Technical Report: Alternative Dispute Resolution in Medical Malpractice

ABSTRACT. The purpose of this technical report is to provide pediatricians with an understanding of past crises within the professional liability insurance industry, the difficulties of the tort system, and alternative strategies for resolving malpractice disputes that have been applied to medical malpractice actions. Through this report, pediatricians will gain a technical understanding of common alternative dispute resolution (ADR) strategies. The report explains the distinctions between various ADR methods in terms of process and outcome, risks and benefits, appropriateness to the nature of the dispute, and long-term ramifications. By knowing these concepts, pediatricians faced with malpractice claims will be better-equipped to participate in the decision-making with legal counsel on whether to settle, litigate, or explore ADR options.

ABBREVIATIONS. ADR, alternative dispute resolution; NPDB, National Practitioner Data Bank.

BACKGROUND

During the 1970s and 1980s the American medical profession experienced a series of professional liability crises. The first sign was a significant rise in the number of malpractice claims filed against physicians. Already high litigation costs increased further with the growing number of medical malpractice claims being filed. Between 1930 and 1994 US tort costs grew almost 4 times faster than the rate of growth of the US economy. The most rapid escalation in US tort costs took place between 1950 and 1985, when they grew by an average of 12% annually, while nominal economic growth averaged 602 PEDIATRICS Vol. 107 No. 3 March 2001

sions insurance, employment liability insurance, managed care liability insurance, billing errors insurance, and malpractice insurance. This technical report focuses specifically on the use of alternative dispute resolution (ADR) in resolving medical malpractice claims; thus the term “malpractice insurance” is used to distinguish these policies from the broader term “professional liability.”

Physicians found it increasingly difficult to obtain malpractice insurance as commercial insurance carriers either stopped offering medical malpractice coverage or abandoned professional liability market altogether. Insurers that continued to carry medical malpractice coverage had to raise insurance premiums, sometimes doubling or even tripling them to meet the rising costs of indemnifying physicians. At the height of this crisis premiums for medical malpractice insurance coverage soared. It was reported that in 1 region of California physicians experienced a 360% increase in malpractice insurance premiums in 1 year.2

Physicians took matters in their own hands and created a network of professional liability insurance companies committed to providing long-term malpractice insurance coverage at reasonable cost. Although the formation of physician-owned medical liability carriers helped stabilize the malpractice insurance market, physicians still felt vulnerable to the lottery-like nature of malpractice allegations. It was clear then as well as now, that medical negligence litigation epitomizes the systemic problems in civil liability. Simply stated, very few acts of medical negligence result in malpractice claims and very few malpractice lawsuits actually involve medical negligence.3 A patient’s motivation to sue a physician for malpractice often rests in factors unrelated to the quality of medical care.

Realizing that the tort system was seriously flawed, several states experimented with various tort reform strategies. Despite these attempts, the lingering threat of malpractice continued to take its toll on health care delivery. Physicians learned to practice defensive medicine, which significantly increased health care cost.4 But far more costly was the damage done to the physician/patient relationship as concerns that the next patient could also be a potential malpractice suit added mistrust to medical encounters.5

Various solutions were proposed to reform the tort system and thereby reduce the rippling effects of the malpractice crises on the cost and delivery of health care. These strategies are best understood when con-
sidered as first-generation and second-generation reforms (see Fig 1). Early interventions, first-generation tort reforms, attempted to reduce the frequency and severity of malpractice claims. Later efforts, second-generation tort reforms, were aimed at streamlining adjudication and compensation systems.6 Those considered ADR devices are noted with an asterisk. ADR refers to a group of processes through which a dispute can be resolved short of litigation. Various ADR techniques are arranged along a continuum in Fig 2 that depicts their relative progression from voluntary to mandated choices, from nonbinding to binding outcomes, and from processes less likely to violate privacy and disrupt personal and professional life to those that are more public and intrusive.7

It is against this landscape of past crises, attempted reforms, and persistent inefficiencies in the US tort system that this technical report is written. The report focuses on four specific ADRs—negotiation, mediation, arbitration, and the pretrial screening panel. It compares their relative advantages/disadvantages against litigation to remedy allegations of medical negligence. The report also defines other less frequently used ADR methods and hybrid techniques as well in its glossary. This technical report is intended to make pediatricians aware of other means of resolving malpractice allegations and the potential risks and benefits associated with ADR processes.

NEGOTIATION

Negotiation, the most frequently used method of ADR, is defined as the process whereby 2 or more disputing parties confer together in good faith so as to settle a matter of mutual concern.8 The approach to negotiation may be positional or principled. In positional negotiation, divergent parties incrementally concede their positions until a compromise is reached. In principled negotiation, the parties generate options focused on their interests to arrive at an agreement based on objective criteria. Negotiation serves as the basis for mediation, an important ADR method used in medical malpractice cases.5

Negotiation has its advantages. The disputants remain in control of the process. Negotiated resolutions tend to have greater durability than agreements reached by other methods.8 The process of negotiation can be educational for both parties and therefore may prevent subsequent discord in the relationship. However, sometimes negotiation alone is not enough to resolve medical malpractice actions. Most negotiated resolutions are reached when the disputing parties are large vertically structured corporations. In these instances, the negotiations are conducted by senior members of the opposing corporations sometimes referred to as “wise people,” or high-level corporate agents with the authority to resolve the dispute. Because the negotiators were not involved in the original conflict, they have sufficient personal and emotional distance to compromise.7 Medical malpractice litigation often involves individuals (a patient versus a physician); typically the disputants are not huge corporate entities. Traditionally physicians have been in relatively small corporations; therefore, it can be difficult to get the kind of dispassionate perspective that is conducive to successful resolution via negotiation alone.

MEDIATION

Mediation is an extension of direct negotiation between the parties, using a neutral third party to facilitate the negotiation process. As a facilitator, the mediator has no authority to impose a solution on the parties nor are the results of the process binding on the disputing parties. The mediator acts by identifying issues, proposing solutions, and encouraging accommodation on both sides.5 Mediation can be effective in medical malpractice cases in which the patient and physician want to preserve their relationship or in which poor communications has led to the dispute. The advantages of mediation over litigation are its decreased costs, more confidential proceedings, and the degree of control enjoyed by the disputing parties over the process and outcome. In resolving allegations of medical negligence, patients tend to favor mediation because it provides a forum in which they can express their concerns and may lead to an acknowledgment of the problem—some-
times in the form of an apology.\textsuperscript{9} Mediation has its limitations. In many jurisdictions mediation is voluntary and can only be pursued if both parties agree to it. Mediators do not have the same authority as judges and therefore cannot compel the release of information nor can their decisions be imposed. The mediator has only as much power as the disputing parties permit and as such can go no further than the disputants themselves are willing to go.\textsuperscript{9}

**ARBITRATION**

In arbitration the parties agree to submit their dispute to a neutral third party, usually an arbitrator or an arbitration panel. The arbitrator conducts a hearing in which each side presents evidence. The arbitrator then makes a determination on liability and/or renders a decision of award. Often the parties agree in advance whether the arbitrator’s decision will be binding.\textsuperscript{10} However, the decision of the arbitrator is subject to limited appellate review for procedural error, arbitrator bias, or fraud. Arbitration can be private, arising from the terms of a contract between the parties, or judicially mandated (court-annexed) by statute or rule.\textsuperscript{8}

Potential advantages of arbitration over judicial trials for resolving malpractice claims are: speed (arbitration can be initiated as soon as the dispute arises), simpler and less expensive proceedings (in arbitration the rules of evidence are less stringent and the processes are often more streamlined than court proceedings), and privacy (arbitration hearings are more private than judicial trials, which can become media events).\textsuperscript{9} An advantage not to be overlooked is the opportunity to use a uniquely skilled arbitrator. Unlike a judge, the arbitrator may possess technical skills or scientific knowledge directly related to the subject of the dispute; this could be a distinct advantage when the dispute is enmeshed in an extremely complex or esoteric content area such as medicine.\textsuperscript{8} However, by choosing an arbitration panel over a court trial, the defendant physician sets aside certain rights. For example, in arbitration there is no right to a trial by jury and no judicial instruction on the law. Similarly, documents from arbitration proceedings are not as complete as court proceedings. This can become problematic, as arbitration panels need not explain the basis of their decisions.

Arbitration has been applied in medical malpractice for more than 20 years. In the state of Michigan it is required by statute and in California by contract between managed care organizations and enrollees. Challenges to medical malpractice arbitration awards in both states have been upheld by their highest courts.\textsuperscript{5} Despite this, arbitration remains an underutilized ADR method in medical malpractice cases across the country.\textsuperscript{11,12}

**PRETRIAL SCREENING PANEL**

The pretrial screening panel is an ADR method that was uniquely developed for medical malpractice cases. About half of the states have statutes establishing pretrial screening panels that review malpractice claims and render a nonbinding advisory opinion on the merits of the claim before a suit being filed. Panel composition varies considerably from state to state. In some states only physicians sit on pretrial screening panels. Other states restrict panels to attorneys. Other states require that the members of a pretrial screening panel include physicians, attorneys, judges, and/or laypersons. The panel reviews the merits of the malpractice case and offers an opinion on the physician’s liability. In some states the panel reviews the claim before legal action is taken. In other states the suit must be filed in court before it is sent to the panel. States also vary on whether the panel renders an opinion on damages. Furthermore, state law determines whether the findings of the pretrial screening panel can be admitted as evidence should the claim go to trial, and if so, how much weight the panel’s findings should be given. The
The earliest malpractice pretrial screening panels date back to the 1960s. In New Mexico a 1962 statute introduced a voluntary pretrial review panel; in the mid 1970s, during the malpractice litigation crisis, the statute was revised to make pretrial screening mandatory. Consequently, from 1976 to 1996 New Mexico panels have heard more than 2100 medical malpractice cases; nearly three-quarters of those cases were resolved without trial. A major disadvantage of pretrial screening panels is the nonbinding nature of most ADR methods. In many states the plaintiff can still litigate after the pretrial screening panel decision is made. Thus, the pretrial screening panel may, in effect, further delay final resolution of the claim. Although there is some evidence that screening panels are effective in eliminating low-merit cases others contend that panels are victims of their own existence, as they can become clogged with frivolous claims that otherwise would not be pursued.

OTHER METHODS
Several other ADR methods are suited to resolving medical malpractice disputes, but are seldom used in this setting. These include early neutral evaluation, mediation-arbitration, mini-trial, neutral fact finder, ombudsman, private judging or rent-a-judge, and summary jury trial. (These ADR terms are defined in the glossary that follows this technical report). Many of these ADR techniques were developed for and are primarily used in the commercial or corporate environment. With the ongoing consolidation of health care entities into massive corporations, these methods may become more commonly used in medical malpractice claims. Should the federal Employee Retirement Income Security Act of 1974 preemption from liability be lifted or amended to permit patients to sue their managed care organizations for malpractice, the use of ADR is likely to increase significantly.

BARRIERS TO ADR
A major impediment to physician use of ADR in medical malpractice is the mandatory reporting of all malpractice payments to the National Practitioner Data Bank (NPDB). It is important that physicians understand that any malpractice payment (eg, settlement or award) made on their behalf, even those derived from an ADR process, must be reported to the NPDB. Entries in the NPDB are specific to the physician on whose behalf the payment was made and are permanent. Every time a physician seeks or renews clinical privileges at a hospitals or new employment his or her NPDB may be queried by authorized entities. Although physicians can furnish a note of explanation in their NPDB files, many prefer to take the odds of litigation, which tends to favor the physician defendant. Repeated efforts to open the NPDB to the public have not succeeded thus far. This could change as patient rights initiatives continue to gain momentum and other databanks of disciplinary actions taken against health care practitioners that are already open to the public (eg, Medicare/Medicaid program exclusions, Occupational Safety and Health Act/Clinical Laboratories Improvement Act sanctions, adverse actions taken by state medical licensing boards) continue to proliferate.

SUMMARY
Various ADR methods are available to resolve medical malpractice claims. Many promise to work more effectively and fairly than the current tort system. Litigation is adversarial, traumatic, and often detrimental to the patient-physician relationship. Litigation stress can take an enormous toll on both the plaintiff and the defendant. The expense of litigation prevents equal access to the system; sometimes patients who have suffered damages from medical negligence are not able to secure representation because their claim is too small. Not only is the US tort system the most expensive in the world, its awards return less than 50 cents on the dollar to the people the system is designed to help. Furthermore, a relationship between patient injuries and malpractice may or may not exist. The literature has noted that malpractice claims are more likely to be triggered by maloccurrence (bad outcome) than malpractice (bad medicine) and that many patients injured by negligent care never file malpractice suits. ADR techniques are often described as bilateral tort reforms because they can make it cheaper for physicians to defend unfounded claims and easier for plaintiffs to prevail on meritorious claims. Given the persistent problems in medical malpractice litigation for both sides it is surprising that ADR methods remain underutilized, especially when reforms based on ADR potentially make the tort system more equitable and affordable to both plaintiffs and defendants.

It is important for pediatricians to understand ADR processes, their relative advantages and disadvantages, and suitability to certain kinds of disputes. Moreover, physicians must clearly understand the degree of privacy, the level of autonomy afforded the disputants, and the binding nature of each ADR method. Beyond knowing the strengths and weaknesses of specific ADR strategies, physicians must also weigh the long-term consequences associated with ADR. For instance, physicians who predominate rely on ADR when faced with a malpractice claim may end up with several entries in their NPDB files because ADR payments made on behalf of physicians are not exempt from mandatory NPDB reporting. Unless a more reasonable reporting trigger or payment threshold can be introduced to the NPDB, defendant physicians may prefer to take their chances in court rather than use ADR to resolve malpractice cases. Helping pediatricians understand the implications of ADR methods may empower them to work more effectively with defense counsel in selecting the best strategy for resolving malpractice allegations.

APPENDIX: GLOSSARY OF TERMS
Alternative dispute resolution (ADR): Refers to procedures for settling disputes by means other than
Arbitration: A form of ADR in which the parties agree to have 1 or more trained arbitrators hear the evidence of the case and make a determination on liability or damages. The disputing parties may specify the rules of evidence and other procedural matters. Arbitration can be binding (ie, subject to limited judicial review) or nonbinding (ie, the parties may proceed to trial if not satisfied with the outcome of the arbitration).

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

Damages: The sum of money a court or jury awards as compensation for a tort or breach of contract. The law recognizes several categories of damages. General damages: typically intangible damages, such as pain and suffering, disfigurement, interference with ordinary enjoyment of life, or loss of consortium. Special damages: out-of-pocket damages that can be quantified, such as medical expenses, lost wages, or rehabilitation costs. Punitive/exemplary damages: damages awarded to the plaintiff in cases of intentional tort or gross negligence to punish the defendant or act as a deterrent to others.

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

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

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

Malpractice: Professional negligence resulting from improper discharge of professional duties or failure to meet the standard of care of a professional, resulting in harm to another.

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

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

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

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

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

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

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

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

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

Statute of limitations: The time period established by law during which a plaintiff may file a lawsuit; the period for reporting malpractice is longer for minor patients than adults. Once this period expires, the plaintiff's lawsuit can be barred. In some states, the time period does not begin until the injury is discovered. The discovery rule states that the date of the injury, from which the time period is measured, is the date that it was reasonable for the plaintiff to have discovered the injury rather than the actual date of injury. Injuries may be discovered years after the treatment was provided. Therefore, the time period for filing actions may be extensive and difficult to verify. The long tail associated with pediatric care is an important consideration in resolving malprac-
tice allegations. The more time that has passed, the more difficult it is to obtain pertinent evidence and available witnesses. Many states have shortened this period from when the minor-aged patient reaches the age of majority to within a specified number of years after the injury occurred or a specified number of years in which a reasonably intelligent person would have discovered the injury. (The Academy has model legislation to help state chapters reform statute of limitation for minors).

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

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

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

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

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REFERENCES

ERRATUM

In the AAP statement “Folic Acid for the Prevention of Neural Tube Defects” (1999;104:326), incorrect information was given in the second recommendation. In the second recommendation, the line that begins “During times in which a pregnancy is not planned” should read as follows:

“During times in which a pregnancy is not planned, these high-risk women should consume 400 µg (0.4 mg) of folic acid per day.”
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