metzloff, *Resolving Medical Malpractice Disputes; Imaging the Jury’s Shadow*, 54 LAW & CONTEMP. PROBS. 43, 54, 59 (1991) (concluding that since attorneys for both plaintiffs and defendants engage in similar pre-trial preparations, it is reasonable to assume relative equality in costs); Thomas B. Metzloff, *Alternative Dispute Resolution Strategies in Medical Malpractice*, 9 ALASKA L. REV. 429, 433 (1992) (explaining that although the majority of medical malpractice lawsuits are settled, these settlements take place “on the courthouse steps,” when the litigation expenses have already been spent).

⁸¹ See Meadows, *supra* note 80, at 167.

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40% to 50% of the compensation.⁸² Thus, even if at the conclusion of the trial there is a large award for the injured patient, a large percentage of the award never reaches the patient.

An often neglected side-effect of the traditional system is the adversarial effect of the resolution process on the relationship between the doctor and patient.⁸³ Litigation can destroy the doctor-patient relationship.⁸⁴ With the prevalence of HMOs and managed care, the need to preserve the doctor-patient relationship has become more significant.⁸⁵ When both the plaintiff and the defendant suffer the psychological consequences of protracted litigation,⁸⁶ it is unlikely that the doctor-patient relationship will survive the litigation.⁸⁷ Unfortunately, if employees are locked into their providers as part of their employment contract,⁸⁸ litigation may not provide the emotional closure needed to move forward in that relationship.⁸⁹ "Litigation may soothe the patient's anger, but it cannot eliminate it."⁹⁰

Finally, a major criticism of the use of litigation to resolve medical malpractice disputes is that it requires lay people to make factual findings and legal conclusions about highly technical is-

⁸² See *Medical Liability Reform Hearings*, *supra* note 24 (testimony of Donald J. Palmisano, M.D., J.D., Immediate Past President of the AMA); see also William Sage, *Unfinished Business: How Litigation Relates to Health Care Regulation*, 28 J. HEALTH POL. POL'Y & L. 387, 392 (2003). Similarly, a claim for nominal damages may face higher transaction costs. An attorney would probably be unwilling to take on a lawsuit that will not yield a judgment large enough to cover his costs of litigating the claim. At the conclusion of the trial, a substantial percentage of the award may be used to pay off fees. And the party's attempt to litigate his claim will have cost him considerable time, money and emotional energy. See *Meadow*, *supra* note 68, at 167.

⁸³ See Scott Forehand, *Helping the Medicine Go Down: How a Spoonful of Mediation Can Alleviate the Problems of Medical Malpractice Litigation*, 14 OHIO ST. J. ON DISP. RESOL. 907, 909 (1999).

⁸⁴ See *id.* Alternatives to the "shut up and fight" risk model in litigation, such as the Sorry Works! program and other apology-based mediation programs, are becoming widespread. See *infra* text accompanying note 220; *infra* discussion Part VI.C.

⁸⁵ See *Caldon*, *supra* note 65.

⁸⁶ See *Meadows*, *supra* note 80, at 167.

Doctors who have been accused of malpractice often perceive a negligence claim as an allegation of near criminal conduct. Likewise, plaintiffs who have been seriously injured are often highly emotional and in need of a process less formal than litigation in which they can discharge emotions, ask questions, and sometimes just be able to pose questions for which there may not be an answer.

Caldon, *supra* note 65.

⁸⁷ See *Caldon*, *supra* note 65.

⁸⁸ See *id.*

⁸⁹ See *Meadows*, *supra* note 80, at 168.

⁹⁰ *Hutkin*, *supra* note 68, at 31.

sues.⁹¹ Juries often face the difficult task of assessing the credibility of conflicting expert testimony.⁹² The juries' undertaking becomes more daunting when "hired guns," compelled by the adversarial pressure of the litigation system, exaggerate or distort their testimony to support the position of those who retained them.⁹³

Given its role in exacerbating the medical malpractice crisis and for the reasons cited *supra*, litigation is not the most effective means to resolve medical malpractice disputes.

IV. THE RISE AND FALL OF ARBITRATION

During the tort reform movement of the 1980's, a majority of the states adopted statutes mandating binding arbitration in hopes of alleviating the delay, expense and vexation⁹⁴ associated with the

⁹¹ See Caldon, *supra* note 65. It has been argued that the process of *voir dire*, in which jurors are questioned and then selected based upon their responses, is designed to minimize the likelihood of better educated, more technically sophisticated individuals serving on juries. In combination with the fact that medical malpractice trials are lengthy and jury service does not offer a high level of compensation, better educated, higher-income persons may choose to opt-out of jury duty due to lack of time and to avoid economic loss. *See id.* A recommended reform to overcome this problem is the implementation of special juries. Special juries are, generally speaking, comprised of individuals "specially qualified to hear, understand, and weigh evidence." *See* Patrick Devlin, *Jury Trial of Complex Cases: English Practice at the Times of the Seventh Amendment*, 80 COLUM. L. REV. 43, 80 (1980). However, despite their widespread use in the first-half of the twentieth century, the utilization of special juries began to dwindle during the latter half of the century. *See* Rita Sutton, Note, *A More Rational Approach to Complex Civil Litigation in the Federal Courts: The Special Jury*, 1990 U. CHI. LEGAL F. 575, 580 (1990). Today, only Delaware maintains a special jury statute. *See* DEL. CODE. ANN. tit. 10, § 4506 (2005).

⁹² *See* Jody Weisberg Menon, *Adversarial Medical and Scientific Testimony and Lay Jurors: A Proposal for Medical Malpractice Reform*, 21 Am. J.L. & Med. 281, 285 (1995).

Assessing the credibility of testimony of conflicting expert witnesses may be extremely difficult for lay jurors who have no general knowledge of the field to guide their judgments about which expert's version seems correct; having "partisan experts . . . frequently operates to confuse the . . . jury rather than to inform." This problem leads to further concerns about juror competency.

Id.

⁹³ *See id.* at 286. There are experts that have been publicly perceived and decried as "hired guns" who find it financially or otherwise profitable to leave ethics aside and provide whatever testimony may be needed. Historically, medical experts disdained their role in the courts and maligned their peers for their participation as expert witnesses, especially when testifying against another doctor. This led to a difficulty in obtaining skilled experts who were willing to testify against colleagues. Furthermore, experts were criticized for being prone to the same cognitive biases, including outcome bias and sympathy bias, as jurors. It follows that if lay jurors rely on experts with skewed opinions, this is likely to exacerbate the problems they already face in evaluating the testimony.

⁹⁴ The reasons commonly cited to resolve medical malpractice disputes through arbitration include the parties' abilities to control the procedure, the ability to select the arbitrator or ex-

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litigation system. Arbitration differs from litigation in one principal way: the judge is replaced by an arbitrator, or a panel of arbitrators.⁹⁵ Compulsory arbitration raised serious issues, including violation of the Equal Protection clause of the Fourteenth Amendment of the U.S. Constitution, and provisions in many state constitutions guaranteeing the separation of legislative and judicial powers, the right to a jury trial and the right to court access.⁹⁶ To redress such concerns, state legislatures superseded mandatory arbitration provisions with voluntary arbitration provisions.⁹⁷ But

pert, reduced costs, shortened time to resolve the dispute, finality of the decision, privacy, reduced emotional trauma of litigation, and self autonomy through the ability to contract and resolve disputes outside of the courts. See Ann H. Nevers, J.D. L.L.M., *Medical Malpractice Arbitration in the New Millennium: Much Ado About Nothing?*, 1 PEPP. DISP. RESOL. 45, 49 (2000). However, even those within the alternative dispute resolution arena believe that arbitration does not alleviate the concerns inherent in the litigation system, but simply replaces a judge with an arbitrator. See *id.* at 50. In addition, “a study performed by the United States General Accounting Office concluded that the costs of arbitration and conventional litigation are virtually the same.” Brian P. Rosander, Note, *Medical Malpractice in Utah: A Plea for Greater Fairness and Equal Bargaining Positions*, 2005 UTAH L. REV. 969, 972 (2005).

⁹⁵ See Thomas B. Metzloff, *The Unrealized Potential of Malpractice Arbitration*, 31 WAKE FOREST L. REV. 203, 204 (1996) (discussing that arbitration, unlike other alternative dispute resolution mechanisms, is not a process designed to promote voluntary settlement. “Rather, it is an alternative method of reaching a decision on the merits of the case.”). Simply, the dispute is referred to an arbitrator or arbitrators chosen by the parties to the dispute who agree in advance to abide by the arbitrator’s or arbitrators’ award issued after a hearing at which both parties have an opportunity to be heard. See Buckner, *supra* note 20, at 311.

⁹⁶ See Morris B. Hoffman, *The Constitution of Mandatory Arbitration*, 18 COLO. LAW. 455 (1989).

⁹⁷ See National Conference of State Legislatures, *State Medical Malpractice Tort Laws: Section 2*, at <http://www.ncsl.org/standcomm/sclaw/statelaws2.htm> (last visited Apr. 18, 2006) [hereinafter *State Medical Malpractice Tort Laws: Section 2*] (presenting the tort laws of every state). The report notes that Alabama, Alaska, Arkansas, California, Colorado, Florida, Georgia, Iowa, Kentucky, Louisiana, Michigan, Mississippi, Montana, Ohio, Rhode Island, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, and West Virginia have provisions providing for voluntary arbitration. See *id.*; see also ALA. CODE § 6.5.485 (LexisNexis 2005); ALASKA STAT. § 09.55.535 (2006); ARK. CODE ANN. § 16-7-102 (West 2006); CAL. CIV. PRO. CODE § 1295 (West 2006); COLO. REV. STAT. ANN. §§ 13-22-201—223 (West 2005); FLA. STAT. ANN. § 766.207 (2005); GA. CODE ANN. §§ 9.9.61—63 (West 2006); IOWA CODE ANN. § 679A.1 (West 2005); KY. REV. STAT. ANN. § 417.050 (West 2006); LA. REV. STAT. ANN. § 9.4231 (2006); MISS. CODE ANN. § 11-15-1 (West 2006); MONT. CODE ANN. §§ 27.6.101—704 (2005); OHIO REV. CODE ANN. § 2711.01 (LexisNexis 2006); R.I. GEN. LAWS §§ 10-3-1—21 (2006); S.D. CODIFIED LAWS §§ 21-25B-1—26 (2006); TENN. CODE ANN. §§ 29-5-101—119 (West 2005); TEX. CIV. PRAC. & REM. CODE ANN. § 74.451 (Vernon 2005); UTAH CODE ANN. § 78-14-12—16 (West 2006); VT. STAT. ANN. tit. 12, § 7002 (2006); VA. CODE ANN. § 8.01-581.12 (2006); W. VA. CODE ANN. § 55-10-1 (LexisNexis 2006). Florida has enacted a statute that provides that a court may require arbitration but it will be non-binding. See FLA. STAT. ANN. § 766.107 (2005). Michigan’s statute provides for voluntary arbitration if damages claimed are less than \$75,000. See MICH. COMP. LAWS ANN. § 600.2912(g) (West 2006). On the other hand, there are states that mandate arbitration. For instance, in Maryland, all claims must be filed with the Director of Health Claims

these provisions, intended to facilitate arbitration, created detailed requirements that remain a barrier to arbitration, and empirical research has shown that these statutes have not increased the incidence of medical malpractice arbitration.⁹⁸ Additionally, and what is most compelling is, these voluntary arbitration provisions still provoke criticism that they violate patients' fundamental rights.

A. Medical Malpractice Arbitration Contracts: Contracts of Adhesion

Medical malpractice arbitration agreements, typically drafted in standard boilerplate form by lawyers who are duty bound to protect the interests of the health care provider,⁹⁹ have been attacked on the grounds that they are unconscionable adhesion contracts.¹⁰⁰

Arbitration Office but there can be unilateral waiver of arbitration. *See* MD. CODE ANN., CTS. & JUD. PROC. §§ 3-2A-04, 3-2A-05, 3-2A-06B (West 2006). Hawaii mandates non-binding arbitration for all cases involving \$150,000 or less. *See* HAW. REV. STAT. ANN. § 601-20 (LexisNexis 2005). In Illinois, arbitration may be court-ordered for cases totaling less than \$50,000, and in New Jersey, the statute mandates arbitration of medical claims under \$20,000, but voluntary arbitration for claims over \$20,000.00 *See* 735 ILL. COMP. STAT. ANN. 5/2-1001A (West 2005); N.J. REV. STAT. § 2A:23A-20 (2006). Lastly, in New York, if liability is conceded, either party may call for arbitration of damages amounts. *See* N.Y. C.L.S. C.P.L.R. § 3045 (McKinney 2006).

⁹⁸ Nevers, *supra* note 94, at 50.

⁹⁹ Rosander, *supra* note 94, at 978.

¹⁰⁰ Nevers, *supra* note 94, at 55. An adhesion contract is defined as a standardized contract form offered to a consumer on a take it or leave it basis without affording the consumer a realistic opportunity to bargain so that the consumer does not have a choice to accept or refuse it. Consider the case of *Broemmer v. Abortion Services of Phoenix*, an Arizona Supreme Court case, which is a good example of a court declaring an arbitration clause unenforceable because it was a contract of adhesion. In *Broemmer*, the plaintiff was a twenty-one-year-old unmarried woman who was 16 to 17 weeks pregnant. She was an Iowa resident, earning less than \$100 per week and had no medical benefits. Her mother made an appointment for her with Abortion Services of Phoenix. When she arrived at the clinic, she was instructed to fill out three forms before she could be seen. One of the forms was an arbitration agreement noting that the arbitrators would be obstetricians and gynecologists. During the procedure, the plaintiff's uterus was perforated. About 18 months later, the plaintiff filed a malpractice suit. The defendants argued that the Court had no jurisdiction because the contract required arbitration. The case eventually reached the Arizona Supreme Court. The Arizona Supreme Court stated that the enforceability of an arbitration agreement is governed by general contract law. Under that law, an adhesion contract is defined as a standardized form offered to consumers of goods and services on a "take it or leave it" basis without affording the consumer a realistic opportunity to bargain, and under such conditions that the consumer cannot obtain the desired goods or services except by acquiescing in the form contract. The weaker party typically has no choice as to the contract terms. The Court found the contract in this case possessed all the characteristics of an adhesion contract. Such a contract is not enforceable if it does not fall within the reasonable expectations of the weaker party or if it is unconscionable. The Court held that the fact the only arbitrators permitted were obstetricians and gynecologists led to the conclusion the contract fell outside the

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In the age of managed care, a contract with an HMO or a health care provider is almost always nonnegotiable and is presented on a “take-it-or-leave-it-basis,” which entirely removes the patient from the negotiation process.¹⁰¹ However, that does not make the agreement per se unenforceable. An arbitration agreement becomes unenforceable if the terms of the agreement are substantively unconscionable¹⁰² and/or if formation of the agreement was procedurally unconscionable.¹⁰³

Substantive unconscionability occurs in two common pre-dispute situations: (1) when a patient, before medical care is provided, signs the contract, agreeing that arbitration will be the sole dispute resolution remedy, and waiving the right to a jury trial and access to the courts;¹⁰⁴ or (2) when an employer negotiates a group contract for its employees, agreeing to mandatory arbitration as a condition of coverage, or as an acceptable trade-off for a reduction in the cost of the insurance.¹⁰⁵ In the first situation, courts have held that patients cannot waive fundamental rights before the patient

plaintiff's expectations and the arbitration agreement was unenforceable. *See* Fillmore Buckner, *supra* note 20, at 314-15. *See generally* Broemmer v. Abortion Services of Phoenix, 840 P.2d 1013, 1014, 1016-17 (Ariz. 1992).

¹⁰¹ Rosander, *supra* note 94, at 979. Note that in California, where the arbitration reform movement commenced, the percentage of physicians using binding arbitration agreements is increasing. A 1990's Rand survey that asked California physicians, hospitals and HMOs about the prevalence of arbitration agreements found that only 9% of the hospitals and 9% of physicians used arbitration agreements. *See* Nevers, *supra* note 94, at 51. However, of those physicians using arbitration agreements, over 60% had adopted them since 1990. *See id.* With the rise of HMOs such as Kaiser Permanente, which provides over 36% of the HMO market (and 12% of the current national HMO membership), health plan participants are routinely subject to a mandatory arbitration program. *See* California Nurses Association, *Corporate Healthcare – For Profit, Not for Profit, or Not for Patients: Kaiser Permanente*, available at <http://www.kaiserpapersnorthwest.org/kaiserwatch.htm> (last visited Feb. 12, 2005); *see also* Juris Publications, Inc., *The Reformation of Kaiser Permanente's Arbitration System*, 13 *WORLD ARB. & MEDIATION REP.* 233, 233 (2002).

¹⁰² Substantive unconscionability takes into account the relative fairness of the obligations assumed and the contents of the agreement (ie. the terms or provisions). When determining whether a contract is substantively unconscionable, the court looks at “whether the terms are so one-sided as to oppress and unfairly surprise an innocent party, whether there exists an overall imbalance in the obligations and rights imposed by the bargain, or whether there is significant cost-price disparity.” Rosander, *supra* note 94, at 981.

¹⁰³ Procedural unconscionability focuses on the formation of the arbitration agreement. It considers “the manner in which [it] was negotiated and the circumstances of the parties.” Procedural unconscionability generally falls within two categories: lack of voluntariness and lack of knowledge. When determining whether a contract is procedurally unconscionable, courts will consider “whether the weaker party had an absence of meaningful choice while the stronger party was given unreasonably favorable terms.” Rosander, *supra* note 94, at 982.

¹⁰⁴ Rosander, *supra* note 94, at 981.

¹⁰⁵ *Id.* at 982.

knows the facts and circumstances of the dispute¹⁰⁶ and in the second situation, courts have insisted that in order for patients to waive any fundamental rights, there must be a knowing, voluntary, and intelligent waiver.¹⁰⁷ A number of states have prohibited predispute medical arbitration agreements as a matter of law because they violate public policy.¹⁰⁸

Procedural unconscionability can be exemplified by the following scenario: “A medical arbitration agreement is presented to the patient minutes before surgery, in a rushed and hurried manner, on a standard boilerplate form, without any verbal explanation.”¹⁰⁹ Here, courts have held that there was no “real and voluntary meeting of the minds” and the arbitration agreement was procedurally unconscionable.¹¹⁰

B. Constitutional Dilemmas of Medical Malpractice Arbitration

After the repeal of mandatory arbitration legislation, voluntary binding arbitration remains controversial because critics argue that

[A]rbitration violates due process on grounds of substantive due process, when medical malpractice litigants are treated differently than other litigants because of the arbitration agreement, or on grounds of procedural due process, when parties are re-

¹⁰⁶ *Id.* at 981.

¹⁰⁷ See Buckner, *supra* note 20, at 315. In *Sanchez v Sirmons*, 467 N.Y.S.2d 757 (N.Y. Sup. Ct. 1983), the court interpreted the arbitration clause in the defendant’s “Consent to Abortion” form to be unenforceable. The court found that the arbitration agreement was concealed in the defendant’s waiver and held it invalid. The court held that the arbitration agreement would have been enforceable if it was on a separate sheet of paper with distinctive large bold-type alerting the patient that she was giving up her right to litigate a medical malpractice suit before a jury. Additionally, the patient must be afforded a reasonable time to reflect and deliberate whether she should revoke the arbitration agreement after it is executed. See *Sanchez*, 467 N.Y.S.2d at 760-61.

¹⁰⁸ Rosander, *supra* note 94, at 981. In 2003, the American Arbitration Association, the world’s largest provider of ADR services, announced that it would no longer administer cases involving patients who signed a predispute arbitration agreement. The AAA decision’s was a response to the fundamental unfairness of preinjury agreements. India Johnson, AAA’s senior vice president, said the decision was driven by the fact that more arbitration clauses are being put into agreements between businesses and individuals and consumer advocates are concerned that businesses know more about the process, which would give the business an unfair advantage. *Id.* at 986.

¹⁰⁹ See *Sosa v. Paulos*, 924 P.2d 357, 363 (Utah 1996).

¹¹⁰ See *id.*; Rosander, *supra* note 94, at 983.

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quired to proceed in the arbitration forum without the same procedural protections available through judicial proceedings.¹¹¹

As noted *supra*, critics also argue that binding arbitration of a medical malpractice dispute violates the constitutional right to trial by jury and is unconstitutional.¹¹² On the other hand, non-binding arbitration¹¹³ does not infringe upon the right to a jury trial because either party may seek a trial *de novo*.¹¹⁴ However, while de

¹¹¹ Nevers, *supra* note 94, at 53. The substantive due process argument is similar to the equal protection challenges where medical malpractice litigants have challenged medical malpractice arbitration provisions on the grounds that they are subject to rules and procedures that do not extend to other tort litigants. Both challenges arise under the Fourteenth Amendment to the Constitution which states that “[n]o state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.” U.S. CONST. amend. XIV. “The Fourteenth Amendment not only guarantees that the laws of the United States will be applied without illegitimate distinctions based on gender or race, but also precludes discriminatory application of laws based on arbitrary classifications.” See Kimberly J. Mann, *Constitutional Challenges to Court-Ordered Arbitration*, 24 FLA. ST. U.L. REV. 1055, 1064 (1997). Not all classifications are unconstitutional, however. Courts usually apply a strict scrutiny test to determine the validity of laws that harm a suspect class or deprive people of fundamental rights. See, e.g., *Regents of Univ. of Cal. v. Bakke*, 438 U.S. 265, 356 (1978) (Brennan, J., concurring in part and dissenting in part). However, “the rational basis test is used when no suspect classification or fundamental right exists. The court imposes a minimal level of scrutiny under this test. Unequal treatments of classes of persons is valid only if a reasonable basis exists between the classification and the objective of the statute.” Moore, *supra* note 18, at 192-193. Generally, courts have deferred to their state legislatures and refused to void arbitration on equal protection grounds. See Mann, *supra*, at 1064.

¹¹² The right to a jury trial is a fundamental common-law right preserved by the Framers of the Constitution. See U.S. CONST. amend. VII (“In suits at common law, where the value in controversy shall exceed twenty dollars, the right of trial by jury shall be preserved, and no fact tried by a jury, shall be otherwise re-examined in any Court of the United States, than according to the rules of the common law.”). “The right is preserved for claims whose origins can be traced to a common-law cause of action that carried a jury trial right, or for legislatively created causes of action that resemble those at common law.” Mann, *supra* 111, at 1056; see also Dwight Gollann, *Making Alternative Dispute Resolution Mandatory: The Constitutional Issues*, 68 OR. L. REV. 487, 503 (1989). However, the Seventh Amendment’s jury trial mandate applies only to actions brought in federal court. See Mann, *supra* note 111, at 1056. “The United States Supreme Court has never incorporated the Seventh Amendment right to a civil jury trial into the due process clause of the Fourteenth Amendment; thus, whatever constitutional right to a civil jury trial exists in state courts, must originate in the state’s constitution.” Moore, *supra* note 18, at 185. Most states, however, do have constitutional provisions for a right to jury trial in civil actions. See *id.*; see also Mann, *supra* note 111, at 1056.

¹¹³ Non-binding arbitration is often staged in the form of pre-trial review or “mediation” panels. The panel’s determination is not binding upon the parties. Metzloff, *supra* note 95, at 217 (remarking that medical screening panels resemble arbitration panels).

¹¹⁴ See Moore, *supra* note 18, at 186. Courts have cited *Capital Traction Co. v. Hof*, 174 U.S. 1 (1899), in support of the proposition that non-binding arbitration does not violate the Seventh Amendment. If a party rejects the arbitration award, he still has a right to have his claim heard by a jury. This is called the guarantee of a trial *de novo*.

novo trials may protect constitutional rights, the delays and penalties suffered by parties ordered to arbitration have been found to effectively impinge upon such rights.¹¹⁵ The transference of costs to unsuccessful parties and the admittance of arbitration results in the de novo trial are penalties and preconditions frequently litigated and criticized as burdens to a patient's right to a jury trial.¹¹⁶ Parties have decried that the former deters meritorious appeals and the latter unduly influences the jury.¹¹⁷

While arbitration may have been touted as the antidote for the medical malpractice crisis in the 1980s, it is now clear that arbitration has largely failed to overhaul the medical malpractice tort infrastructure, especially when it comes at the expense of patients' fundamental rights.

¹¹⁵ See E. Scott Henley, Ph.D., J.D., FACHE, *The Use of Pretrial Mediation and Arbitration in Medical Negligence Cases*, 40 MED. TRIAL TECH. Q. 524, 535 (1994). For instance, in *Mattos v. Thompson*, 421 A.2d 190 (Pa. 1980), "the Supreme Court of Pennsylvania held that the Exclusive Jurisdiction provision of the Health Care Services Malpractice Act [mandating review of malpractice claims by a review panel] was unconstitutional because the delays caused by the provision infringed upon the plaintiff's right to a jury trial." This holding was affirmed in *Heller v. Frankston*, 475 A.2d 1291 (Pa. 1984). See Henley, *supra*, at 536. In contrast, a clear majority of cases have indicated that the pretrial use of medical "mediation" panels have been found constitutional. For instance, the Supreme Court of Indiana in *Cha v. Warnick*, 476 N.E.2d 109 (Ind. 1985), found that delays that averaged 23.8 months were not sufficient to hold the use of panels unconstitutional. See *id.* at 536-38.

¹¹⁶ See Mann, *supra* note 111, at 1058. Unlike arbitration or medical "mediation" or review panels, traditional mediation does not result in a settlement, and its conclusions cannot be submitted at the jury trial. Thus, it does not unduly impair the ability of the jury to decide all issues of fact de novo. See Dennis J. Rasor, *Mandatory Medical Malpractice Screening Panels: A Need to Reevaluate*, 9 OHIO ST. J. DISP. RESOL. 115, 125 (1993).

¹¹⁷ See Mann, *supra* note 111, at 1058-59. *Contra Eastin v. Broomfield*, 570 P.2d 744 (Ariz. 1977) (holding that the admission of the arbitration panel's findings did not violate the right to a jury trial because both parties had the opportunity to impeach the findings by presenting their own evidence. The court analogized the panel's findings to the testimony of an expert witness, which is rebuttable through the introduction of other expert testimony); *Firelock Inc. v. District Court*, 776 P.2d 1090 (Colo. 1989) (holding that requiring the prevailing party to pay arbitration costs when the trial judgment was not 10% higher than the corresponding arbitration result was not unreasonable).

416 *CARDOZO J. OF CONFLICT RESOLUTION* [Vol. 7:393]V. MEDIATION: SURPASSING LITIGATION AND ARBITRATION AS
THE IDEAL METHOD TO RESOLVE MEDICAL
MALPRACTICE DISPUTES

A. Litigation and Arbitration versus Mediation

The most crucial difference between litigation and arbitration, on one hand, and mediation, on the other is the role of the impartial party. The arbitrator, like the judge or jury, is a decision-maker, whereas the mediator plays the role of settlement-facilitator.¹¹⁸ Thus, arbitration resembles a small trial and retains the rigidity of LITIGATION.¹¹⁹ Mediation, on the other hand, deflects the focus of the dispute away from rights, winners, and losers.¹²⁰ Instead, the parties create their own mutually acceptable

¹¹⁸ See Gitchell & Plattner, *supra* note 66, at 421 (“Mediation is defined as intervention; interposition; the act of a third person who interferes between two contending parties with a view to reconcile them or persuade them to adjust or settle their dispute.”).

¹¹⁹ See *id.* at 456-57. Parties must abide by the arbitrator’s decision, which is generally unaccompanied by any explanation of why that result was reached, and is almost always without any possibility of appeal.

¹²⁰ See Meadows, *supra* note 80, at 176-77. Before delving into further discussion of the mediation process, it should also be noted that there are different types of mediation (though “purists” believe there is only one—facilitative mediation). However, the most common types also include evaluative mediation and co-mediation. A fine line separates each style and each style is dependent upon the mediator. Evaluative mediation focuses on the merits of each case and the case’s value in litigation, and the mediator offers her views about what would happen if the case was adjudicated.

Evaluative mediation is effective but also controversial, and is embedded with an inherent “win-lose” ideology which can result in putting the “neutral” at odds with the “loser.” The evaluative mediator is presumed to be able to analyze the strengths and weaknesses, as well as the risks and costs of cases after exploring the relevant facts and legal issues with the parties and their counsel. The evaluative mediator assumes the participants want and need the mediator to provide direction as to settlement based on law, industry practice or technology. The evaluative mediator should be able to form credible judgments on the issues and arrive at a value of the litigated case, thus influencing what the parties will view as a reasonable settlement range.

Gitchell & Plattner, *supra* note 66, at 430-31.

Facilitative mediation is also referred to as “empowerment mediation,” “pure form mediation,” or “community model mediation.”

When the parties feel as if they lack a sense of empowerment, when there are perceived barriers to resolution in the negotiation process, and when the information obtained seems entirely one-sided, the mediator may employ a facilitative approach. . . . The facilitative approach incorporates creativity, intuition, and problem solving skills to empower the parties to discuss and resolve the issues in a way that is acceptable to both sides. The facilitative mediator generally believes that the parties can create a fair settlement, without having the mediator discuss the actual sub-

resolution, and, if no resolution is found, they can simply walk away and pursue litigation.¹²¹

While preparing to mediate a medical malpractice dispute may be comparable to the pre-litigation preparation by trial attorneys,¹²² the goals of the litigation system clash with the goals of mediation. The goals of mediation include enhancing communication, focusing on the human side of a dispute, giving an opportunity for conciliation and restoration of relationships, allowing closure, an opportunity for healing, and an opportunity for a cost-effective and timely resolution.¹²³ The paramount goal of medicine is con-

stance of the claims. Yet, like the evaluative mediator, the facilitative mediator inevitably deals with the merits of the case, albeit through assisting the process itself, in order to fully discuss the principle of settlement. Thus, the facilitative mediator's "mission" is to enhance and clarify communications between the parties in order to help them decide a proper settlement.

Id. at 433.

Lastly, co-mediation is a variation on traditional mediation, in which each disputant is represented by counsel, and both sides act in tandem to resolve the dispute.

Co-mediation is also described as one mediator concentrating on the factual content of the dispute, while the other helps the parties deal with communication barriers and the emotional content of the dispute. One mediator may be talking with the parties, while the other may be observing nonverbal clues or communication patterns that may be helpful in facilitating a settlement. Co-mediation evolved from the reality that most of the conflicts confronted by mediators are multidimensional issues. Because mediators/lawyers often lack interdisciplinary training or experience, a team of mediators may be used to fully address the emotional, legal and technical aspects of the disputants' case. Allowing mediators to focus on the aspects of the dispute with which they are most familiar may enhance the process of mediation.

Id. at 434.

¹²¹ See Gitchell & Plattner, *supra* note 66, at 423. If the parties do decide to litigate, the process of mediation has already clarified many issues, and has created opportunities for the parties to realize arguments which could be presented during litigation. The process of mediation does not produce a binding agreement, as does binding arbitration, which holds much less of a chance for either side to lose simply by engaging in mediation.

¹²² See *id.* at 424.

Attorneys and/or mediators must be aware of the details of each case; they must undertake depositions, interrogatories, and a pre-mediation settlement submission discussing the evidence; they must present photographs, x-rays, tabulations, medical literature, and they must prepare and present opening and closing arguments to begin the mediation process. . . . Attorneys must decide which cases are appropriate to mediate. This decision includes the same analysis an attorney undertakes when evaluating a case for trial and/or settlement potential including the likelihood of a favorable or adverse verdict, the amount of discovery needed to fairly estimate a verdict [or resolution], the amount of time needed to obtain discovery, and the cost of pre-trial and trial or pre-mediation and mediation.

Id. at 424-25.

¹²³ See Eric Galton, *Mediation of Medical Negligence Claims*, 28 CAP. U. L. REV. 321, 321 (2000) (noting that in writing this article, Galton's challenge was to distill his experience mediating medical negligence claims since 1990, in which he presided over 600 of these disputes, into a coherent article).

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sistent with the healing function of mediation.¹²⁴ In contrast, litigation has absolutely nothing to do with healing.¹²⁵

B. Advantages to Mediating Medical Malpractice Disputes

i. Mediation Avoids Excessive Litigation Costs and a Less-timely Resolution

“It is estimated that 95% of cases filed in the California court system settle before trial.”¹²⁶ “Some settle early, some settle at the eve of trial or as close as after a jury is picked.”¹²⁷ The difference between the former and the latter may be hundreds to thousands of dollars.¹²⁸ Mediation can avoid the soaring costs associated with the litigation, such as attorneys’ fees and other out-of-pocket expenses that reduce the award as much as 50%.¹²⁹ Moreover, mandating mediation is justified as states continue to enact tort reform limiting non-economic damages.¹³⁰ Parties with the most to benefit

¹²⁴ *See id.*

¹²⁵ *See id.* It is common knowledge that litigation is almost always stressful and often emotionally damaging to the parties.

“Trial is like surgery without anesthesia.” The language of the lawyers in their offices after a day of trial often involves comments such as “I really carved up their expert witness” or “I left that witness bleeding on the stand.” The language implies a legitimized form of savagery that may hardly be considered a therapeutic or enjoyable process.

Id.

¹²⁶ Adrienne L. Krikorian, Esq., *Litigate or Mediate?: Mediation as an Alternative to Lawsuits*, Mediate.com, <http://www.mediate.com/articles/krikorian.cfm> (last visited Apr. 19, 2006).

¹²⁷ *Id.*

¹²⁸ *See id.* Often the costs are not recovered by the time of settlement. Thus both parties will bear the burden of their own costs. In contrast, the cost of mediating a case can be as little as a few hundred dollars, or as much as several thousand dollars per day but is minimal compared to the costs incurred through the life of a lawsuit.

¹²⁹ *See* Forehand, *supra* note 83, at 919.

¹³⁰ Non-economic damages are also known as punitive damages or damages for pain and suffering. Laws regulating punitive damages and/or damages for pain and suffering are variable throughout the states. In Alaska, non-economic damages are limited to \$250,000 or \$400,000 for wrongful death or any injury over 70% disabling. Punitive damages are limited to \$500,000 or three times the compensatory damages. In Arkansas, punitive damages are limited to \$250,000 per plaintiff or three times amount of economic damages, with damages not to exceed \$1 million. Colorado has a \$300,000 non-economic damage limit and a \$1 million total limit on all damages. Florida’s per-claimant limit on non-economic damages is \$500,000 but death or permanent vegetative state results in damages that may not exceed \$1 million. Punitive damages are limited to the greater of \$500,000 or three times economic damages, but if there is deliberate intent to harm, there is no limit. In Georgia, non-economic damages are limited to \$350,000 against physicians; \$350,000 against a single medical facility; and \$700,000 against multiple facilities. The aggregate amount of non-economic damages is limited to \$1.05 million. Hawaii’s limit for pain

from mandatory mediation are those involved in medical malpractice controversies where the transactional cost of processing the dispute through the legal system approximates or exceeds the amount in dispute. Such parties can consider settlement earlier in the dispute process to avoid the additional time and money spent on the litigation avenue.¹³¹

ii. Mediators are More Suitable to Medical Malpractice Disputes than Juries

There are several benefits to the use of a mediator in resolving a medical malpractice dispute. First, the facilitated resolution of a complex, multi-party dispute through the assistance of a trained mediator is oftentimes more efficient than the uncertainties of a trial resolved by a jury with no background or expertise in the tech-

and suffering damages is \$375,000. Indiana places a \$1.25 million total limit but a \$250,000 limit per health care provider. It is interesting to note that in Illinois, punitive damages are not recoverable in medical malpractice cases, but with regard to non-economic damages, there is a \$500,000 limit against physicians and a \$1 million limit against hospitals. Louisiana's limit for total recovery is maximized at \$500,000 while health care provider liability is limited to \$100,000. Maine limits non-economic damages to \$400,000 while punitive damages are limited to \$75,000. But damage limits are only granted in wrongful death cases. In Michigan, there is a \$280,000 limit on non-economic damages and a \$500,000 limit on punitive damages. Missouri limits non-economic damages to \$350,000 and punitive damages are limited to \$500,000 or five times the amount of judgment. Nebraska limits total damages at \$1,750,000 while health care provider liability is limited at \$500,000. Nevada limits its non-economic damages to \$350,000 while punitive damages are limited to \$300,000 or three times compensatory damages and are only awarded for fraud, oppression and malice. New Jersey's limit is the greater of \$350,000 or five times compensatory damages. Oklahoma's limit on non-economic damages in obstetric and emergency room care is \$300,000 but there are no limits for negligence or wrongful death. South Carolina limits non-economic damages to \$350,000 against a single health care provider or facility and \$1.05 million for multiple defendants. In South Carolina, there are no limits on non-economic or punitive damages for cases of willful negligence or misconduct. South Dakota adjusts its limits based on the Consumer Price Index. In California, Idaho, Kansas, Montana, North Carolina, Ohio, Texas, and West Virginia, non-economic damages are limited to \$250,000. Massachusetts', North and South Dakota's and Mississippi's limit for non-economic damages is twice that at \$500,000. Utah's limit on non-economic damages is capped at \$400,000. New Mexico's limit is a little higher at \$600,000. Maryland's limit increases annually and is currently at \$650,000 from 2005 to 2008. Virginia's limited its recovery to \$1.5 million, but that number will be increased annually by \$50,000 each year from 2001 to 2006. On the other hand, there are no limits in Alabama, Arizona, Connecticut, Delaware, Iowa, Kentucky, New Hampshire, New York, Oregon, Pennsylvania, Rhode Island, Tennessee, Vermont, Washington, Wisconsin and Wyoming. In Minnesota, punitive damages are unlimited but only if the defendant has proved to have had deliberate disregard to the patient's safety. See National Conference of State Legislatures, *State Medical Malpractice Tort Laws: Section 1*, <http://www.ncsl.org/standcomm/sclaw/statelaws1.htm> (last visited Apr. 18, 2006).

¹³¹ See Amy B. Jenkins, *Preparing for Effective Participation in Mediation*, 27-OCT WYO. L. 21, 21-22 (2004).

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nicalities of the dispute.¹³² Additionally, juries rarely have contact with the parties. In contrast, the mediator extends the negotiation process by enhancing communication between the parties in order to arrive at a mutually agreeable settlement.¹³³ Finally, one of the most fundamental advantages is that the disputants have autonomy in determining the outcome in the mediation forum.¹³⁴ The mediator does not render a verdict. Instead, by listening to and/or evaluating each party's claims, the mediator can facilitate communication and help the parties clarify the issues so that more effective negotiations and settlement possibilities can be considered.¹³⁵

iii. Mediation Maintains Confidentiality

Medical malpractice lawyers and insurance carriers have traditionally recommended—indeed insisted—that physicians refrain from further communication with the patient.¹³⁶ This is not an issue in mediation because confidentiality, as a basic tenet of mediation, encourages the participants to speak freely.¹³⁷ Medical negligence litigators are often concerned that clients will say something from the heart¹³⁸ that will be detrimental to their case, some-

¹³² See *id.* at 22; see also *supra* text accompanying note 91. Medical malpractice mediation would require more than generic mediation skills. It would require substantive familiarity with the subject matter. To be effective at all, the medical mediator must be trained in medical matters, including medical culture, and cross-cultural mediation (recognizing that cultural differences between physicians and patients exist). See Marc R. Lebed & John J. McCauley, *Mediation Within The Health Care Industry: Hurdles and Opportunities*, 21 GA. ST. U. L. REV. 911, 914 (2005).

¹³³ Gitchell & Plattner, *supra* note 66, at 422. Many times, in pre-trial settlement proceedings, issues have not been articulated in a manner the parties and parties' attorneys can understand. Therefore, the parties may elect to commence litigation. This makes the pre-trial process inefficient, costly, and time-consuming. Mediation, however leaves the ultimate authority of fashioning a solution in the hands of the parties whose goals are to reach a specific outcome, while considering each party's values, norms and principles. See *id.* at 422-23.

¹³⁴ See *id.* at 422.

¹³⁵ See *id.*

¹³⁶ Ansley Boyd Barton, *Recent Remedies for Health Care Ills*, 21 GA. ST. U. L. REV. 831, 845-46 (2005).

¹³⁷ See Sheila M. Johnson, *A Medical Malpractice Litigator Proposes Mediation*, 52 DISP. RESOL. J. 42, 51 (1997). Certain principles must be honored in every medical malpractice mediation in order to insure that the rights of the parties involved are respected and the integrity of the process is maintained. Along with confidentiality, the other main principles are self-determination, impartiality and fairness.

¹³⁸ Until recently with the explosion of "apology" legislation, medical malpractice defense attorneys have warned physicians that an apology offered outside the context of settlement discussions or in mediation may be admissible into evidence at trial. But because of "a growing appreciation for the power of apology," some states have enacted legislation protecting expressions of sympathy or regret. See Barton, *supra* note 136, at 846; see also *infra* text accompanying

thing that will take away their leverage in the negotiation, or worse, something that will prejudice them at trial.¹³⁹ Yet these are the types of statements that a mediator needs to hear to facilitate negotiations and move the parties toward a resolution.¹⁴⁰ Accordingly, if the parties trust that statements made during the mediation are kept confidential, the integrity and efficacy of the process will be maintained.¹⁴¹

iv. Mediation Preserves the Doctor-Patient Relationship

The adversarial nature of litigation creates an environment where the parties often mask their underlying needs and interests. Litigation can resolve the legal claims but it does not create solutions that address the parties' underlying emotions or concerns.¹⁴² When medical negligence occurs, patients usually want three things: the error's cause, an apology from the doctor or hospital and an assurance that the mistake will not occur again.¹⁴³ Yet

note 219. However, some states only protect expressions of sympathy and not expressions of admissibility or fault while other states have more expansive protection. See Barton, *supra* note 136, at 846-48. Medical malpractice litigators' concerns may remain because the majority of this legislation has been passed within the last year or two and it would be interesting to see whether some courts may interpret the term "apology" to include fault. See *id.* at 848.

¹³⁹ See Johnson, *supra* note 137, at 51.

In litigation, plaintiffs' attorneys carefully prepare their clients not to reveal thoughts such as: "No amount of money can bring back my father. I know this. It's not the money. It's the principle of the thing. I just want to hurt that doctor the way he hurt me." Attorneys for defendants carefully prepare their clients not to testify to real feelings either. There would be a tremendous loss of leverage in negotiation, not to mention an evidentiary faux pas, if a doctor blurted out: "Can't we just get rid of this thing? What do I pay all that insurance for? Just pay them and get them off my back."

Id.

¹⁴⁰ See *id.*

¹⁴¹ See *id.*; see also UNIF. MEDIATION ACT § 8 (2001) ("[M]ediation communications are confidential to the extent agreed by the parties or provided by other law or rule of this State."). In addition, if the parties were assured by the mediator and their attorney that it was acceptable to reveal confidences during the mediation, then the mediator has essentially stepped into the shoes of the attorneys and has agreed to adopt the attorney-client privilege. A mediator must never reveal settlement statements made by an attorney in confidence unless the confidence is waived. See Johnson, *supra* note 137, at 51-52.

¹⁴² See Jenkins, *supra* note 131, at 22.

¹⁴³ See Valerie Reitman, *Healing Sound of a Word: 'Sorry'; Doctors and Hospitals are Learning to Disclose Their Mistakes. Patients Often Respond with Lowered Demands for Damages*, L.A. TIMES, Mar. 24, 2003, pt. 6, at 1. (summarizing a statement from Leonard Marcus, director of the Program for Health Care Negotiation and Conflict Resolution at Harvard University's School of Public Health. Marcus and his research team formed these conclusions after analyzing several dozen mediations between patients and caregivers after the patients filed complaints with the Massachusetts medical board that oversees physician licensing and discipline).

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many physicians, while striving to be truthful, are reluctant to provide the patients with this basic information.¹⁴⁴

Doctor-patient relationships have a slim chance of surviving the hostile forum of litigation where the war nature of the process pits the patient and doctor as enemies.¹⁴⁵ Conversely, mediation provides a forum for the doctor to respond to the patient's needs and apologize for any mistakes or unexpected results without adverse consequences.¹⁴⁶ This softer approach, in turn, may allow the doctor-patient relationship to remain intact.¹⁴⁷

v. Mediation May Be the Better Deterrent to Future Similar Conduct

It is widely believed that imposing liability for careless errors through litigation induces people to avoid making errors in the future.¹⁴⁸ This relationship is referred to as the compensation-deterrence theory of the law of torts.¹⁴⁹

¹⁴⁴ See *id.* Historically, physicians' idea of error disclosure involved being a "spin doctor," ie. describing the event in the most positive yet factually accurate light possible. Other doctors choose silence when struggling between truth and fear. See Lee Taft, *Apology and Medical Mistake: Opportunity or Foil?*, 14 ANN. HEALTH L. 55, 55 (2005).

¹⁴⁵ See Jenkins, *supra* note 131, at 22.

¹⁴⁶ See Rachel Zimmerman, *Medicine Means Knowing How to Say You're Sorry*, PITTSBURGH POST-GAZETTE, May 23, 2004, at A16; see also *infra* discussion Part VI.C.

¹⁴⁷ See Gitchell & Plattner, *supra* note 66, at 444. It is in the best interests of both patients and physicians to maintain amicable relations, because with an increase in managed care, patients will be required to utilize certain health plans with certain physicians, and physicians will be required to treat a certain set of patients for the length of the insurance contract. See *id.* at 444-45. For example, as employers lock large groups of employees into a particular provider system, the HMO will want to maintain customer satisfaction or risk losing many clients at once. Maintaining the physician-patient relationship is becoming important to hospitals as they are increasingly incorporating individual physicians into the institution as employees. See Johnson, *supra* note 137, at 49.

¹⁴⁸ See Edward A. Dauer et al., *Prometheus and the Litigators A Mediation Odyssey*, 21 J. LEGAL MED. 159, 161 (2000). Patient safety is well within the best traditions of both law and medicine. There are some, in medicine, who are concerned with patient safety, and see every accident as a "treasure"—a treasure of information useful to the goal of improving health care quality for the future. In the law, the task of compensating today's injured plaintiff with the goal of avoiding tomorrow's potential negligence is always linked. However, while mediation may serve the goal of legal resolution, it may also serve the purpose of medical improvement, and it may be able to do that better than litigation does. See Edward A. Dauer, *When the Law Gets in the Way: The Dissonant Link of Deterrence and Compensation in the Law of Medical Malpractice*, 28 CAP. U.L. REV. 293, 295 (2000).

¹⁴⁹ See WILLIAM L. PROSSER, HANDBOOK OF THE LAW OF TORTS 23 (4th ed. 1971). The linkage of compensation and deterrence is based upon a law and economics argument. It starts by posing the question, "[h]ow much should we as a society invest in preventing accidental injuries?" The answer is an "efficient amount."

When the patient-now-plaintiff receives an amount of money that is dictated by (though seldom exactly equal to) the amount of his or her loss, the patient is restored to as good a position as if the negligent act had not occurred, insofar as money can do that. This is commonly referred to as the compensatory function of the law of torts. At the same time, legal theorists believe by requiring that the money the plaintiff receives be paid by or on behalf of the negligent defendant, similarly situated doctors will be made aware of the fact that similar negligent acts will result in mandatory payments; they, so the theory goes will be encouraged by that financial threat to guard against committing some similar negligent act. This is the deterrence prong of the compensatory-deterrence theory. The liability of today, in theory, works to deter the negligence of tomorrow, and thereby, reduces the incidence of avoidable errors.¹⁵⁰

The empirical data, however, does not endorse this theory.¹⁵¹ Researchers in the Harvard Medical Practice Study examined their data for evidence of the compensation-deterrence theory and they found essentially none.¹⁵² Even more disturbing is Thomasson's

Suppose a hospital has a medication error rate of 1,000 incidents a year. If that hospital could reduce that error rate to half by investing a modest amount of money in risk-reducing techniques such as single-dose units or double-sign-off procedures, society would certainly want the hospital to make that investment. Suppose, however, that after all the easy things are done, there is still some residual risk of error, perhaps just a few incidents a year. If the only way to reduce those remaining risks was to post a registered nurse and a doctor of pharmacy continuously at every bedside, society would not want to force the hospital to do that.

Dauer, *supra* note 148, at 295-96. The law of torts tries to give people the incentive to invest in accident avoidance—to take “due care”—but only up to the point at which the burden of taking care produces a benefit of equal or greater value. This is also called in economics, the marginal-cost versus marginal-benefit rule. So by this economic theory, the amount that negligent doctors should pay by way of deterrence to patients whom they injure should be the same as the amount that injured patient should receive by way of compensation.

¹⁵⁰ Dauer, *supra* note 148, at 294-95.

¹⁵¹ See Dauer et al., *supra* note 148, at 161. The empirical findings are from such studies as the Harvard Medical Practice Study and Thomasson's and Passineau's study, described *infra*. Likewise, Frank L. Sloan's analysis of the tort law in general suggests a lack of evidence for the deterrent effect anywhere. See Frank L. Sloan et al., *Tort Liability and Obstetricians' Care Levels*, 17 INT'L. REV. L. & ECON. 245, 245-47 (1997). Moreover, in a study of dentists practicing in states with different tort law regimes, no correlation between a higher liability risk for practitioners and a lower injury risk for patients were found. See Douglas A. Conrad, Ph.D. et al., *The Incentive Effects of Malpractice Liability Rules on Practitioner Behavior*, 36 MED. CARE 706 (1998).

¹⁵² See Dauer, *supra* note 148, at 298 (“Their report can be most faithfully read to say that the evidence for a correlation between more liability and less error—as the theory of deterrence would predict—is weak.” Dauer sarcastically comments that “this is fortunate, because the sign of the correlation seemed to be negative.”). Douglas W. Taylor states that one of the reasons litigation does not reduce the rate of medical error is that it causes the physicians under review to undergo a greater amount of self-doubt and puts them under psychological strain which hin-

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and Passineau's independent findings that the malpractice litigation process itself may actually lead to additional medical errors.¹⁵³

Notwithstanding the theoretical arguments, mediation can improve upon the traditional system. It could replace the compensation of a plaintiff with the satisfaction of a patient, and it could replace the supposed deterrence of future defendants with small-scale but useful improvements in medical practice-changing.¹⁵⁴ The implementation of mediation in this way could yield improvements in the quality of care and patient safety and eradicate the

ders their performance. See Taylor, *supra* note 57, at 350. Atul Gawande, a physician and author, wrote about his conversation with a well-respected surgeon who lost control of a patient's bleeding while removing a benign tumor:

After the patient died from his negligence, this prominent surgeon admitted to becoming "tentative and indecisive" in the operating room and that the case negatively affected his performance "for months." The physicians that undergo the malpractice review process feel a large amount of stress which leads them to alter their behavior in detrimental ways, which then may lead to a higher probability of errors.

Id. Lucian Leape, one of medicine's leading experts on error, stated that "fear, reprisal, and punishment produce not safety, but rather defensiveness, secrecy, and enormous human anguish." *Id.*

¹⁵³ See Dauer, *supra* note 148, at 298; THOMASSON ET AL., PATIENT SAFETY IMPLICATIONS OF MEDICAL MALPRACTICE CLAIMED RESOLUTION PROCEDURES, IN PROCEEDINGS OF ENHANCING PATIENT SAFETY AND REDUCED ERRORS IN HEALTH CARE (1998); Passineau, *Why Burned-out Doctors Get Sued More Often*, MED. ECON. (May 1998). Thomasson and Passineau found that physicians against whom a malpractice claim was pending experienced an elevated risk of incurring a second claim—an increase in the probability of making another error—during the year following the filing of the first claim. Thomasson and Passineau's conclusions mimic Douglas W. Taylor's view:

Physicians who are under the malpractice gun are isolated from both their patients and their professional colleagues; they feel vilified by the accusations and the personal invective that litigation requires; they are distracted and engage in excessive rumination, to the detriment of timely and effective medical decision-making; and they experience a marked loss of professional self-confidence. Litigation causes stress; stress causes dysfunctional behaviors; and these behaviors can contribute to the making of additional errors.

Dauer, *supra* note 148, at 298-99.

¹⁵⁴ See Dauer, *supra* note 148, at 302. Mediation allows the parties to escape the traditional system's singular focus on money and address as well the explicit concern for correction. Consider the results at the Massachusetts Board of Medical Registration mediation program:

While it is true that the disputes in that program are complaints brought to a regulatory agency rather than claims brought to a court, the incidents are alleged medical errors all the same. Of the first group of cases mediated, 90% were resolved; and of those, the majority were resolved with corrective actions rather than with money. For example, a urologist who had failed to diagnose an early cancer agreed to take refresher training in oncology; a pediatrician agreed to change his office procedures to avoid a repeat of the accident involving an unprotected syringe with which this claimant's child had stuck himself; two doctors and a health center agreed to change the information systems for clinical trial protocols that had endangered a patient with a potentially fatal drug interaction; and other outcomes of similar kind. These are typical of the kinds of outcomes that mediation allows.

Id.

adversarial tendency of the tort system and the defensiveness and general feeling of opposition that it encourages.¹⁵⁵

vi. Mediation Is Successful

The conventional process has resisted change.¹⁵⁶ Yet, litigation is the least likely response to medical negligence when it occurs.¹⁵⁷ According to the Harvard Medical Practice Study, only 1.53% of the patients injured by medical negligence file claims against their tortfeasors.¹⁵⁸ That indicates that the current tort infrastructure is depriving over 98% of patients, harmed by medical negligence, of a remedy. The onus is therefore on federal and state legislatures to rectify such disparities. Mandating participation in mediation is not without its issues of law and policy. However, mediation has been a successful device when used. Of cases that generally go to mediation, approximately 85% settle as a result of the

¹⁵⁵ See Taylor, *supra* note 57, at 351.

¹⁵⁶ See Dauer et al., *supra* note 148, at 159.

¹⁵⁷ See Johnson, *supra* note 137, at 43. "It is estimated that there are over 150,000 deaths and 30,000 serious injuries every year caused by physician and hospital negligence in the United States. . . . If litigation was the sole response to negligent medical care, there would be 180,000 meritorious lawsuits filed every year." *Id.* Instead, only about 2754 lawsuits are filed every year. *See id.* "Medical malpractice litigation has not been an effective tool in compensating patients for the injury caused by the physician negligence because it rarely identifies health care providers who are negligent and it rarely holds them accountable." *Id.* Paul Weiler, Professor of Law at Harvard University, and one of the researchers and authors of The Harvard Medical Practice Study, opines that the system of litigation not only fails to compensate patients, it further undercompensates those claims with minor injuries while overcompensating the major injuries. *See id.* at 44; PAUL C. WEILER, *MEDICAL MALPRACTICE ON TRIAL 12* (Harvard University Press, 1991).

¹⁵⁸ See Johnson, *supra* note 137, at 43.; Meadows, *supra* note 80, at 169; *see also* A. Russell Localio, J.D., M.P.H., MS. et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence. Results of the Harvard Medical Practice Study III*, 325 *NEW ENG. J. MED.* 245, 245-51 (1991); Taylor, *supra* note 57, at 344. In 1990, Harvard Medical School in conjunction with medical record administrators, as well as board-certified physicians and nurses, conducted The Harvard Medical Practice Study (HMPS) in New York. The purpose of the study was to investigate and examine the incidence of injuries resulting from medical interventions or "adverse events." The study involved a sample of more than 31,000 New York hospital records drawn from the year 1984. The study utilized medical record administrators and nurses in the screening phase, and board certified physicians in the physician-review phase. The Harvard Medical Practice Study analyzed 30,121 (96%) of the 31,429 records selected for the study sample. Between 2,967 and 3,888 patients during the study year filed malpractice claims. The investigators of this study were able to use these numbers, compared with the projected statewide number of injuries from medical negligence during the same period, to conclude that one out of every eight injuries due to negligence resulted in a malpractice claim. They went on to conclude that only half of the patients who filed malpractice claims received compensation via the current tort-liability system. *See* Taylor, *supra* note 57, at 343-344.

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mediation.¹⁵⁹ Additionally, when mediation is conducted early in the dispute resolution process, 80% of the cases that would otherwise be litigated are settled; and parties are responsible only for the preparation and costs equivalent to paying for a single deposition.¹⁶⁰

C. Remaining Barriers to the Use of Mediation in Medical Malpractice Disputes

i. Misconceptions about Mediation

There are societal impediments that have prevented the use of mediation in medical malpractice disputes. Nevertheless, mandating mediation may be the least intrusive measure of overcoming these barriers.¹⁶¹

The onset of a medical malpractice claim can drive the parties into their trenches.¹⁶² The resulting deficiency in communication can be both a substantive and a procedural obstacle to agreement.¹⁶³ Mandating mediation can cease the hostility and assist in the facilitation of communication and the commencement of negotiations.

Skepticism about mediation is commonplace among doctors, patients and litigators. A closely related hurdle is lack of knowledge about the availability and benefits of mediation.¹⁶⁴ Both situations can be best summed up by the following: “The American consciousness often naturally turns to tort law and litigation—with their clear-cut battles over right and wrong.”¹⁶⁵ These limitations

¹⁵⁹ See Edward M. McNally & Barbara MacDonald, *The New Delaware Mediation Statute*, 21 DEL. J. CORP. L. 87, 87 (1996).

¹⁶⁰ See Gitchell & Plattner, *supra* note 66, at 423-24.

¹⁶¹ See Andreas Nelle, *Making Mediation Mandatory: A Proposed Framework*, 7 OHIO ST. J. ON DISP. RESOL. 287, 293 (1992).

¹⁶² This analogy refers to the warfare mentality that surrounds the entire issue of medical malpractice.

¹⁶³ See Nelle, *supra* note 161, at 295.

¹⁶⁴ Lebed & McCauley, *supra* note 132, at 912. Lebed and McCauley say it best: “in short, not enough people know about mediation, and those that do are discouraged by their sense that health care is indeed a special case, burdened by a combination of challenges that make its disputes relatively resistant to the power of mediation.” *Id.* at 912-13.

¹⁶⁵ Bovbjerg, *Medical Malpractice on Trial: Quality of Care is the Important Standard*, 49 LAW & CONTEMP. PROBS. 321, 325 (1986); see also Dauer et al., *supra* note 148, at 165 (noting that in a focus group conducted by Dauer et al., a moderator summed up his belief about the litigation system with the following: “[i]t’s the only game in town.”). The legal system is authoritative if not coercive. In health care, or at least with respect to the behavior of physicians in the health

can be tackled by education and information about mediation, a necessary precursor to mandatory mediation.¹⁶⁶ On the other hand, the other extreme follows when both parties would like to try mediation but do not suggest it because the other party may read it as a sign of weakness. It is such stalemates that are the motivation for mandatory mediation.¹⁶⁷

The adversarial process is the fundamental barrier to mediation.¹⁶⁸ The flipside of mediation's potential for reducing costs is

care process, some patients and their representatives feel that there is "no other avenue" than conventional malpractice liability for imposing accountability on practitioners. Dauer et al. cites evidence from their findings:

"The whole system is broken down . . . Physicians' peers aren't getting involved in solving some of these problems and hospitals aren't getting involved in solving some of these problems, [and neither are] the professional organizations." The legal process therefore has a regulatory function that operates in parallel, and consistently, with the individual interests of patients who call it into play: "The malpractice system is probably the only place where the patient gets a chance to deal with accountability issues." Specifically, legal procedures are seen as fostering accountability by, among other things, adding visibility: "I remember [hearing] that the major reason why claims are filed is so the patient can find out what happened. I think that gets right at a part of accountability."

Dauer et al., *supra* note 148, at 166.

¹⁶⁶ See Nelle, *supra* note 161, at 295. Although in the past there was no opportunity to gain such knowledge, the situation is increasingly improving. For many years, law schools failed to provide exposure to mediation, and the skills and training underlying the procedure were not otherwise emphasized in law school. The same was true for the legal community as a whole. However, as evidenced by Cardozo Law School, more law schools are offering clinics and classes in mediation (even journals). Court and community-based mediation programs, which offer training to lawyers are commonplace. See Comment, *Mediation and Medical Malpractice Disputes: Potential Obstacles in the Traditional Lawyer's Perspective*, 2 J. DISP. RESOL. 371, 382-83 (1990) [hereinafter *Mediation and Medical Malpractice Disputes: Potential Obstacles*].

¹⁶⁷ See Nelle, *supra* note 161, at 296. A related barrier is the fear of destabilizing the insurer's, the hospital's, the other doctor colleagues' relationships by agreeing to an ad hoc mediation. The physician may fear that the sudden willingness to mediate a dispute may be read by its other partners as yielding in the substance of the dispute or admitting liability, which could turn out to be costly. Mandatory mediation avoid such complications.

¹⁶⁸ However, note the meaningful differences in results:

Not surprisingly, parties in cases that settled were more likely to be satisfied with the final outcome of the mediation and to report cost savings and time reduction than were parties that did not settle [and eventually endured litigation]. Parties in cases that settled also were more likely to feel that the mediator had understood their views very well and were more likely to report that they would recommend mediation . . . than were parties in cases that did not settle. Defendants in cases that settled were more likely to rate the mediation process as very fair and were marginally more likely to feel that they had ample opportunity to express their views than were defendants in cases that did not settle. Plaintiffs in cases that settled were more likely to feel that mediation had helped them understand the other side's views than were plaintiffs in cases that did not settle.

Roselle L. Wissler, Symposium, *The Effects of Mandatory Mediation: Empirical Research on the Experience of Small Claims and Common Pleas Courts*, 33 WILLIAMETTE L. REV. 565, 599 (1997).

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the threat to attorneys' revenues.¹⁶⁹ Some attorneys eschew mediation not because of skepticism, but because of their self-interest, even where it conflicts with the client's interest.¹⁷⁰ Mandating mediation may be the least intrusive means to tackle this "agency problem."¹⁷¹

ii. Lack of Enforcement Power

Since the mediation process is non-binding, the lack of enforcement power or "decisions" weaken the image of the effectiveness of the mediation process.¹⁷² The most pervasive problem is when one of the parties drags its feet in attempting to resolve the dispute (such as a defendant who knows that the plaintiff will probably not be able to sustain protracted litigation).¹⁷³ However, the countervailing pressure for the physician is pressure to settle and avoid the time, financial and emotional resources and reputation¹⁷⁴ that are worn away by lengthy litigation.

¹⁶⁹ See Nelle, *supra* note 161, at 295; see also *Mediation and Medical Malpractice Disputes: Potential Obstacles*, *supra* note 166, at 379. Many lawyers see mediation of medical disputes as an economic threat. Medical malpractice cases are usually extremely complex and require extensive research and preparation in order to achieve successful results. Defense attorneys, in preparing a medical malpractice case, normally charge an hourly rate for their service, which can yield a large amount of money. On the other hand, plaintiffs' attorneys often receive contingency fees. As noted *supra* Part III.B, contingency fees and other overhead fees may take as much as 40-50% of the amount of judgment recovered. With the average award in 2002 close to \$6.25M, plaintiffs' lawyers risk a great deal of money in mediation. Mediation can reduce the amount recovered, because by focusing on the underlying needs of each party, nonmaterial considerations such as an apology or some practice-changing punishment, may take the place of monetary awards. Because medical malpractice cases present extreme investments in time and the possibility of recovering enormous amounts of money through the court system, it is not difficult to imagine some lawyers' extreme reaction against mediation as an alternative to resolving these types of disputes.

¹⁷⁰ See Nelle, *supra* note 161, at 295.

¹⁷¹ See *id.*

¹⁷² Catherine S. Meschievitz, *Mediating Medical Malpractice Claims in Wisconsin: A Preliminary Report*, 10-2 DISP. PROCESSING RES. PROG. 1, 19 (Apr. 1990).

¹⁷³ See Nelle, *supra* note 161, at 294.

¹⁷⁴ Dr. Fillmore Buckner presents a dramatic representation of a physician's reaction to a pending lawsuit:

The vast majority of physicians served with a summons and complaint have an immediate emotional and physical reaction. It matters not whether the suit is titled a professional liability action or a professional negligence suit, the physician knows it is staining his ability with the ultimate pejorative, malpractice. Being accused of irresponsibility cuts to the core of the physician's sense of self and sense of commitment to patients. Feelings of devastation, surprise, and intense anger are the most common immediate reactions. As the process continues, physicians tend to fall into one of two separate clinically identifiable clusters. Thirty-five to forty percent of the physicians named in a suit will demonstrate symptoms of a major depression. Approximately another thirty percent will demonstrate symptoms akin to traumatic stress syndrome.

This critique of the system is significant. However, mediators can provide “early neutral evaluation” of the case.¹⁷⁵ If the mediation becomes unproductive, the mediators can ask the parties whether they want to hear the panel’s opinion on the stakes and issues of the case.¹⁷⁶ The evaluation may then forestall the parties’ progression into the litigation arena.

iii. Statutorily Required Reporting of Any Settlement

The Health Care Quality Improvement Act of 1986 (HCQIA) has been designated as a physician’s greatest obstacle to mediation.¹⁷⁷ The HCQIA established the National Practitioner Data Bank,¹⁷⁸ which collects information about malpractice payments paid by, and disciplinary actions taken against, individual physicians. The HCQIA requires that any payment, regardless of the amount or reason for the settlement, be reported to both the National Practitioner Data Bank and the appropriate State Licensing

Physicians resort to elaborate defense mechanisms based on suppression and denial to cope with their psychological reactions. They put their suit “aside” and attempt to continue to practice. However, the suit automatically transfers the physician into the legal arena, an environment in which the average physician is ill-prepared to function. Under these circumstances, the physician’s coping mechanisms are not strong enough to survive. The clinical clusters break through and begin to affect the physician’s work. The physician begins to labor over clinical decisions, to develop overutilization of diagnostic and treatment modalities and ineffectually evaluate his findings. The effects can be long term and probably account for the increased future incidence of malpractice suits.

Buckner, *supra* note 20, at 307-308.

¹⁷⁵ See Meschievitz, *supra* note 172, at 21; *see also supra* text accompanying note 120 about evaluative mediation. Early neutral evaluation is defined as an objective assessment of the strengths and weaknesses of a case by an impartial panel early on the proceedings of the case.

¹⁷⁶ See Meschievitz, *supra* note 172, at 21.

¹⁷⁷ See *generally* Health Care Quality Improvement Act, 42 U.S.C. § 11101 et. seq. (1986). This legislation was formulated to protect hospital peer review committees after two antitrust cases the American Medical Association considered disastrous. The American Medical Association lobbied Congress arguing that the only way malpractice could be controlled was by national incentives to protect physician peer reviewers from suit. In response, Congress adopted the HCQIA and passed the Act in two parts. Part A offered a degree of immunity to professional review organizations of hospitals, other health care entities, and to individuals serving on these organizations or assisting those entities. Part B consisted of the establishment of the National Practitioner Data Bank. See Buckner, *supra* note 20, at 308-309.

¹⁷⁸ See Metzloff, et al., *supra* note 17, at 147. The Data Bank was first put into operation in September 1990 to provide a central repository of information so that hospitals and other permitted users could query the Data Bank to obtain accurate information about physicians for purposes such as credentialing. It has also been stated that the National Practitioner Data Bank was conceived as a national way to prevent incompetent physicians from moving from state to state to escape disciplinary consequences. See *id.*

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Board.¹⁷⁹ Doctors fear reported settlement information can directly or indirectly negatively impact their ability to maintain good standing with their malpractice carriers, providers, peers, and patients, and may even jeopardize hospital staff privileges and medical board status.¹⁸⁰ Therefore, physicians would rather bet on winning through litigation than attempting mediation because of the pain of a generally punitive reporting system.¹⁸¹ But this fear seems exaggerated given the ever increasing number of physicians

¹⁷⁹ See Buckner, *supra* note 20, at 309. Information reported to the State Medical Board is considered by the medical board for physician censuring and disciplinary actions including, but not limited to, licensing restrictions, remedial mandates, and practice restrictions. Lebed & McCauley, *supra* note 132, at 921-22.

¹⁸⁰ Buckner, *supra* note 20, at 920. Physicians fear a listing that will prevent them from being able to practice in the hospital or physician group of their choice because hospitals must access the Data Bank before granting or regrating a physician staff privileges (though other entities and licensing boards may do so electively). In addition, physicians with multiple listings have found it difficult to obtain membership in managed care organizations. See Buckner, *supra* note 20, at 309. See generally Metzloff et al., *supra* note 17, at 148-150 (concluding that the Data Bank's reporting requirement was in fact a major issue in malpractice cases from its study of data from records in all malpractice cases ordered to mediation pursuant to the North Carolina Mediated Settlement Conference Program. The Data Bank was a significant issue in 25% of the cases in which a defendant doctor subject to the reporting requirement was involved. In fact, this percentage significantly understates the importance of the Data Bank issue. In several of the cases, liability was clear, and, predictably, the Data Bank was not a concern. In nearly 50% of the cases in which liability was an issue, the Data Bank was expressly referenced. In each of these cases, the affected doctor discussed the Data Bank as a major issue in the settlement of the case. Often, the doctor spoke personally to the mediator about the impact of the Data Bank. However, simply because a point is raised in a mediation does not necessarily mean that it is a serious issue. Indeed, there would appear to be little reason for a physician not to raise an objection to settlement based upon the Data Bank. It provides a principled basis for opposing a settlement, and indicates that the physician has a strong reason to contest liability, perhaps in hopes that the plaintiff will lower the settlement demand. It is interesting to note the reactions from the defense and plaintiff attorneys. In the survey to attorneys, the researchers asked whether the Data Bank constituted an obstacle to the settlement of malpractice claims. The results indicated clearly that defense counsel believed it to be a serious issue. Half of all the attorney respondents indicated that the Data Bank was "a significant issue in most cases." Another third indicated that it was a "significant issue in some cases." Overall, only 12% indicated that it was "rarely a significant issue." As for the views of the plaintiffs' lawyers, none of the plaintiffs' attorneys questioned the legitimacy of the Data Bank concerns raised by physicians; they acknowledged the reality of the obstacle to settlement created by the Data Bank. One plaintiff's attorney put it best: the Data Bank is an "additional hurdle on a track where hurdles abound . . . often, this is the last straw." In the words of another plaintiff's attorney, the Data Bank is a "big stumbling block and the public is hurt because of it." However, it is interesting to mention that the impact of the Data Bank was more keenly felt by younger doctors who were more concerned with the growing trend toward managed care. Faced with a business environment in which alliances with various health care providers are necessary, younger doctors were more concerned with the long-range impact of having been reported to the Data Bank. Older physicians who did not anticipate any change in the structure of their practice could more easily ignore the Data Bank's impact).

¹⁸¹ See Lebed & McCauley, *supra* note 132, at 923.

with one or more malpractice cases.¹⁸² In addition, early mediation may eliminate such concerns because settlements paid on behalf of the doctor do not have to be reported to the National Practitioners Data Bank in the absence of written demand for compensation.¹⁸³ Nevertheless, the fear may no longer be well-founded. In this era of “apology” legislation¹⁸⁴ and programs such as Sorry Works!¹⁸⁵ more health care providers are admitting errors, accepting responsibility for adverse outcomes, and openly discussing such matters with their patients. Furthermore, with the passage of a recent reporting reform, the Patient Safety and Quality Improvement Act of 2005,¹⁸⁶ this attitudinal resistance to settlement and a settlement process such as mediation should gradually disappear.

VI. LEGISLATING MANDATORY MEDIATION: LESSONS STATES CAN LEARN FROM MEDIATION IN PRACTICE TODAY

Mediation has slowly begun to gain favor with courts and health care providers as the way to resolve conflict in the area of medical error.¹⁸⁷ Mandating mediation as the first step in the med-

¹⁸² See Buckner, *supra* note 20, at 309. Even in cases of clear liability, the negative impact of the Data Bank probably does not overcome the logic of settlement. It seems that the Data Bank will have the most impact where the physician and insurer perceive that there is no liability. *Id.*

¹⁸³ Virginia L. Morrison, *Heyoka: The Shifting Shape of Dispute Resolution in Health Care*, 21 GA. ST. U. L. REV. 931, 960 (2005); see also Drexel University College of Medicine Medical Malpractice Mediation Program, Apr. 2004, <http://www.prhi.org/pdfs/MEDIATION%20PROGRAM%20DESCRIPTION.pdf>.

¹⁸⁴ See *infra* text accompanying note 219.

¹⁸⁵ See *infra* text accompanying note 220.

¹⁸⁶ See generally Patient Safety and Quality Improvement Act of 2005, Pub. L. No. 109-41, 119 Stat. 424 (2005). This Act establishes a confidential reporting structure in which physicians, hospitals, and other health care professional and entities can voluntarily report information on errors to Patient Safety Organizations (PSOs). The legislation stipulates that the patient safety information will be confidential and legally protected, and provides appropriate penalties for unlawful disclosures. Physicians could voluntarily report confidential and legally protected Patient Safety Work Products (PSWP) to a certified PSO and the PSWP cannot be used in a civil, criminal, or administrative proceeding (including disciplinary actions) against a provider. The legislation is designed to strike a balance between maintaining confidentiality and legal protections for reporting error information, and maintaining accountability and patients' legal rights. American Medical Association, *Summary of S. 544/H.R. 3205, the "Patient Safety and Quality Improvement Act of 2005,"* Aug. 3, 2005, <http://www.ama-assn.org/ama/pub/category/15341.html>. It is hoped that more physicians will be more forthcoming in reporting errors of themselves and others. Lebed & McCauley, *supra* note 132, at 923.

¹⁸⁷ See Christopher Gorton, *Using Mediation to Resolve Disputes in Health Care; Conflict Management*, PHYSICIAN EXECUTIVE, July-Aug. 2005, at 34; Ellwood F. Oakley, *The Next Generation of Medical Malpractice Dispute Resolution: Alternatives to Litigation*, 21 GA. ST. U. L. REV. 993, 1007 (2005). In April 2006, California's Third Appellate District announced plans to begin

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ical malpractice dispute resolution process retains the flexibility of its non-binding nature but allows the parties to consider settlement at an earlier stage in the process, saving the parties valuable time and expense.¹⁸⁸ Likewise, it ensures that both parties have the chance to discover creative solutions to their dispute that may not be considered in litigation or arbitration.¹⁸⁹

A. Mandatory Pre-Litigation Screening and “Mediation” Panels

A few state legislatures have been slowly adopting mandatory mediation to address their medical malpractice claims.¹⁹⁰ However, other state tort reform laws have established mandatory review of all medical malpractice claims in front of a “mediation” panel, in which the “mediation” in “mediation panel” is a misnomer.¹⁹¹ “Medical malpractice pretrial screening panels” (“screening panels”) is the more descriptive and more accurate name.¹⁹² As legislative responses to the medical malpractice crisis of the 1970’s,¹⁹³ these panels’ main goals were never to mimic true media-

screening all civil cases on its docket to determine whether they are eligible for mediation and require litigants to participate if the case is appropriate. ADRWorld.com, Apr. 13, 2006, <http://www.adr.world.com/sp.asp?id=39730>.

¹⁸⁸ See Holly A. Streeter-Schaefer, *A Look at Court Mandated Civil Mediation*, 49 *DRAKE L. REV.* 367, 384 (2001).

¹⁸⁹ See Wissler, *supra* note 168, at 568.

¹⁹⁰ State legislatures have combined features of different traditional conflict resolution methods and incorporated practices that are outside a neutral’s traditional role in their statutory schemes. See Morrison, *supra* note 183, at 956. While these approaches are innovative alternatives to litigation, for the sake of clarity, I would view these laws through a “purist” perspective and label them what they would traditionally be labeled in the ADR world. Therefore, the states that seem to have instituted pure mandatory mediation for malpractice claims are Maryland, South Carolina, and Washington. See MD. CODE ANN., CTS. & JUD. PROC. § 3-2A-06-C (West 2006); S.C. CODE ANN. §§ 15-79-120, 15-79-125 (2005); 2006 Wash. ALS 8 (LexisNexis). It is interesting to note that both South Carolina and Washington enacted such legislation within the last year.

¹⁹¹ See Johnson, *supra* note 137, at 45; Caldon, *supra* note 65. Both Johnson and Caldon cite Michigan’s and Wisconsin’s programs as examples. They state that nothing in the Michigan and Wisconsin “mediation” programs resemble the definition of mediation. Michigan and Wisconsin are actually typical of states that have mandatory medical malpractice pretrial screening/evaluation panels, which have been also viewed as a form of arbitration. See Henley, *supra* note 115, at 526. Caldon ventures further and states that if you were to suggest “mediation” to a plaintiff’s attorney in one of those states, the response would be understandably negative. See Caldon, *supra* note 65.

¹⁹² See Johnson, *supra* note 137, at 45.

¹⁹³ See Jean A. Macchiaroli, *Medical Malpractice Screening Panels: Proposed Model Legislation to Cure Judicial Ills*, 58 *GEO. WASH. L. REV.* 181, 186 (1990). The decade of the 1970’s evinced an unprecedented increase in both the frequency and the severity of medical malpractice

tion, but to screen all medical malpractice claims to get rid of those that were considered non-meritorious.¹⁹⁴ These “mediation” pro-

claims filed. The increase resulted in significantly higher medical malpractice insurance rates and a reduction in coverage availability for health care providers. As with the current crisis, the malpractice crisis of the 1970's compromised the health care of the nation. Responding to the deleterious effects of the crisis, state legislatures enacted tort reform measures known as medical malpractice screening panels. More than one-half of the states enacted screening panel legislation at one time or another. Currently, about sixteen states have such statutes. *See, e.g.*, DEL. CODE ANN. tit.18, § 6803 et seq. (2005) (stating that Delaware has established a system of mandatory negligence review panels where the panel's findings are admissible as evidence at trial); IDAHO CODE § 6-1001 et seq. (2006) (explaining that in Idaho, all medical malpractice injury or death cases must, as a condition precedent to bringing suit, be presented to a malpractice hearing panel established by the Idaho state board of medicine, which will decide whether a suit is frivolous or meritorious); IND. CODE ANN. § 34-18-10-1 et seq. (West 2006) (declaring that in Indiana, as a prerequisite of commencing action against a health care provider, the claimant's complaint must be presented to a medical review panel. The panel would then provide an expert opinion admissible at trial in which the panelists may also testify); KAN. STAT. ANN. § 65-4901 et seq. (West 2005); KAN. CIV. PROC. CODE ANN. §§ 60-3502—3509 (West 2005) (stating that in Kansas, upon the request of any party in a medical malpractice action, or on the judge's motion, the action must be submitted to a medical malpractice screening panel made up of three health care providers and a non-voting lawyer. As in Indiana, the panel's report is admissible at trial and the panelist may testify at trial); LA. REV. STAT. ANN. § 40:1299.47 (2006) (setting forth that review panels reports are considered expert opinions and are admissible as evidence at trial where panelists may be called as expert witnesses); ME. REV. STAT. ANN. tit. 24, §§ 2851—59 (2005) (reporting that in Maine, while their panels are called pre-litigation screening and “mediation” panels, the panel's findings are admissible at a subsequent litigation if suit is sought to enforce the claim); MASS. GEN. LAWS ANN. ch. 231, § 60B (West 2005) (stating that there is mandatory submission of claims to a medical malpractice court tribunal where the decision is admissible at trial); MICH. COMP. LAWS ANN. § 600.4903 et seq. (West 2006) (noting that in Michigan, malpractice claims must undergo mandatory review by a mediation panel and findings are not admissible at trial. However, there are penalties should the losing party pursue subsequent litigation and the panel determines that the action or defense is without merit); MONT. CODE ANN. § 27-6-101 et seq. (2005) (noting that in Montana, the legal panel reviews all malpractice claims or potential claims against health care providers except those claims subject to a valid arbitration agreement allowed by law); NEB. REV. STAT. ANN. §§ 44-2840—2847 (LexisNexis 2005) (explaining that under the Nebraska Hospital-Medical Liability Act, all malpractice claims against qualified health care providers must be viewed by a medical review panel prior to suit); N.H. REV. STAT. ANN. §§ 519-B: 1—12 (LexisNexis 2005) (stating that in New Hampshire, screening panels will identify meritorious claims and its findings are admissible under certain conditions); N.M. STAT. ANN. § 41-5-14 et seq. (West 2006) (noting that New Mexico's laws require mandatory submission of malpractice claims to a hearing panel); UTAH CODE ANN. § 78-14-17 (West 2006) (stating that Utah requires compulsory filing of a notice of intent to commence an action and for review by a prelitigation review panel); VA. CODE ANN. § 8.01-581.2 et seq. (West 2006) (explaining that the Virginia Medical Malpractice act provides a system of medical malpractice review panels to assess the validity of newly-filed medical malpractice claims); W. VA. CODE ANN. § 55-10-1 (LexisNexis 2006) (providing that in West Virginia, a health care provider may demand pre-litigation mediation with a claimant but the process requires a screening certificate of merit); WYO. STAT. ANN. §§ 9-2-1517—1523 (2006) (noting that in Wyoming, a medical review panel reviews all medical malpractice claims and their decisions and all materials submitted by the parties are admissible in a subsequent litigation).

¹⁹⁴ *See* Caldon, *supra* note 65; Johnson, *supra* note 137, at 45.

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grams did not contemplate the peaceful and mutual resolution of claims to the mutual satisfaction of both parties.¹⁹⁵ In fact, in actual practice, attorneys vigorously advocate for their clients in this “mediation,” and the process resembles just another competition where somebody wins and somebody loses.¹⁹⁶

Pretrial medical malpractice screening panels more closely resemble non-binding arbitration. Akin to arbitration, in most states, screening panel members deliberate and issue formal decisions as to the legal rights and responsibilities of the parties.¹⁹⁷ In addition, these screening panels often make quantitative assessments about liability.¹⁹⁸ While the conclusions of the screening panels are not absolutely binding upon the parties, the decisions do significantly affect the parties’ interests.¹⁹⁹ Analogous to arbitration’s preconditions that shift costs to unsuccessful appellants, many states require that the losing party of a screening party decision, who seeks subse-

¹⁹⁵ See Johnson, *supra* note 137, at 45. In contrast, the definition of mediation is a process by which parties resolve their dispute to their mutual satisfaction with the facilitation of a neutral person who has no interest in the outcome and no authority to impose a solution or make a ruling.

¹⁹⁶ See *id.* at 46. Catherine S. Meschievitz, Associate Dean of the Office of the International Studies and Programs and Associate Director of the International Institute at the University of Wisconsin-Madison, found in her study of Wisconsin’s mandatory “mediation” program that the attorney-chair of the panel and the lawyers representing the parties control the panel process. Party participation and input were minimal. Sessions also did not allow direct exchange between the claimant and the respondent. In fact, Meschievitz found that traditional lawyer bargaining and settlement practices in the personal injury area influenced the form, content and outcome of discussions occurring in and around the “mediation” process. She notes that the process bears little resemblance to mediation as it is commonly thought of, i.e. a voluntary, private process in which a neutral third party facilitates parties’ efforts within an informal and unstructured setting to reach a mutually satisfactory resolution. See Meschievitz, *supra* note 172, at 2.

¹⁹⁷ See Rasor, *supra* note 116, at 116-117. Pretrial medical malpractice screening panels make qualitative assessments about liability, thereby acting as a “screen” by separating valid claims from frivolous ones.

¹⁹⁸ See Macchiaroli, *supra* note 193, at 191. States diverge on whether the screening panel should determine damages. States such as Alaska, Delaware, Indiana, Louisiana, and Virginia permit a determination of the existence and extent of damages suffered by the claimant but do not authorize the panel to assess the actual value of the damages. See *id.* Hawaii and Idaho expressly authorize screening panels to determine the amount of damages. See HAW. REV. STAT. ANN. § 671-15 (LexisNexis 2005) (noting however, that the panel shall not determine punitive damages); IDAHO CODE ANN. § 6-1004 (2006) (“If the panel is unanimous with respect to an amount of money in damages that in its opinion should fairly be offered or accepted in settlement, it may so advise the parties.”). Montana grants the screening panel the authority to approve settlements and to “recommend an award.” See MONT. CODE ANN. § 27-6-606 (2005). In Nevada, if the panel issues a decision favorable to the plaintiff, a mandatory settlement conference must take place with a judge, after which the judge must determine the settlement value of the case. See NEV. REV. STAT. § 41A.059(1) (2005).

¹⁹⁹ See Rasor, *supra* note 116, at 133.

quent litigation, post a bond to the court.²⁰⁰ Screening panel procedures also deny core values such as confidentiality. For example, the decision of the medical screening panel may be admitted in a subsequent trial on the merits of the same claim²⁰¹ and in some states, the panelists may be called as witnesses in the subsequent trial.²⁰²

There are few lessons to learn from medical “mediation” panels. E. Scott Henley has opined that pretrial screening or “mediation” panels have not turned out to be the panacea envisioned.²⁰³ Legislation mandating pre-litigation use of review panels have fallen under constitutional challenges.²⁰⁴ In addition,

²⁰⁰ See *id.*; see also Johnson, *supra* note 137, at 46. This bond is used to pay the costs of the opposing party if the panel award is not substantially modified at trial. In Massachusetts, a plaintiff who does not prevail before the screening panel must post a bond in the amount of \$6,000 to proceed to trial. If the plaintiff does not prevail at trial, the court will assess costs against the plaintiff, including attorney fees and witness and expert fees. See Macchiaroli, *supra* note 193, at 194. In Michigan, if the party rejects the award and the case proceeds to trial, the rejecting party must better his position by 10% or face sanctions which include costs and attorney fees. In effect, any party who loses at trial could be punished twice, once by the verdict and once by the sanctions. See Johnson, *supra* note 137, at 46.

²⁰¹ See Macchiaroli, *supra* note 193, at 193. Although some division exists, in a majority of states the panel decision is admissible at trial in some form or other. Massachusetts and Wyoming allow the decision of the panel to be admissible at trial. See MASS. GEN. LAWS ANN. ch. 231, § 60B (West 2005); WYO. STAT. ANN. §§ 9-2-1517—23 (2006). In some states, the panel decision is mere evidence at trial. Accordingly, the trier of fact must not treat the panel decision as conclusive on any issue: the trier must assess the panel decision along with the other evidence presented in the case and determine the weight to accord it. See IND. CODE ANN. §§ 34-18-10—26 (West 2006) (Indiana); KAN. STAT. ANN. §§ 65-4901—4908 (2005) (Kansas); LA. REV. STAT. ANN. § 40:1299:47 (2006) (Louisiana). Delaware and Virginia characterize the panel decision as “prima facie evidence” at trial, but emphasize that the trier of fact must not consider the decision conclusive. See DEL. CODE ANN. tit. 18, § 6812 (2005); VA. CODE ANN. §§ 8.01-581.2—11.1 (West 2006). Maryland requires that the panel decision be accorded a “presumption of correctness” at a subsequent trial. See MD. CTS. & JUD. PROC. CODE ANN. § 3-2A-06(d) (2004) (“The award shall be presumed to be correct, and the burden is on the party rejecting it to prove that it is not correct.”). Other states such as Idaho, Maine, and New Hampshire will only admit the panel’s decision in trial if the losing party still decides to pursue subsequent litigation. See IDAHO CODE ANN. § 6-1004 (2006); ME. REV. STAT. ANN. tit. 24, §§ 2851—59 (2005); N.H. REV. STAT. ANN. §§ 519-B:1—12 (LexisNexis 2005).

²⁰² In Indiana, Kansas, Louisiana, and Nebraska, the panelists are considered expert witnesses. See IND. CODE ANN. §§ 34-18-10—26 (West 2006); KAN. STAT. ANN. §§ 65-4901—4908 (2005); LA. REV. STAT. ANN. § 40:1299:47 (2006); NEB. REV. STAT. ANN. §§ 44-2840—47 (LexisNexis 2005) (stating that unlike Indiana, Kansas, and Louisiana, in Nebraska, the proceedings of the panel are confidential)

²⁰³ See Henley, *supra* note 115, at 545. It was envisioned that the use of panels would assure faster compensation of plaintiffs, expedite claims, increase pressure for settlement of claims, reduce the cost of litigation, identify at an early date the providers who pose a medical threat, and screen out unjustified claims. See *id.* at 542.

²⁰⁴ See Hoffman, *supra* note 96, at 456. See *e.g.*, Hoem v. Wyoming, 756 P.2d 780 (1988) (holding that the Wyoming Medical Review Panel Act was unconstitutional by finding that it

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experts have found that the use of the panels actually increased the number of medical negligence cases brought into the system.²⁰⁵ There is also evidence that the use of these screening panels has prolonged the length and increased the cost of litigation of medical negligence cases.²⁰⁶ Finally, settlement rates of such panels have been extremely low.²⁰⁷

was not rationally related to protection of the public health or economic and social stability of the state because the legislation did not constitute a reasonable and effective means of limiting or reducing frivolous causes of actions against health care providers. The Wyoming Supreme Court has held that the mandatory submission of all medical malpractice claims to a pre-litigation screening panel was unconstitutional because it violated the equal protection clause when it classified plaintiffs into two groups, medical malpractice plaintiffs and all other tort plaintiffs, who are not subjected to similar proceedings); *Carson v. Maurer*, 424 A.2d 825 (N.H. 1980) (holding that N.H. REV. STAT. ANN. § 507-C violated the Equal Protection Clauses of the United States and New Hampshire Constitutions, in that it improperly singled out victims of medical negligence and treated them differently than victims of other types of negligence. In so holding, the court found that the classifications created by § 507-C were required to be reasonable and to have a fair and substantial relation to the object of the legislation; the restrictions on expert testimony placed too burdensome a restriction on the patients; the statute of limitations set forth in § 507-C improperly made the “discovery rule” unavailable to the patients and impermissibly extinguished the “saving clause” for minors and incompetents; the notice provision of § 507-C afforded special treatment to doctors and bore no reasonable relationship to § 507-C’s stated purpose; the statute improperly restricted the amount of damages the patient’s could recover; and the valid provisions of § 507-C were not severable from the invalid ones); *Boucher v. Sayeed*, 459 A.2d 87 (R.I. 1983) (finding unconstitutional the Medical Malpractice Reform Act of 1976 mandating that trial justices in the state conduct a preliminary hearing in medical malpractice cases to determine if the evidence was sufficient to raise a question of liability appropriate for judicial inquiry. The court determined that the law mandating the procedure denied malpractice litigants equal protection of the laws. The court held that the classifications created by the Act did not infringe upon fundamental rights or employ suspect classifications and thus the rational basis review standard was applicable; but because no malpractice crisis existed at the time of enactment, the Act did not have a rational basis and therefore, the legislation impermissibly imposed unequal treatment on the malpractice litigants).

²⁰⁵ See Henley, *supra* note 115, at 543; see also Michael J. Saks, *Commentary: Malpractice Reform is Making Matters Worse*, SPECTATOR, Fall 1991, at 2, col. 1. Michael J. Saks, Law Professor and Social Psychologist at the University of Iowa reviewed the effectiveness of medical negligence pretrial screening panels. Saks observed that attorneys have taken questionable medical negligence cases which they would otherwise not have taken because the review by a medical panel is a “low-cost alternative to full-scale litigation,” thereby causing more defendants to defend more medical negligence cases.

²⁰⁶ See Henley, *supra* note 115, at 543 (“For example, where the findings of the panel were admissible in court, the panel members are entitled to additional expert witness fees.”); see also Comment, *An Analysis of State Legislative Responses to the Medical Malpractice Crisis*, 1975 DUKE L.J. 1456, 1461 (1975).

²⁰⁷ See Johnson, *supra* note 137, at 47, citing Catherine S. Meschievitz, *Mediation and Medical Malpractice: Problems with Definition and Implementation*, 54 LAW & CONTEMP. PROBS. 195, 207 (1991) (concluding from Meschievitz’s study of medical “mediation” panels that, “by almost any measure of program settlement rates, the MMPS settlement rate must be considered extremely low.”).

B. Intermediation

Approaching the outskirts of traditional mediation is the Supreme Court of Pennsylvania's self-created "intermediation." With Pennsylvania designated as a state in "crisis,"²⁰⁸ amendments to the state's Rules of Civil Procedure were made to "enhance the role of the mediation process as an important tool in helping to effectively decide medical malpractice cases."²⁰⁹

Intermediation shares many similarities to "pure" mediation, but the process has been modified to reflect the often-cited barriers to mediation. For instance, while intermediation is mandated, there are no binding results. The process actually parallels evalua-

²⁰⁸ See American Medical Association, *America's Medical Liability Crisis Backgrounder on Pennsylvania*, <http://www.ama-assn.org/ama/pub/category/print/12396.html> (last visited Apr. 20, 2006). According to the Pennsylvania Medical Society, a large amount of physicians have left the state: from 1997 to 2002, the amount of general surgeons has decreased from 1,600 to 1,000; from 1997 to 2002, the amount of orthopedic surgeons has decreased from 890 to 745; from 1995 to 2002, the amount of neurosurgeons has dropped from 215 to 180; and from 1997 to 2002, Philadelphia alone lost 450 physicians. Pennsylvania's out-of-control legal climate has caused physician's liability insurance premiums to skyrocket. In Philadelphia, premiums range from \$115,000 to \$155,000 for a typical obstetrician-gynecologist, from \$100,000 to \$140,000 for a typical orthopedic surgeon, and from \$135,000 to \$190,000 for a typical neurosurgeon. Judge Mark I. Bernstein, a judge in the First Judicial District, Philadelphia Court of Common Pleas, explains the reason for Pennsylvania's recent crisis in his article, *The Opportunity for ADR in Medical Malpractice Cases: A Judge Urges Alternatives to Court to Resolve Med Mal*, 26-DEC PA. LAW. 32 (2004). As a result of Pennsylvania's Day Forward program, since 2000, medical malpractice cases were routinely brought to trial within two years from initiation. But instead of medical malpractice premiums normalizing at a different level, something else occurred. The economic bubble burst and the stock market plummeted, and insurance companies lost the ability to earn enough through investments to cover losses in the two-year period to trial. Thus, while at least two-thirds of all medical malpractice cases eventually settled, they did so at a premium payment because the prevailing malpractice claims culture, derived from earlier economic and legal times, still fails to settle cases until the eve of trial. The current medical malpractice crisis has been caused by an industry that did not adjust its premiums and practices to the changing case management environment in Pennsylvania (the Day Forward program), and it was vulnerable to the changed economic conditions. The medical malpractice insurance's industry historical solution to a poor investment climate is to raise rates dramatically or close down.

²⁰⁹ See Allegheny County Bar Association, *Court Announces Rules Changes in Med-Mal Litigation*, 6 NO. 20 LAWYERS J. 7, 7 (2004) ("Rule 4011 adds to provisions of an existing rule limiting the scope of discovery and deposition and in conformity with current state law, which provides that most mediation communications and documents are privileged."). Along with these amendments, the Pennsylvania Supreme Court instituted the requirement that by January 1, 2005, all Pennsylvania jurisdictions that deal with medical malpractice claims have a mediation program in place to provide "early intervention" in all cases. To meet this mandate, the Supreme Court, under the leadership of former Justice William H. Lamb, responded with the Medical Malpractice Mediation Task Force and the process of "intermediation." See Bernstein, *supra* note 208, at 35.

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tive mediation.²¹⁰ The role of the intermediary is to point out the strengths and weaknesses of each side and, based upon professional experience, affix a realistic, predictable value range to the case.²¹¹ The fundamental conciliatory foundation of mediation remains: intermediation is “designed to facilitate negotiation in a non-judgmental, neutral atmosphere, to help the parties find a consensual solution to their dispute and to assist the parties in reaching an acceptable settlement.”²¹²

Intermediation differs perceptibly from classic mediation. To illustrate, intermediation does not occur until all sides have had adequate discovery to evaluate the merits of the claims presented.²¹³ In addition, intermediation is conducted in the courthouse to allow access to judges who are available to help resolve issues and problems that may arise.²¹⁴ Lastly, the intermediary prepares a confidential report that judges may assess if the matter progresses to the litigation stage.²¹⁵

While intermediation is in its early stages of implementation in Pennsylvania, there is a valuable lesson that other state courts and legislatures can gain: mandating mediation need not subtract from the flexibility of the mediation process.

²¹⁰ See *supra* text accompanying note 120 regarding evaluative mediation.

²¹¹ See Bernstein, *supra* note 208, at 35. Senior attorneys with vast trial experience who are frequently well known to litigators and are respected members of the bar serve as intermediators. The decision to use practicing attorneys rather than judges was made to avoid “judicial muscle-mediation,” arm twisting and the overbearing atmosphere sometimes referred to as “black robe fever.”

²¹² See *id.* at 36. Volunteer attorneys are used to prevent the self-interest barrier to mediation. These attorneys also allow for franker discussion and less posturing than might be possible before a judge. The discussion allows each side’s counsel to see more clearly weaknesses in their cases and to consider seriously reevaluating positions they thought appropriate before the conference. The intermediary, while facilitating communication, can provide an objective analysis and, where appropriate, evaluation to further focus settlement consideration.

²¹³ See *id.* at 35. As part of the case management system, intermediation occurs after discovery has been completed, all expert reports have been exchanged and disposition motions have been ruled upon. In addition, each party submits memoranda and provides copies of their expert reports to the intermediary prior to the conference. Intermediation occurs twenty-one months after the case has been initiated, months before the costs of trial preparation are incurred, costs that can often equal all the litigation expenses incurred to that time. While differing from mediation, this development counters the obstacle that mediation does not provide the adequacy of information that discovery provides.

²¹⁴ See *id.* This deeply contrasts with mediation where the mediator or other co-mediators are the only resource for the parties.

²¹⁵ Judge Bernstein states that most judges would find this invaluable in the later resolution of these cases. Simply, even if actual settlement does not occur at the intermediation stage, parties are voluntarily dismissed and issues and witnesses are clarified.

C. Apology-Based Mediation

The health care industry is in the midst of a culture change from age-old “defend and deny” tactics to embracing an apology as a means of suppressing hostile feelings between the patient and the physician.²¹⁶ Historically, physicians were reluctant to apologize out of a fear of an apology translating to an admission of liability.²¹⁷ Yet an apology could be the one factor that mitigates an intensifying conflict between the patient and doctor.²¹⁸ State legislatures, recognizing such a predicament, have introduced or enacted legislation that specifically disallows a patient from using a physician’s apology against him or her in litigation.²¹⁹ In 2005, Illi-

²¹⁶ Ashley A. Davenport, *Forgive and Forget: Recognition of Error and Use of Apology as Preemptive Steps to ADR or Litigation in Medical Malpractice Cases*, 6 PEPP. DISP. RESOL. L.J. 81, 96-7 (2006). Michael Woods, a Colorado surgeon and author of *Healing Words: The Power of Apology in Medicine* (Doctors in Touch 2004), has recognized that “nothing is more effective in reducing liability than an ‘authentically offered apology.’” *Id.* at 97, 97 n. 91. Prominent institutions from the Dana-Farber Cancer Institute in Boston to Johns Hopkins Hospital in Baltimore have made it a policy to urge their doctors to own up to mistakes and apologize. At some medical schools, including Vanderbilt University School of Medicine in Nashville, Tenn., courses in communicating errors and apologizing are now mandatory for medical students and residents. Insurers across the country, including General Electric Co.’s giant Medical Protective unit, are beginning to urge their clients to acknowledge errors and apologize. See Zimmerman, *supra* 146; American Political Network, *supra* note 1.

²¹⁷ Davenport, *supra* note 216, at 97. The interpretation of an apology as an admission of liability is fundamentally important because the Federal Rules of Evidence contains an exception to the hearsay rules that allows out of court statements that are admissions by a party-opponent to be admitted into evidence for the truth of the matter asserted. *Id.*; see also FED. R. EVID. 801(d)(2). So, physicians had an interest in phrasing their apologies in terms of a proposed settlement to circumvent the admissibility of the apology as an admission. Davenport, *supra* note 216, at 97; FED. R. EVID. 408.

²¹⁸ See generally Davenport, *supra* note 216, at 97.

²¹⁹ *Id.* Massachusetts was the first state that adopted a rule of evidence in 1986 that prohibited the admission of apologies. It states:

Statements, writings, or benevolent gestures expressing sympathy or a general sense of benevolence relating to the pain, suffering or death of a person involved in an accident and made to such person or to the family of such person shall be inadmissible as evidence of an admission of liability in a civil action.

Id. (quoting from MASS. GEN. LAWS ANN. ch. 233, § 23D (West 2005)).

As of the end of 2005, the states that have enacted apology legislation are Arizona, Colorado, Connecticut, Florida, Georgia, Illinois, Louisiana, Maine, Maryland, Massachusetts, Missouri, Montana, New Hampshire, North Carolina, Ohio, Oklahoma, Oregon, South Dakota, Virginia, West Virginia and Wyoming. See ARIZ. REV. STAT. § 12-2605 (LexisNexis 2005); COLO. REV. STAT. ANN. § 13-25-135 (West 2005); CONN. GEN. STAT. ANN. §§ 52-195—98 (2005); FLA. STAT. ANN. § 90.4026 (2005); GA. CODE ANN. § 24-3-37.1 (West 2006); 735 ILL. COMP. STAT. ANN. 5/8-1901 (West 2005); LA. REV. STAT. ANN. § 13:3715.5 (2006); ME. REV. STAT. ANN. tit. 24, § 2908 (2005); MD. CODE ANN., CTS. & JUD. PROC. § 10-920 (West 2006); MASS. GEN. LAWS ANN. ch. 233, § 23D (West 2005); MO. ANN. STAT. § 538.229 (West 2005); MONT. CODE ANN. § 26-11 (2005); N.H. REV. STAT. ANN. § 507-E: 4 (LexisNexis 2005); N.C. GEN.

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nois enacted legislation establishing a Sorry Works! pilot program²²⁰ for its hospitals—in the hope that the approach will mimic the success at the University of Michigan Hospital system, Stanford Medical Center, Children’s Hospitals and Clinics of Minnesota, and the VA Hospital in Lexington, Kentucky.²²¹ To maintain the Apology Works! momentum, Senators Mike Enzi and Max Baucus have introduced legislation which would provide federal funding for other states to enact the Sorry Works! pilot program.²²²

STAT. ANN. § 8C-4.413 (West 2006); OHIO REV. CODE ANN. § 2317.43 (LexisNexis 2006); OKLA. STAT. ANN. tit. 63.1, § 1708H (West 2005); OR. REV. STAT. ANN. § 677.082 (West 2005); H.B. 1148, 2005 Leg., 80th Sess. (S.D. 2005); VA. CODE ANN. § 8.01-581.20:1 (West 2006); W. VA. CODE ANN. § 55-7-11 (LexisNexis 2006); WYO. STAT. ANN. § 1-1-130 (2006). In 2006, Hawaii, Indiana, Iowa, Maryland, South Carolina, and Vermont have introduced but not enacted similar legislation. See National Conference of State Legislators, *2006 State Introduced Legislation*, <http://www.ncsl.org/standcomm/sclaw/medmalreform06.htm> (last visited Apr. 18, 2006); see also S.B. 3279, 2006 Leg. (Haw. 2006); H.B. 1260, 2006 Leg. (Ind. 2006); H.F. 2150, 2006 Leg. (Iowa 2006); S.B. 229, 2006 Leg. (Md. 2006); H.B. 306, 2006 Leg. (Md. 2006); S. 1057, 2006 Leg. (S.C. 2006); S. 1059, 2006 Leg. (S.C. 2006); S. 198, 2006 Leg. (Vt. 2006).

²²⁰ See MedicalNewsToday.com, June 12, 2005, <http://www.medicalnewstoday.com/medicalnews.php?newsid=25537>. Under Senate Bill 475, Illinois will establish a committee of medical, insurance, and legal experts to administer the Sorry Works! program. The committee will determine whether lawsuits and liability costs increase, remain the same or are reduced under the program. The legislation was backed by The Sorry Works! Coalition, an organization dedicated to educating doctors and hospitals about the value of apologies and upfront compensation in reducing lawsuits, liability costs and medical errors. Under Sorry Works!, doctors and hospital staff conduct root cause analysis after every bad outcome, and if a medical error caused the bad outcome, the doctors and hospital staff members apologize, provide solutions to fix the problem, and offer upfront compensation to the patient, family and their attorney(s). The benefit of this approach is that it removes anger and reduces the costs of litigation and costly defense litigation bills. It has been successful in the small number of hospitals that have tried this approach.

²²¹ The release of a study reported on what was then a revolutionary concept known as “extreme honest” at the Lexington, KY, Veterans Affairs Hospital:

After losing two major malpractice suits in the 1980s, the hospital told staff that every medical error must be disclosed fully and immediately. Doctors and staff apologized to harmed patients and their families, and proposed ways to prevent recurrence. Conventional wisdom suggested the hospital would be hammered with lawsuits. But according to the study published in a 1999 edition of the *Annals of Internal Medicine*, the hospital’s average cost of error-related payouts—including settlements and a jury verdict—was \$15,622, putting the Lexington VA in the bottom quarter of 35 comparable VA hospitals.

Zimmerman, *supra* note 146. See generally Jonathon R. Cohen, *Apology and Organizations: Exploring an Example from Medical Practice*, 27 *FORDHAM URB. L.J.* 1447 (2000) (examining the “atypical, and in some ways revolutionary” approach to instances of medical error that the Lexington VA initiated in 1987 and has followed since). At the University of Michigan Health Systems, where Apology Works! has also been adopted, the system’s annual attorneys fees have since dropped from \$3 million to \$1 million, and malpractice lawsuits and notices of intent to sue have fallen from 262 filed in 2001 to about 130 per year. Lindsey Tanner, *Doctors Eye Apologies for Medical Mistakes*, Yahoo.com, Nov. 8, 2004, http://story.news.yahoo.com/news?tmpl=story&u=/ap/20041108/ap_on_he_me/sorry_doctors_1.

²²² See Doug Wojcieszak, *Sorry Works! Legislation Introduced in Congress*, The Sorry Works! Coalition, July 7, 2005, <http://www.sorryworks.net/press2.phtml>. The Sorry Works! legislation, S.

But mediation programs such as Chicago's Rush-Presbyterian-St. Luke's Medical Center's hospital-based mediation program ("The Chicago Rush Hospital mediation model") have always recognized the power of apology.²²³ Established in 1995, the Chicago Rush Hospital mediation model is now one of the most well-regarded and thoroughly researched medical mediation systems in the United States.²²⁴ Institutions such as the Drexel University College of Medicine in Pennsylvania and other medical malpractice insurers have adopted the Chicago Rush Hospital mediation model.²²⁵ Why? The Chicago Rush Hospital mediation model has produced results. Since 1995, it has successfully expedited resolution and lowered legal costs associated with medical malpractice cases.²²⁶ In the cases that go into mediation each year, 90% are successfully settled, which produces a 50% reduction in annual defense costs and a 40% to 60% savings in payouts as compared to comparable cases that have gone to trial.²²⁷

1337, was introduced as a "middle ground solution to the nation's medical malpractice crisis." *Id.* According to Wojcieszak, spokesperson for The Sorry Works! Coalition, this is a bold move by the Senators at a time the Sorry Works!/full-disclosure movement is starting to pick up speed. *Id.*

²²³ See Max Douglas Brown, *Rush Hospitals' Medical Malpractice Mediation Program: An ADR Success Story*, 86 ILL. B.J. 432, 432 (1998) (Max Douglas Brown is the General Counsel of Rush-Presbyterian-St. Luke's Medical Center). See generally Symposium, *Medical Malpractice: Innovative Practice Applications Panel I: Alternative Dispute Resolution Strategies in Medical Malpractice*, 6 DEPAUL J. HEALTH CARE L. 249 (2003) [hereinafter *Alternative Dispute Resolution Strategies in Medical Malpractice*].

²²⁴ Davenport, *supra* note 216, at 105. Rush-Presbyterian-St. Luke's Medical Center is a major tertiary care center and is licensed to operate 978 beds with 1,254 members on its medical staff. Its annual revenues exceed \$638 million. *Alternative Dispute Resolution Strategies in Medical Malpractice*, *supra* note 223, at 249.

²²⁵ See Christopher Guadagnino, Ph.D., *Malpractice Mediation Poised to Expand*, PHYSICIAN'S NEWS DIGEST, Apr. 2004, <http://www.physiciansnews.com/cover/404.html>; see also Stephen K. Klasko, *Mediation is a Win for Everyone in Malpractice Cases*, FIN. TIMES, July 21, 2004, at 12 (Stephen K. Klasko is dean of Drexel University's College of Medicine in Philadelphia, PA.). In addition, on February 11, 2005, the Pennsylvania Bar Institute held a first-of-its-kind, intensive program: "Mastering Med Mal Mediation: Preparation, Strategy, and Ethics," focusing on the "Rush-style" mediation model. See Carl Oxholm III, *Med Mal Mediations in Philadelphia: Report on Drexel Med's First Year*, ARBITRATION & MEDIATION: A NEWSLETTER OF THE PENNSYLVANIA BAR ASSOCIATION ALTERNATIVE DISPUTE RESOLUTION COMMITTEE, Winter 2005, at 1. The program was taught by faculty who participated in the "Rush-style" mediation program at Drexel University College of Medicine. Insurance adjusters, risk managers, in-house counsel, mediators, judges, doctors and lawyers were encouraged to attend. In addition, the Philadelphia Court of Common Pleas cancelled jury selection in medical malpractice cases that day so that attorneys could attend.

²²⁶ See Guadagnino, *supra* note 225; see also Brown, *supra* note 223, at 440.

²²⁷ See Guadagnino, *supra* note 225 (quoting figures from the Pennsylvania Office of Health Care Reform Deputy Director Susan Anderson).

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The Chicago Rush Hospital mediation model largely mimics traditional mediation except that two co-mediators are used instead of a single mediator and both mediators are practicing medical malpractice plaintiff and defense attorneys from throughout the city.²²⁸ The mediation usually commences after discovery has begun or ended so that both sides are fully aware of the facts of the case.²²⁹ But the real cornerstone of the process is the apology—it is the apology that fosters the trust needed in mediation;²³⁰ a trust unavailable in litigation and arbitration.²³¹ What the rest of the health care industry, state legislatures and the federal government are belatedly realizing is simple: an apology allows the patient to forgive.²³² Carl (Tobey) Oxholm III, General Counsel of Drexel

²²⁸ See *id.*; see also Klasko, *supra* note 225, at 12. Max Douglas Brown has accredited the success of the program to the mediators that participate in the Chicago Rush Hospital mediation program. See *Alternative Dispute Resolution Strategies in Medical Malpractice*, *supra* note 223, at 253. The practicing attorneys are experts in that area of the law and are trained in mediation, whereas traditional mediators often are not experts in malpractice law. Selected from an assembled panel of leading malpractice trial attorneys in a region, the co-mediators bring expertise from both sides of the bar in appraising the merits and valuation of malpractice cases, which adds credibility and trust among litigants during the resolution process. See Guadagnino, *supra* note 225. Another advantage of the Chicago Rush Hospital mediation model is that:

[I]t can integrate co-mediation into a health system's risk management system more programmatically than is traditionally done. Under the model, the hospital's counsel reviews cases brought against it and/or its employed physicians and selects the ones that are most appropriate for mediation, such as those with the potential for a runaway jury verdict, or those that are not easily defensible. The hospital's counsel then contacts the plaintiff's attorney to ask if the plaintiff is interested in mediation. If so, the plaintiff picks the two mediators, one plaintiff's attorney and one defense attorney, from a panel. Most mediations are conducted within a year of the lawsuit being filed and are concluded within a day, or even a few hours.

Guadagnino, *supra* note 225.

²²⁹ Davenport, *supra* note 216, at 105.

²³⁰ See *Alternative Dispute Resolution Strategies in Medical Malpractice*, *supra* note 223, at 255.

²³¹ See Klasko, *supra* note 225, at 12.

²³² See Oxholm III, *supra* note 225, at 3. The following is a testament to the power of apology:

A Philadelphia court officer suffered a stroke while hospitalized for an entirely unrelated condition. As a friend of the family, I was at the hospital shortly after this unfortunate incident occurred. The family of course was sophisticated in court procedures and specifically with medical malpractice cases. Instead of being cloistered by the Claims Management Department of the hospital, the physician in charge asked to meet with the family. At their request, I participated. The doctor arrived with the patient's full medical chart and explained in detail everything that had occurred, going over the medical records with them, answering every question, including repetitive ones, and showing no impatience. At no time did the physician give ambiguous or self-protective answers. At no time did he duck any question or in any way avoid direct responsibility for the care of his patient. Despite the sophistication of the family and the dire consequences of the event, there was no breakdown in the physician-patient relationship, and no lawsuit was filed.

University²³³ sums it up best:

[An apology] is not what litigators are used to, or what happens in courtrooms. [However], [i]t provides both victims of medical error—the patient and the physician—the opportunity to reach closure more quickly than having to suffer through depositions, motions or trial; it allows the doctors to answer the patient’s/ family’s questions about how this could have happened; and it allows everyone to focus on the relief that the family really needs.²³⁴

VII. CONCLUSION

As physicians continue to lobby their legislatures and patients continue to lament over the cost of health care to their local congressman, there exists a need to overhaul the way medical malpractice disputes are resolved. The traditional model, in the face of the current medical malpractice crisis, has been declared severely inadequate to meet the needs and interests of the patient and the doctor. Furthermore, litigation does not effectuate any improvements in patient safety and remains the fuel that drives this vicious cycle. The states’ enactment of mandatory arbitration panels, and then

Bernstein, *supra* note 208, at 36. (quoting from Judge Mark I. Bernstein of the First Judicial District, Pennsylvania Court of Common Pleas, who attests to the success of the approach from his personal experience as a mediator in a med-mal dispute).

²³³ In early 2004, Drexel University’s College of Medicine in Philadelphia implemented a pilot program using the Chicago Rush Hospital mediation model. The results were a success. See Klasko, *supra* note 225, at 12. In addition, mediation saved Drexel University in defense costs as it took less time to mediate than to prepare for and conduct a trial. See Oxholm III, *supra* note 225, at 3; see also Robert A. Creo, Esq. et. al., *Malpractice Case Alternative Dispute Resolution*, PHYSICIAN’S NEWS DIGEST, Nov. 2005, <http://www.physiciansnews.com/law/1105creo.html> (reporting that mediation has proven to resolve cases more efficiently and cost-effectively. The University of Pittsburgh Medical Center (UPMC) implemented its mediation program, with the facilitation of JUSTUS Medical Malpractice Group in the fall of 2004. Creo, the director of JUSTUS Medical Malpractice Group, reports that in a year, UPMC saved a \$1 million in litigation cost savings). It is not just doctors and mediators who endorse mediation. In June of 2005, Drexel University College of Medicine’s malpractice mediation project received recognition from the Joint State Government Commission, Advisory Committee on Medical Professional Liability, stating that the program was a successful model for medical liability reform. *Drexel University College of Medicine’s Medical Liability Reform Plan Gets High Marks*, June 27, 2005, <http://www.drexelmed.edu/med/News/newsprint.asp?ID=55>. The Commission’s Advisory Committee on Medical Liability looked into various systems including “no-fault,” screening panels, specialized tribunals, and arbitration. It reached the consensus that mediation was “attractive,” “promising,” and “particularly well-suited to dealing constructively with the emotional aftermath of an adverse medical outcome.” *Id.*

²³⁴ See Oxholm III, *supra* note 225, at 3.

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voluntary binding arbitration panels have fallen flat, both in the face of constitutional concerns and the realization that arbitration retains much of the rigidity of litigation.

Mandating mediation can produce an efficient, cheaper, less emotionally-exhausting, and generally more satisfactory alternative to litigation and arbitration. States can learn valuable lessons assimilating the missteps of pre-litigation screening panels, the potential of Pennsylvania Supreme Court's intermediation process and the successes of the apology-based mediation models. It is within these frameworks that states can discern the substantive and procedural facets to provide its citizens with some relief from the medical malpractice crisis.