THE CASE FOR USING ADR IN MEDICAL MALPRACTICE DISPUTES

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I.
INTRODUCTION

The future trajectory of healthcare is a contemporary issue on the minds of many Americans clamoring for a change. The relevance of this subject was reflected in the Democratic debates ahead of the 2020 presidential primaries where, as of October 15, 2019, candidates had spent a total of 93 minutes discussing healthcare issues, far eclipsing the second most addressed subject—immigration—by about 17 minutes.[1] According to a Gallup poll conducted in August 2019, roughly 48 percent of people have very or somewhat negative views about the healthcare industry, compared to just 38 percent who hold very or somewhat positive views.[2] While most of the commentary rightfully focuses on the skyrocketing costs of health insurance and plans to reduce that financial burden,[3] addressing the problem of healthcare costs requires a deeper foray into those expenses.

* J.D., New York University School of Law, 2021; B.A., History, Yeshiva University, 2017. I would like to thank Professor Kathleen Roberts for helping me develop the topic, Professor Carol Liebman for providing me insights into the research, and the editors of the *Annual Survey of American Law* for working to prepare this piece for publication. A version of this Essay was originally prepared for Professor Roberts for the Fall 2019 course in Alternative Dispute Resolution at New York University School of Law.

1. Hannah Brown & Dylan Scott, *The Democratic Debates Have Spent 93 Minutes on Health Care*, VOX (Oct. 15, 2019, 4:00 PM), https://www.vox.com/policy-and-politics/2019/10/15/20914415/democratic-debates-health-care-issues [https://perma.cc/2VC2-4CBC].

2. *Healthcare System Polling*, GALLUP, https://news.gallup.com/poll/4708/healthcare-system.aspx [https://perma.cc/SDA2-WGPK] (last visited Dec. 16, 2019).

3. *See, e.g.*, Danielle Kurtzleben, *Elizabeth Warren's Plan to Pay for 'Medicare for All'*, NPR (Nov. 1, 2019, 8:56 AM), https://www.npr.org/2019/11/01/775335150/read-elizabeth-warrens-plan-to-pay-for-medicare-for-all [https://perma.cc/G6J5-52C6]; HHS, FACT SHEET: THE AMERICAN RESCUE PLAN: REDUCES HEALTH CARE COSTS, EXPANDS ACCESS TO INSURANCE COVERAGE AND ADDRESSES HEALTH CARE DISPARITIES (2021), https://www.hhs.gov/about/news/2021/03/12/fact-sheet-american-rescue-plan-reduces-health-care-costs-expands-access-insurance-coverage.html [https://perma.cc/A99H-WJRP].

One large expense in the healthcare system is medical malpractice liability.[4] The medical malpractice system, like general tort liability, is primarily geared towards deterring unsafe medical practices, compensating injured patients, and exacting corrective justice.[5] In theory, the system should safeguard patients' well-being by providing compensation and deterrence when physicians breach the accepted professional standard of care.[6] However, medical malpractice liability has evolved into an inefficient, costly system where "the fear of litigation obstructs progress in ensuring patient safety."[7]

In the 1970s and 1980s, there was a significant rise in medical malpractice suits against physicians.[8] This rise corresponded with an overall increase in U.S. tort costs that, between 1930 and 1994, grew almost four times faster than the rate of economic growth.[9] In addition to the direct costs of a jury verdict or settlement, medical malpractice suits also incur many other indirect costs, including indemnity payments, administrative costs, increased defensive medicine practices, and other minor considerations.[10] Indemnity payments on a national scale are divided roughly between 55 percent economic damages, 42 percent non-economic damages (which include pain and suffering), and 3 percent punitive damages.[11] Administrative costs include plaintiff attorney fees and litigation expenses, defendant attorney fees and expenses, and various other overhead expenditures.[12] Additionally, a medical malpractice suit can create other harmful strains on the healthcare

4. *See, e.g.*, Phillip J. Moore, Nancy E. Adler & Patricia A. Robertson, *Medical Malpractice: The Effect of Doctor-Patient Relations on Medical Patient Perceptions and Malpractice Intentions,* 173 WEST J. MED. 244, 244-45 (2000), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1071103/ [https://perma.cc/4WM8-4BD4] (finding that medical malpractice insurance premiums total more than $5 billion annually, and the practice of defensive medicine to protect against a potential lawsuit costs over $14 billion a year).

5. David M. Studdert, Michelle M. Mello & Troyen A. Brennan, *Medical Malpractice*, 350 NEW ENG. J. MED. 283, 283 (2004).

6. *Id.*

7. *Id.* at 287.

8. John J. Fraser, Comm. on Med. Liab., *Technical Report: Alternative Dispute Resolution in Medical Malpractice*, 107 PEDIATRICS 602, 602 (2001), https://pediatrics.aappublications.org/content/pediatrics/107/3/602.full.pdf [https://perma.cc/PN6A-Q2D7].

9. *Id.*

10. Michelle M. Mello et al., *National Costs of the Medical Liability System*, 29 HEALTH AFF. 1569, 1570-71 (2010), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3048809/pdf/nihms269333.pdf [https://perma.cc/4FYG-VRKG].

11. *Id.* at 1572.

12. *Id.* at 1572.

system: lost clinician work time, reputational and emotional tolls on clinicians,[13] and sub-optimal alterations in medical practices. In a 2008 study, Michelle Mello et al. concluded that nationwide, the medical malpractice liability system costs more than $55 billion annually.[14]

This paper focuses on reforming the current state of medical malpractice liability as a method of complementing other cost-reducing efforts in the healthcare industry. This paper posits that replacing traditional tort litigation with systems of Alternative Dispute Resolution (ADR)—particularly understanding-based mediation—in medical malpractice cases could lower the associated costs[15] and help reduce instances of medical error. This is a sustainable solution that could benefit all Americans by leading to improved patient safety and lower health insurance premiums.[16]

II.
COMMON REFORM SUGGESTIONS & ISSUES WITH THE TRADITIONAL LITIGATION MODEL

To address the rising tide of malpractice liability costs, researchers have suggested various tort reforms, such as caps on non-economic and punitive damages; however, all of these proposals still operate within the traditional adversarial litigation system.[17] Mello, for instance, advances a reform proposal that would aggregate liability at the hospital or hospital network level rather than at the individual level.[18] She argues specifically that hospital networks should consolidate malpractice coverage in a single carrier and pay the premiums for their physicians,[19]

13. *Id.* at 1575-6.

14. *Id.* at 1577.

15. *See* David H. Sohn & B. Sonny Bal, *Medical Malpractice Reform: The Role of Alternative Dispute Resolution*, 470 CLINICAL ORTHOPEDICS & RELATED RES. 1370, 1377 (2012) (concluding that mediation programs can reduce healthcare costs, including savings of $50,000 per claim on average).

16. *See id.* at 1371; Ronen Avraham et al., *The Impact of Tort Reform on Employer-Sponsored Health Insurance Premiums*, 28 J.L. ECON. & ORG. 657, 680 (2012) (finding that "tort reform reduces healthcare expenditures broadly").

17. *See, e.g.*, Avraham et al., *supra* note 16 (limiting their analysis to traditional tort reforms).

18. *See* Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1624 (2002).

19. *Id.* at 1625. In this system, the hospital enterprise faces the brunt of the liability and will encourage providers within their network to correct their negligent practices. Note, however, that Mello's suggestion is only workable for physicians who are employed directly by the hospital, not for those who remain as independent private practitioners.

allowing malpractice insurers to mount joint defenses to claims and to adjust premiums based on collective experience.[20] Insurers could also compensate patients for a predetermined class of avoidable adverse events which would incur automatic no-fault liability.[21] Others suggest a multifaceted approach of allowing premiums for malpractice insurance to rise, using caps on non-economic damages to reward physician error reporting, incentivizing other health care workers to report problems, and requiring repeat defendants to undergo quality audits with publicized results.[22]

These reform efforts, however, miss a critical opportunity to address the deeper, core issues involved in an adversarial proceeding between a doctor and patient. The problems inherent in traditional litigation—from both the patient and physician perspective—coalesce roughly into two different categorical issues: cost (both pecuniary and psychological) and lack of disclosure of medical errors to patients.

A. The Costs of Traditional Litigation

Under the traditional model, patients must overcome substantial obstacles to initiate a suit, such as the high costs involved in litigation that "affect a litigant's access to the civil justice system."[23] Patients who sustain non-life-threatening, relatively minor injuries are disincentivized from filing suit, as only 28 cents of every dollar recovered actually goes to the litigant.[24] When patients face issues accessing the courts, the threat of malpractice is weakened. This tempers the deterrent effect of malpractice liability, thwarting an important tool for ensuring patient safety.

There is a significant mismatch between instances of physician negligence and claims actually filed by patients.[25] Traditional litigation

20. *Id.* at 1626.

21. *Id.* at 1626-27.

22. *See generally* David A. Hyman & Charles Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?*, 90 CORNELL L. REV. 893 (2005).

23. Brittany Kauffman, *Study on Estimating the Cost of Civil Litigation Provides Insight into Court Access*, UNIV. OF DENVER: IAALS BLOG (Feb. 26, 2013) (citation omitted), https://iaals.du.edu/blog/study-estimating-cost-civil-litigation-provides-insight-court-access [https://perma.cc/6265-3N5W].

24. *Cf.* Sohn & Bal, *supra* note 15, at 1371.

25. *See generally*, A. Russell Localio et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence: Results of the Harvard Medical Practice Study III*, 325 NEW ENG. J. MED. 245 (1991), https://www.nejm.org/doi/pdf/10.1056/NEJM199107253250405?articleTools=true [https://perma.cc/AJ7N-JEVE].

infrequently compensates patients injured by medical negligence and rarely holds providers accountable for delivering substandard care.[26] One explanation is the patient's inability to recognize negligent care as the cause of their adverse health condition.[27] Additionally, patients do not wish to spoil their relationships with their doctors (which can be addressed by mediation, as discussed below), and trial lawyers will only accept cases with high probabilities of recovering substantial amounts.[28]

Another issue emanates from the physician's perspective. Physicians are frightened by the prospect of their life earnings being swallowed up by a staggeringly high verdict from a lay jury that does not understand the complexities of medicine.[29] Aside from the emotional toll on physicians,[30] the traditional litigation process has other serious negative consequences for our healthcare system. There is evidence that an increasing number of physicians believe society is too litigious and are choosing not to practice in high-risk areas, which traditionally are the sources of medical innovation.[31] It is also becoming increasingly difficult to obtain malpractice insurance, and premiums can double in a single year.[32]

Additionally, the traditional litigation system encourages the use of defensive medicine, in which the fear of future lawsuits results in over-testing and extended hospital stays.[33] While there is a socially optimal level of caution and some amount of defensive medicine is positive, overly cautious behavior strains the system and increases costs to the

26. *Id.* at 250.

27. *Id.* at 249.

28. *Id.*

29. *See, e.g.*, Sohn & Bal, *supra* note 15, at 1371 ("Between 2001 and 2002, the national jury award in medical liability cases almost doubled from $3.9 million to $6.2 million. Jury awards in medical malpractice are roughly 17 times greater than nonmedical fields.").

30. *See* Sara C. Charles, *Coping with a Medical Malpractice Suit*, 174 WEST J. MED. 55, 55 (2001) ("More than 95% of physicians react to being sued by experiencing periods of emotional distress False").

31. *See* Natasha C. Meruelo, *Mediation and Medical Malpractice: The Need to Understand Why Patients Sue and a Proposal for a Specific Model of Mediation*, 29 J. LEGAL MED. 285, 287 (2008).

32. *See* Fraser, *supra* note 8, at 602. This source also provides an example of how in one region of California, physicians experienced a 360 percent increase in malpractice premiums in one year.

33. James D. Reschovsky & Cynthia B. Saiontz-Martinez, *Malpractice Claim Fears and the Costs of Treating Medicare Patients: A New Approach to Estimating the Costs of Defensive Medicine*, 53 HEALTH SERVS.' RES. 1498, 1499 (2018). *Contra* Hyman & Silver, *supra* note 22, at 942 ("The defensive-medicine critique of tort liability implausibly assumes that rational providers respond to liability risks only by taking steps that harm patients.").

healthcare industry. This excess cost "is a leading driver of the higher health insurance premiums affecting every American."[34] People have a psychological tendency to overestimate the risk of rare events and to fear the unknown,[35] so objective tort law reforms that make the law more favorable to physicians will likely have little effect on defensive medicine, which is driven by the subjective fear of individuals.[36]

B. The Effects of Traditional Litigation on Nondisclosure

The current model of medical malpractice may also be contributing to physicians' nondisclosure of adverse events to patients. According to a study conducted by the American Medical Association (AMA), less than half of harmful errors are actually disclosed to patients.[37] Although under the AMA's Code of Medical Ethics, physicians have a fairly clear obligation to inform the patient of all complications,[38] in practice many are fearful about revealing inculpatory information that could ultimately harm them in a lawsuit.[39] Canadian physicians, by contrast—who practice in a less stringent malpractice environment—tend to have a higher rate of disclosure than American physicians,[40] suggesting that

34. *Unneeded Medical Care is Common and Driven by Fear of Malpractice, Physician Survey Concludes*, JOHNS HOPKINS MED. (Sept. 6, 2017), https://www.hopkinsmedicine.org/news/media/releases/unneeded_medical_care_is_common_and_driven_by_fear_of_malpractice_physician_survey_concludes [https://perma.cc/4VUP-WUP4] ("Unnecessary medical services . . . account[ed] for an estimated $210 billion in excess spending each year."); *see also* Joseph L. Dieleman et al., *Factors Associated With Increases in US Health Care Spending, 1996-2013*, 318 JAMA 1668, 1677 (2017) (finding that increases in spending on medical treatment had the strongest association with increasing health care spending).

35. Reschovsky & Saiontz-Martinez, *supra* note 33, at 1499-1500.

36. Johns Hopkins Medical, *supra* note 34.

37. *See* Thomas H. Gallagher et al., *Choosing Your Words Carefully: How Physicians Would Disclose Harmful Medical Errors to Patients*, 166 ARCHIVES INTERNAL MED. 1585, 1585 (2006), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/410785 [https://perma.cc/M4KZ-ZVY4].

38. *Ethics Case Study: Must You Disclose Mistakes Made by Other Physicians?*, AM. COLL. PHYSICIANS (Nov. 2003), https://www.acponline.org/system/files/documents/clinical_information/must_you_disclose_mistakes_made_by_other_physicians.pdf [https://perma.cc/5GS6-ND6T].

39. Gallagher et al., *supra* note 37, at 1585.

40. *Id.* at 1592. In Canada, punitive damages are rarely awarded, and pain and suffering is subject to a modest judicial cap. Peter C. Coyte et al., *Medical Malpractice – The Canadian Experience*, 324 NEW ENG. J. MED. 89, 90 (1991). Importantly, there are institutional differences between the Canadian and American systems: malpractice cases in Canada are decided by a judge without a jury, the attorneys' fees are substantially less

disclosure rates are affected by the American system of malpractice liability. Nondisclosure ultimately harms the physician-patient relationship by increasing hostility. It can also prevent the patient from understanding their condition, thus making it less likely that they will be able to hold the negligent physician accountable.[41]

While superficial modifications to the traditional medical malpractice litigation model may reduce some costs,[42] a sustainable solution requires innovation that can address lingering issues left by the aforementioned tort reform proposals.

III.
POTENTIAL BENEFITS OF ADR IN THE MEDICAL MALPRACTICE CONTEXT

ADR could address those underlying deficiencies plaguing the system and could alleviate some of the hurdles patients face to file claims. ADR has the potential to reduce costs to the system,[43] which will lower transaction costs for patients filing suits. It can also increase physician disclosure of mistakes; by providing an opportunity to confront the patient directly in a problem-solving atmosphere, ADR has the potential to make physicians feel more comfortable sharing information about medical complications, producing a tangible increase in patient safety.

From a technical standpoint, ADR is appealing for its ability to reduce the costs of litigation. Courts are too expensive, time-consuming, and require high-priced lawyers and substantial time from all parties involved.[44] These concerns are heightened in medical malpractice cases, which virtually always require expert testimony to set the professional standard of care needed to prove a negligence case.[45] ADR systems, by contrast, offer opportunities to cut costs by giving the parties flexibility to establish the parameters of the proceeding and to effectively control

onerous, and the same malpractice insurance company covers over 90 percent of all Canadian physicians. *Id.* at 91.

41. *See* Localio et al., *supra* note 25, at 249.

42. Avraham et al., *supra* note 16, at 679 (pointing out that cost reductions average roughly two percent).

43. Sohn & Bal, *supra* note 15, at 1377.

44. LEONARD RISKIN ET AL., DISPUTE RESOLUTION AND LAWYERS 888 (5th ed. 2014).

45. B. Sonny Bal, *The Expert Witness in Medical Malpractice Litigation*, 467 CLINICAL ORTHOPEDICS & RELATED RES. 383, 383 (2009), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2628518/pdf/11999_2008_Article_634.pdf [https://perma.cc/L7QQ-KKA4].

the process.[46] ADR can take place early in the litigation process, thereby saving time and reducing the costs associated with trial preparation.[47] Parties can agree to limit the amount of expert testimony and impose standards to ensure the quality of such testimony.[48] Reducing the astronomical costs of litigation will ultimately lower the costs of health insurance for the aforementioned reasons,[49] and will enable more plaintiff attorneys to take on less lucrative cases.

A. Arbitration as a form of ADR in Medical Malpractice

ADR in the medical malpractice context primarily refers to interest-based mediation - probing the interests of both parties in an open, confidential forum in pursuit of a mutually beneficial agreement. However, arbitration is also an attractive form of ADR that could offer distinct advantages over traditional litigation in medical malpractice cases: decisions can be reached promptly without the need for drafting a reasoned opinion, parties can select an arbitrator (perhaps one with medical knowledge), the dispute can be kept private, and discovery limited.[50]

Arbitration, however, is not popular in medical malpractice cases. Notwithstanding the U.S. Supreme Court decisions over the past 50 years that have expanded the reach of arbitration and created a substantive law of arbitration that preempts conflicting state law,[51] arbitration has been slow to arrive in the healthcare field. Medical malpractice is generally a creature of state law, [52] which allows states to craft their own arbitrability policies not preempted by the Federal Arbitration Act (FAA) and thus unaffected by the federal zeitgeist in

46. Chris Stern Hyman et al., *Interest-based Mediation of Medical Malpractice Lawsuits: A Route to Improved Patient Safety?*, 35 J. HEALTH POL., POL'Y & L. 797, 798-99 (2010).

47. *Id.* at 811.

48. Thomas B. Metzloff, *The Unrealized Potential of Malpractice Arbitration*, 31 WAKE FOREST L. REV. 203, 209 (1996).

49. Some examples from the previous discussion include less defensive medicine, more deterrence of costly and negligent mistakes, and general litigation costs being translated into healthcare costs.

50. RISKIN ET AL, *supra* note 44, at 889-90.

51. *See e.g.*, Prima Paint Corp. v. Flood & Conklin Mfg. Co., 388 U.S. 395 (1967) (establishing the notion that the FAA is substantive law and embodies a congressional declaration of policy); AT&T Mobility LLC v. Concepcion, 563 U.S. 333 (2011) (invalidating a state court understanding of unconscionability using pre-emption by the FAA).

52. Daniel P. Kessler, *Evaluating the Medical Malpractice System and Options for Reform,* 25 J. ECON. PERSPS. 93, 94 (2011) ("In general, malpractice claims are adjudicated in state courts according to state laws.").

favor of arbitration.[53] States are inclined to distinguish medical malpractice cases from standard contractual agreements, concluding that where one's health is involved, heightened due process protection is more appropriate than arbitration.[54] This inclination is manifested in court opinions that have scrutinized how medical malpractice arbitrations are conducted,[55] and in others that have invalidated arbitration clauses in agreements to receive medical treatment as unconscionable and contrary to public policy.[56]

There are other issues with arbitration for medical malpractice. For instance, arbitration fails to address some of the fundamental flaws of the litigation process.[57] Arbitrators, like jurors, are susceptible to emotional persuasion upon seeing the condition of the injured plaintiff, compelling them to award large sums for non-economic damages.[58] These large sums do not need to be justified in a written opinion (unless agreed to by both parties) which provides little oversight of the arbitrator's discretion.[59] Essentially, the same uncertainties surrounding a jury's award of non-economic damages can apply to arbitration, leaving the issues outlined above unresolved. Furthermore, there is limited appellate review of an arbitrator's decision.[60] Finally, despite the cost savings as compared to a trial, arbitration still can be an expensive process, especially if a panel of arbitrators is selected. In private arbitration, the costs of the arbitrator's time and other incidentals (which are free in a public courtroom) may be borne by the parties.[61]

B. Advantages of Mediation as a form of ADR

Due to the disadvantages of arbitration described above, mediation has been the preferred method of ADR among researchers and is the approach advocated for in this paper. Mediation can avoid some of the potential pitfalls of arbitration while capitalizing on the benefits of ADR. The parties select a single third-party mediator who will issue a non-

53. Federal Arbitration Act ("FAA"), 9 U.S.C. § 2 (1947) (making covered arbitration agreements binding).

54. *See* Metzloff, *supra* note 48, at 213.

55. *See* Engalla v. Permanente Medical Group, Inc., 43 Cal. Rptr. 2d 621 (Cal. Ct. App. 1995), *review granted*, 905 P.2d 416 (Cal. Nov. 2, 1995).

56. *See* Broemmer v. Abortion Servs. of Phoenix, Ltd., 840 P.2d 1013 (Ariz. 1992) (en banc); Cannon v. Lane, 867 P.2d 1235 (Okla. 1993).

57. Metzloff, *supra* note 48, at 215-16.

58. *Id.*

59. RISKIN ET AL, *supra* note 44, at 640.

60. FAA, 9 U.S.C. § 16 (1988).

61. RISKIN ET AL, *supra* note 44, at 640.

binding recommendation, which does not include an opinion on the merits.[62] Mediation, therefore, protects patients' interests by allowing them to opt for traditional litigation after both sides have had the opportunity to be heard. As a systemic benefit beyond mere cost savings, mediation offers the potential for an existing physician-patient relationship to continue,[63] which can facilitate physician disclosure of negligent errors, reduce excessive awards, and curtail the multifaceted deleterious effects of defensive medicine.

This thesis is corroborated by Professor Carol Liebman's studies on the effects of mediation in the medical malpractice system.[64] Professor Liebman took 29 cases from the public New York City Health and Hospitals Corporation and 37 from some private NY hospital systems.[65] Both studies utilized co-mediators who were chosen based on their comfort with discussing emotionally-charged issues and skill in exploring a range of non-economic issues.[66] Overall, most of the plaintiffs and attorneys found the mediation to be a positive experience, and the lawyers spent about one-tenth of the time they would preparing for litigation.[67]

In addition to the cost and time savings, Professor Liebman found that mediation offers a personal element absent from traditional litigation.[68] Relatives and family members of the victimized patient have a forum to relay their anguish and suffering, hear directly from the physician about how the medical complications arose, and gain closure by acquiring new perspective.[69] According to Professor Liebman, most patients and family members value receiving a detailed explanation of what happened and assurances that appropriate steps will be taken to

62. *Mediation Defined: What is Mediation?*, JAMS https://www.jamsadr.com/mediation-defined/ [https://perma.cc/NCV5-H8AH] (last visited Mar. 15, 2021).

63. Hyman et al., *supra* note 46, at 822 ("Anecdotes abound of injured patients and their family members who have continued to seek care from—and even recommended to their friends—hospitals that apologize for medical errors and adverse events."); *see also* Andrew McMullen, *Mediation and Medical Malpractice Disputes: Potential Obstacles in the Traditional Lawyer's Perspective*, 1990 J. DISP. RESOL. 371, 374 (1990), ("[M]ediation tends to enhance the human values of trust, caring, and respect, while emphasizing similarities between the parties rather than their differences.").

64. Carol B. Liebman, *Medical Malpractice Mediation: Benefits Gained, Opportunities Lost*, 74 L. & CONTEMP. PROBS. 135, 136 (2011).

65. *Id.*

66. *Id.* at 137.

67. *Id.* at 138-39.

68. *Id.* at 140.

69. *Id.*

rectify the problem in the future.[70] Her study identified that the primary goal for plaintiffs in malpractice litigation is an admission of fault or responsibility for the error; many plaintiffs also reported that they sued to ensure that the harm never occurs again.[71] Based on a 5-point scale (with a score of one being the most positive), plaintiffs rated the mediation process with a mean score of 1.98, "indicating overall clear satisfaction with mediation."[72] While patients may still be concerned with money, they feel more vindicated after direct conversations with their physicians.[73]

Max Brown, General Counsel of Rush Presbyterian-St. Luke's Medical Center in Chicago, corroborated Professor Liebman's study with anecdotal evidence while speaking at a symposium at DePaul University College of Law. He recounted one case where a child died when hospital staff failed to recognize that the child's father had provided them with the wrong dose of the child's medication.[74] Under the hospital's established mediation program, two mediators were selected—one from the plaintiff bar and one from the defense bar—and the mediation was held at a neutral location.[75] This provided the hospital a forum to apologize to the family, and, according to Mr. Brown, this process was a healing moment that relieved a lot of the guilt.[76] The apology is an important part of the process, and interest-based mediation, which is predicated on building trust between the parties, can encourage that apology.

Traditional litigation forecloses this critical information gathering opportunity and perpetuates the nondisclosure of mistakes. By default, when unexpected outcomes occur, physicians avoid apologizing to the patient or explaining future precautions to prevent reoccurrence.[77] This is perhaps due to fear of malpractice litigation.[78] However, assuming the mistake comes to light, these omissions will only increase the patient's resolve to file suit to gain closure and to obtain more detailed information about their medical complication.[79] Mediation can rectify

70. *Id.* at 141.

71. *Id.* at 142.

72. Hyman et al., *supra* note 46, at 808.

73. Liebman, *supra* note 64, at 138.

74. Symposium, *Panel I: Alternative Dispute Resolution Strategies in Medical Malpractice*, 6 DEPAUL J. HEALTH CARE L. 249, 254 (2003).

75. *Id.* at 253.

76. *Id.* at 254.

77. *See* Lauris C. Kaldjian et al., *Disclosing Medical Errors to Patients: Attitudes and Practices of Physicians and Trainees*, 22 J. INTERNAL MED. 988, 988 (2007).

78. *Id.* at 994.

79. *Cf.* Liebman, *supra* note 64, at 141.

these issues by utilizing problem-solving techniques to bring the parties together. In most cases, skilled mediators are able to successfully guide participant communication in a productive fashion.[80] Without the physician's participation in the mediation process, there is a "loss of opportunity for patients and physicians to reconcile, loss of the opportunity for information giving and gathering, and loss of the opportunity to consider changes in institutional policies and practices."[81]

There is further empirical evidence to support the proposition that mediation can increase the disclosure rate of medical errors to patients. According to one study, although 90 percent of respondents reported that they would disclose a hypothetical medical error which resulted in a minor or major harm, in reality, only 41 percent had ever disclosed a minor error and only five percent a major error.[82] However, 74 percent of physicians and surgeons who had disclosed a serious error reported that they experienced relief after disclosure, and where forgiveness was an integral part of their faith, physicians were more likely to disclose a hypothetical error that resulted in harm.[83] What this all suggests is that even though disclosure is likely in the best interest of the physician,[84] they are dissuaded from doing so due to external pressures such as the threat of a medical malpractice suit.[85] Implementing a robust mediation program where the parties communicate face-to-face to reach an amenable solution can facilitate this disclosure, especially as "[i]nformation and, when appropriate, assumption of responsibility for errors by the medical team can provide release for family members."[86]

IV.
INCENTIVES SURROUNDING IMPLEMENTATION OF ADR

In evaluating the potential to encourage widespread use of mediation, it is important to examine the various incentives of the different players in medical malpractice and how mediation advances or impedes their goals.

80. *Id.* at 143.

81. *Id.* at 140.

82. Kaldijian et al, *supra* note 77, at 994.

83. *Id.*

84. *See id.*

85. *See* Reschovsky & Saiontz-Martinez, *supra* note 33, at 1499-1500 (recounting the psychological stress physicians face with medical malpractice suits).

86. Liebman, *supra* note 64, at 145 (noting that patients and their families are willing to settle for less money, particularly in punitive damages, when they hear an apology directly from the physician).

Mediation provides several clear advantages for physicians over traditional litigation. It gives physicians the opportunity to speak directly to the patient and address their medical complications personally, as compared to a trial where the physician must indirectly convey complex medical issues to a lay jury. Under a carefully designed mediation system, the parties can set certain criteria for a mediator. They can ensure the mediator has expertise in the field, a requisite level of knowledge of the issues, and experience in facilitating direct conversations between doctor and patient. As acknowledged by a plaintiff's lawyer speaking at the aforementioned symposium, choosing the right mediator is crucial to success; Rush-Presbyterian's mediation program uses experienced medical malpractice trial lawyers.[87] The mediation process is also more confidential, which can protect the physician's reputation among colleagues, alleviating one of the other primary obstacles to disclosure of mistakes.[88]

There are some potential barriers to widespread acceptance of mediation by physicians. Federal law requires mandatory reporting of all malpractice payments to the National Practitioner Data Bank, thus discouraging early settlement and incentivizing physicians to take their chances with litigation.[89] It may in fact be rational for defendants to choose litigation, as only 10 percent of cases are actually resolved by a jury, while the rest are either dropped by the plaintiff or settled, and most often the defendant prevails.[90] These types of claims are also legally very challenging for a plaintiff to prove in court, which favors defendants who choose trial.[91]

Nevertheless, for the physician, the advantages of mediation should outweigh these countervailing concerns. Even though mediation is non-binding and defendants can still opt for a trial, physicians who undergo mediation sessions choose to settle cases more frequently.[92]

The patient's incentives to replace litigation with mediation seem even stronger than those of the physician. One of the distinct advantages

87. Symposium, *supra* note 74, at 253.

88. *See* Reschovsky & Saiontz-Martinez, *supra* note 33, at 1499.

89. Fraser, *supra* note 8, at 605.

90. Metzloff, *supra* note 48, at 206. Notwithstanding the small percentage of cases that ultimately reach a jury, the mere potential of a large discretionary jury verdict alters physician practices detrimentally, imposing greater costs on the healthcare system. *Id.*

91. Symposium, *supra* note 74, at 264.

92. In Professor Liebman's study, of the 19 cases actually mediated in HHC, 68.4 percent of them settled through mediation, and of the 31 cases in MeSH, 70.6 percent were settled. *See* Liebman, *supra* note 64, at 137.

to mediation is the ability to preserve relationships,[93] and in the medical malpractice context the doctor-patient relationship is very important. This relationship is predicated on a high level of trust and is essential to maintain given that one's health is of paramount concern.[94] Added benefits are that mediation is more cost effective for patients, the parties can control the process instead of enduring an emotionally draining trial, and the dispute could be resolved quickly.[95] This means reducing the period of hardship for a malpractice plaintiff and swiftly compensating the patient to cover imminent medical expenses.

The largest impediments to the use of mediation, however, are the lawyer—particularly defense counsel—and the medical malpractice insurer. According to Professor Liebman, while plaintiff lawyers are willing to engage in mediation because they are still assured payment and save tremendously on litigation expenses, defense lawyers are resistant to mediation.[96] She commented in her study that "[a]ttorneys, especially on the defense side, showed some reluctance to try mediation despite the considerable financial benefit to their clients of avoiding . . . trial."[97] Defense lawyers have perverse monetary incentives; they are paid hourly, which incentivizes them to favor a longer dispute resolution process.[98] As a result, defense lawyers may be less likely to recommend mediation even though it may be advantageous to their clients:

> [I]n assisting disputants to understand their cases and what can be done about them, lawyers as gatekeepers to legal institutions virtually always transform disputes[.] . . . [L]itigants' experiences and extralegal aims are translated, reconstituted, and coerced by lawyers to fit into legal and monetary compartments, ignoring aspects deemed irrelevant in law and ultimately translating them into money.[99]

Considering that medical malpractice typically involves clients who are not repeat players in civil litigation, they are generally uninformed about alternatives to trial and rely on counsel to be a source of

93. U.S. OFFICE OF SPECIAL COUNSEL, ADVANTAGES OF MEDIATION, https://osc.gov/Services/Pages/ADR-Advantages.aspx [https://perma.cc/PC35-S32S].

94. Patients are reluctant to bring a malpractice claim partially because they fear destroying their long-lasting relationship with their doctor. *See* Localio et al., *supra* note 25, at 249.

95. *Id.*

96. Telephone Interview with Carol B. Liebman, Clinical Professor Emerita of Law, Columbia Law School (Nov. 25, 2019) [hereinafter Liebman interview].

97. Hyman et al., *supra* note 46, at 813.

98. *See id.*

99. Liebman, *supra* note 64, at 142-43, citing TAMARA RELIS, PERCEPTIONS IN LITIGATION AND MEDIATION: LAWYERS, DEFENDANTS, PLAINTIFFS, AND GENDERED PARTIES 53 (2009).

information.[100] Another reason attorneys prefer traditional litigation is that they are comfortable with the system; lawyers are trained in applying legal rules to facts and ADR stymies that vision.[101] Risk aversion pulls lawyers towards what they are more comfortable with, namely presenting in the courtroom before a judge.[102] Additionally, lawyers are inclined to focus on monetary damages, so they instinctively superimpose their own views, convincing clients that economic gains should be the primary goal (for which traditional litigation is superior to mediation).[103]

These considerations raise ethical issues regarding defense lawyers acting as proper fiduciaries to their physician-clients. Lawyers can serve as an impediment to ADR because they lack the proper education on alternative forms of dispute resolution and are ill-prepared to counsel their clients on the subject.[104] The Model Rules of Professional Conduct have tried to address this issue. Rule 1.1 requires a lawyer to provide competent representation, which entails lawyers possessing "the legal knowledge, skill, thoroughness and preparation reasonably necessary for the representation."[105] Comment 2 further clarifies that the most important legal skill a lawyer must have is the ability to analyze a legal problem and determine the best method for its resolution.[106] Riskin extrapolates from this that lawyers must have sufficient knowledge about the available dispute resolution options in order to properly advise a client on how to proceed.[107] It is not clear that there is an affirmative obligation on lawyers to provide advice to clients on the potential use of ADR, but a lawyer is ethically obligated to explain a matter to the extent necessary to allow a client to make an informed decision.[108] In addition to the Model Rules, there are some state codes that require or strongly encourage lawyers to advise their clients on ADR options.[109] Some

100. Donna Shestowsky, *When Ignorance is Not Bliss: An Empirical Study of Litigants' Awareness of Court-Sponsored Alternative Dispute Resolution Programs*, 22 HARV. NEGOT. L. REV 189, 211 (2017); *see also* Liebman, *supra* note 64, at 149 ("Medical malpractice plaintiffs are unlikely to be involved in repeat litigation, so they are less likely to understand the system well enough False").

101. Liebman, *supra* note 64, at 143.

102. *Id.*

103. *Id.*

104. Shestowsky, *supra* note 100, at 222.

105. MODEL RULES OF PROF'L CONDUCT r. 1.1 (AM. BAR. ASS'N 2018).

106. *Id.* at Comment 2.

107. RISKIN ET AL, *supra* note 44, at 139.

108. *Id.* at 140-41.

109. *Id.* at 141.

ethics opinions require lawyers to advise if the other side has proposed using ADR.[110]

Lawyers who fail to advise their clients on mediation because of perverse monetary incentives risk violating core ethical obligations.[111] Professor Liebman suggests such when commenting that "[i]n theory, decisions about whether or not to mediate should be made jointly by lawyers and clients (ABA Model Rules of Professional Conduct 2006)."[112] To facilitate legal advice on ADR options, attorney education surrounding the different systems must be expanded. Lawyers may discourage their physician-clients from participation in mediation because they lack information and knowledge about mediation; however, with more robust attorney education, comfort with the concept of mediation in medical malpractice could be increased.[113]

There are some other factors to consider that may explain lawyers' distaste for mediation. Lawyers have a general preference for an evaluative mediation, where the principal strategy of the mediator is to learn about all of the circumstances and underlying interests of the parties, and utilize that knowledge to direct the parties toward a particular solution.[114] Studies have shown that many attorneys who use mediation prefer that mediators use analytical techniques during the mediation; 95 percent responded that a mediator's analysis of the case, including strengths and weaknesses on each side, was helpful to the resolution of their case.[115] Professor Liebman's study corroborates these findings; she commented that some lawyers in her study preferred an evaluative approach to mediation.[116]

The problem is that the optimal form of mediation for medical malpractice cases is one in which the mediator encourages the parties to discuss all issues that are important to them and to control the session. This provides the greatest opportunity to reap the benefits of apology, empathy, and direct communication. Under Riskin's understanding-based mediation approach, primary responsibility for resolving the dispute lies with the parties themselves as opposed to with the

110. *Id.* at 142.

111. *See* MODEL RULES, *supra* note 105.

112. Liebman, *supra* note 64, at 139 (quoting Hyman et al., *supra* note 46, at 813).

113. *Id.* at 146. Note also how Richard Donahue, a defense attorney in Chicago focusing exclusively on medical malpractice cases who spoke at the DePaul symposium, mentioned he detested mediation initially because it detracted from lawyer fees, but once he learned more about it and utilized it more often, he grew to become fond of it. Symposium, *supra* note 74, at 257.

114. RISKIN ET AL, *supra* note 44, at 313.

115. *Id.* at 452.

116. Liebman, *supra* note 64, at 138.

mediator.[117] The mediator's role is that of a facilitator—bringing the parties together, developing a rapport, establishing trust, and ultimately eliciting direct communication. An evaluative mediator who suggests a settlement amount and analyzes the merits of the case resurrects some of the same issues present in arbitration.

In spite of these challenges, greater attorney education can provide a solution to this problem. The root cause of this issue seems to be a lack of attorney comfort with ADR;[118] attorneys' preference for evaluative mediation indicates that they want more active participation from the mediator in crafting a settlement. With education, perhaps attorneys can feel better able to control the mediation process themselves.

Medical malpractice insurers, like attorneys, are also roadblocks to implementation of mediation programs. At first glance, it would appear that insurers would favor a system that provides more predictable results and the possibility of lower median settlement amounts. The differences between traditional litigation and mediation should not affect insurers, as actuarial probabilities from different processes could be adjusted and reflected in premiums charged. Nevertheless, insurers are seen as reluctant to endorse mediation.[119] Just as with attorneys, insurers are comfortable with the current system.[120] Despite traditional litigation's potential for extreme variability in verdicts, jury trials are well studied and the insurer can precisely calculate the likelihood of plaintiff verdicts and the median amount recovered for different injuries.[121] Essentially, there is just not enough of a track record with mediation for insurers to comfortably assess the likely settlement amounts.

Malpractice insurers do not face the same pressures as the defendants they insure. The individual physician is risk averse and faces the immense stress of a verdict, which could significantly impact their personal assets and savings. However, insurance companies cap the amount that they can be liable to pay.[122] Additionally, traditional litigation often takes years to resolve, allowing the insurer to hold onto the money longer and continue earning interest on it before they are required to make a claim payment.[123] Insurers also fear that widespread

117. RISKIN ET AL, *supra* note 44, at 351.
118. Liebman, *supra* note 64, at 148.
119. Metzloff, *supra* note 48, at 212.
120. Liebman interview, *supra* note 96.
121. *Id.*
122. *Id.*
123. *Id.*

adoption of ADR programs, by lowering the costs of bringing suit, will significantly increase the number of claims.[124]

Short of adopting additional regulations on the insurance market, these incentives for medical malpractice insurers are difficult to overcome. Perhaps more initiative from legal organizations who have already been instrumental in pursuing plans for adopting mediation could be beneficial.[125] If mandatory or presumptive mediation is adopted, more cases will be resolved via mediation and insurers will have more data to calculate probable outcomes, making the insurers more comfortable referring cases for mediation. New York can serve as a model for this effort. Recently, an Advisory Committee established by the Chief Judge recommended presumptive, automatic mediation for all cases.[126] The plan gives courts in each Appellate Division substantial flexibility to design their own process with relatively little guidance from the state, but with a policy goal of substantially increasing usage of ADR in civil cases.[127] If state supreme courts exhibit a clear and unequivocal policy preference for ADR use, it is possible insurers will be compelled to participate in the process and may grow to appreciate the beneficial effects of general cost reduction.

V.
CONCLUSION

Mediation has greater potential than traditional litigation to increase patient safety while simultaneously reducing costs to an already over-burdened healthcare system. Reduced costs will lower barriers for patients seeking compensation for their injuries, thereby closing the gap between medical negligence and rates of filing suit. Physicians will face lower settlement amounts as a result of the opportunity to apologize to a patient and their family in a collaborative, and not adversarial, environment. This could not only reduce the costs stemming from excessive defensive medical care, but also encourage disclosure of medical errors to patients and other physicians, thus tangibly improving

124. Metzloff, *supra* note 48, at 219.

125. *See, e.g.*, Sarah Konnerth, *Pro Se, No Say?: The Impact of Presumptive Mediation in the New York State Court System on Self-Represented Litigants*, 88 FORDHAM L. REV. 1365, 1370 (2020) (describing the efforts of federal judges, legal scholars, and the American Bar Association to alleviate burdens on the court system).

126. Press Release, Lawrence K. Marks, Chief Administrative Law Judge, New York State Unified Court System, Court System to Implement Presumptive, Early Alternative Dispute Resolution for Civil Cases (May 14, 2019), https://ww2.nycourts.gov/sites/default/files/document/files/2019-05/PR19_09_0.pdf [https://perma.cc/BX2M-ZQ5C].

127. *Id.*

patient safety. Mediation is the most promising way to change our medical malpractice liability system to achieve the tort goal of optimal deterrence, resulting in a cheaper and better system for all Americans.