COMMENT

ALTERNATIVE DISPUTE RESOLUTION STRATEGIES IN MEDICAL MALPRACTICE

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I. INTRODUCTION

Perhaps no other litigation area has been the subject of as much interest in reform as has medical malpractice. A distinct element of this interest has centered on efforts to change the *process* by which malpractice cases are handled. Since the mid-1970's, virtually every state has attempted some type of "tort reform" intended to impact the manner in which medical malpractice suits are handled.[1] In light of the incredible growth in the use

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1. For discussions of malpractice reform efforts including descriptions of procedural changes, see U.S. GEN. ACCT. OFF., MEDICAL MALPRACTICE: A FRAMEWORK FOR ACTION (1987) [hereinafter FRAMEWORK FOR ACTION]; PAUL C. WEILER, MEDICAL MALPRACTICE ON TRIAL (1991); Glen O. Robinson, *The Medical Malpractice Crisis of the 1970's: A Retrospective*, 49 LAW & CONTEMP. PROBS., Spring 1986, at 5; Walter J. Wadlington, *Legal Responses to Patient Injury: A Future Agenda for Research and Reform*, 54 LAW & CONTEMP. PROBS., Spring 1991, at 199.

of alternative dispute resolution ("ADR") methods in the past decade,[2] it is inevitable that policy-makers will become interested in exploring how the myriad ADR techniques might be best employed in the malpractice context. This comment will examine actual and potential applications of ADR approaches for handling medical malpractice disputes, focusing particularly on ADR strategies for Alaska.

II. CONCEPTUALIZING THE POTENTIAL BENEFITS OF ADR: UNDERSTANDING THE CURRENT SYSTEM

An initial task is to describe ADR's potential benefits in the malpractice context. This requires an understanding of the current litigation framework. Illustration 1 (Appendix A) depicts a simplified time line showing how a typical malpractice claim is processed through the current system. The "X" indicates the point of the alleged malpractice. Malpractice suits are typically not filed until at least one or two years after the alleged negligence. Relatively little is known about why some potential plaintiffs decide to assert a malpractice claim while others elect to do nothing.[3] No doubt the decision involves several factors, such as the sophistication of the patient, the patient's access to legal information, and the seriousness of the patient's injury.[4]

Malpractice claimants usually must resort to filing a formal lawsuit if they are to obtain compensation. While there is some pre-litigation settlement of malpractice claims, it is rare; most claimants who obtain any compensation do so only after filing a lawsuit.[5] Once a lawsuit is filed, the litigation system has three primary phases, each of which is shown in Illustration 1: (1) the *pleading stage*, which defines the parties' claims and defenses; (2) the *discovery stage*, during which the litigants investigate the facts surrounding their dispute;[6] and (3) the *trial stage*, in which the

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2. For a general overview of ADR techniques and discussion of issues relating to their development, see STEPHEN B. GOLDBERG ET AL., DISPUTE RESOLUTION (2d ed. 1992).

3. Recent evidence shows that most patients with potential malpractice claims -- those patients who have suffered an iatrogenic injury attributable to a physician's negligence -- do not assert any claim. *See* HARVARD MEDICAL PRACTICE STUDY, PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK (1990).

4. *See generally* Marlynn L. May & Daniel B. Stengel, *Who Sues their Doctors? How Patients Handle Medical Grievances*, 24 LAW & SOC'Y REV. 105 (1990).

5. *See* JAMES S. KAKALIK & NICHOLAS M. PACE, COSTS AND COMPENSATION PAID IN TORT LITIGATION 31 (1986) (noting that approximately 90% of the dollars paid to claimants occurred after a lawsuit was filed). In comparison, only about 33% of the dollars awarded to automobile accident claimants required a lawsuit; the balance was paid in settlements reached without the need to resort to a lawsuit. *Id.*

6. Rules of procedure permit both parties full access to all relevant information

dispute is resolved by the jury. In addition, for those cases that run the course of the procedural gauntlet, the system provides an appeal process.

While one can articulate the goals of the procedural system in various ways, the following seem paramount, at least in the context of medical malpractice disputes: (1) to identify and dismiss non-meritorious litigation; (2) to provide a framework in which voluntary settlement negotiations can operate; and (3) to provide a dispute resolution process (the jury) for resolving non-settled claims.[7]

A. Identifying Non-Meritorious Litigation

It is well known that the vast majority of malpractice cases (upwards of ninety percent) are resolved prior to trial. In fact, this high percentage of settlements combines two very different phenomena: (1) plaintiffs dismissing their suits without receipt of any payment; and (2) settlements in which the plaintiff receives a monetary indemnity. The former category potentially includes a large number of non-meritorious claims that arguably should not have been filed in the first place. One of the major criticisms of malpractice litigation is that it permits, or even fosters, such claims.

Existing empirical evidence suggests that a significant percentage of filed malpractice claims are eventually dismissed or dropped without payment to the plaintiff.[8] To some observers, this suggests that those claims were lacking in merit and should never have been filed. While this is not necessarily true, it does raise serious concerns as to whether there are too many "frivolous" malpractice cases. The procedural device known as summary judgment is intended to discourage non-meritorious litigation by giving the courts the opportunity to dismiss such claims. Although there

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relating to a claim. This investigatory process includes several different methods of obtaining information, including requests for relevant documents (such as medical records); interrogatories (written questions of the opposing party); and depositions (in which the parties, relevant witnesses, and experts respond to oral questions asked by the attorneys).

7. *See* Thomas B. Metzloff, *Researching Litigation: The Medical Malpractice Example*, 51 LAW & CONTEMP. PROBS., Autumn 1988, at 199, 202 [hereinafter Metzloff, *Researching Litigation*].

8. The extent of "frivolous" malpractice litigation is a sharply contested point. The best current empirical evidence suggests that the percentage of non-meritorious malpractice claims is substantial, probably near the 40% level. *See* Frederick W. Cheney et al., *Standard of Care and Anesthesia Liability*, 261 JAMA 1599 (1989). Cheney's study involved expert review of over 1,000 case files to determine whether inadequate medical care was in fact rendered. The study found that 46% of the claims involved appropriate care (and thus were technically "non-meritorious" claims). The majority of the plaintiffs in those cases received no compensation, although about 40% did receive some amount. However, the amount received was usually far less than for those plaintiffs with similar injuries who were victims of inadequate care. *Id.*; *see generally* Henry S. Farber & Michelle J. White, *Medical Malpractice: An Empirical Examination of the Litigation Process*, 22 RAND J. ECON. 199 (1991) (finding that 95 of 252 claims against a hospital involved "appropriate" care).

has been no empirical study directed towards the use of summary judgment in malpractice cases, the conventional wisdom is that summary judgment is ineffective.[9] Medical professionals concerned with plaintiffs bringing seemingly non-meritorious malpractice claims also have made repeated efforts to seek sanctions or damages against plaintiffs' attorneys.[10] These efforts, however, also have proven largely unsuccessful.

B. Settlement of Malpractice Litigation

To date, there has been no comprehensive analysis of the settlement process in malpractice cases either with respect to when settlements typically occur in the course of the litigation or with respect to the exact factors which determine whether a settlement will occur at all.[11] It is clear, however, that settlements are common in malpractice cases. On average, about fifty percent of all malpractice lawsuits are settled with the plaintiff receiving a payment.[12] Critics of the system suggest that the high cost of malpractice litigation and the unpredictability of the results (1) force patients to settle claims for significantly less than the true value of their claims,[13] and (2) force physicians to settle claims in which they have meritorious defenses.[14]

In the past, most malpractice insurance contracts provided that the physician had to consent to settlement prior to the insurer agreeing to a compromise of the claim.[15] Now, however, the majority of malpractice insurers probably have the right to settle without the physician's consent. As a practical matter, insurers remain interested in complying with a physician's preference with respect to settlement. The prevailing view is

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9. *See generally* Edward Brunet, *The Use and Misuse of Expert Testimony in Summary Judgment*, 22 U.C. DAVIS L. REV. 93 (1988).

10. *See generally* Sheila L. Birnbaum, *Physicians Counterattack: Liability of Lawyers for Instituting Unjustified Medical Malpractice Actions*, 45 FORDHAM L. REV. 1003 (1977).

11. *Cf.* Metzloff, *Researching Litigation*, *supra* note 7, at 199. Among the factors that malpractice insurers likely consider in deciding whether to settle are (1) the merits of the case; (2) the risk of a large damages award should the jury find in favor of the plaintiff; (3) the wishes of the defendant physician as to whether or not to settle; (4) the costs of proceeding to trial; (5) the quality of the plaintiffs' attorney; (5) the sympathetic qualities of the plaintiff; and (6) any unusual facts in the case (such as missing medical records) that might influence a jury. Some malpractice insurers may give some of these factors relatively more weight than other insurers. *Id.*

12. *See generally* U.S. GEN. ACCT. OFF., MEDICAL MALPRACTICE: CHARACTERISTICS OF CLAIMS CLOSED IN 1984 (1987) [hereinafter CLAIMS CLOSED IN 1984].

13. WEILER, *supra* note 1, at 53-54.

14. *See, e.g.*, WALTER K. OLSON, THE LITIGATION EXPLOSION: WHAT HAPPENED WHEN AMERICA UNLEASHED THE LAWSUIT 267-68 (1991) (arguing that the merits of the case constitute but a minor ingredient in explaining malpractice case results).

15. *See* Samuel R. Gross & Kent D. Syverud, *Getting to No: A Study of Settlement Negotiations and the Selection of Cases for Trial*, 90 MICH. L. REV. 319, 361 (1991).

that most physicians prefer to litigate to protect their reputation (and to avoid any adverse consequences with disciplinary authorities).[16]

Illustration 1 depicts the existing settlement system as a parallel process co-existing with the ongoing formal court procedures. Under the current regime, litigants are free to consider settlement whenever they so choose. Despite this autonomy, there are a number of predictable "settlement points" (shown by the arrows on the settlement line in Illustration 1). These common settlement points include: (1) the pre-litigation period, (as noted above, settlements are rare during this period in the malpractice context); (2) the summary judgment stage; (3) the period immediately preceding trial ("on the courthouse steps"); (4) the trial itself; and (5) the appeal stage. The largest number of settlements appear to occur immediately before trial, often after the parties have incurred sizable litigation expenses.[17] Under traditional rules of civil procedure, there are no formal procedural events that require the parties to assess settlement of their claim immediately preceding trial. However, many courts have the power to raise the settlement issue during a pre-trial conference.[18]

C. The Role of the Jury in Malpractice Cases

One of the most frequent complaints about malpractice litigation is that the jury is an untrustworthy decision-maker.

In fact, the jury resolves only a small percentage (about ten percent) of malpractice cases, with the balance either being dropped by the plaintiff or settled.[19]

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16. *See* Kent D. Syverud, *The Duty to Settle*, 76 VA. L. REV. 1113, 1172-73 (1990).
It is now widely speculated that settlement of malpractice cases will become more difficult. In 1990, the federal government began requiring all malpractice insurers to report any malpractice judgment or settlement to a data bank. Hospitals and other interested parties will have the right to search the data bank to determine a physician's history with respect to successful malpractice claims. This process raises serious concerns on the part of physicians as to the possibility that even a single malpractice settlement might impact their future ability to obtain hospital privileges and the like. *See* Ilene D. Johnson, *Reports to the National Practitioner Data Bank*, 265 JAMA 407 (1991).

17. For some quantification of the timing of settlements in malpractice cases, see Thomas B. Metzloff, *Resolving Malpractice Disputes: Imaging the Jury's Shadow*, 54 LAW & CONTEMP. PROBS., Winter 1991, at 43, 59 n.54 [hereinafter Metzloff, *Resolving Disputes*] (noting that about 25% of all malpractice suits in a three-year survey of North Carolina cases were settled immediately preceding a scheduled trial).

18. *See* FED. R. CIV. P. 16 (noting that one purpose of pre-trial conferences is to consider prospects for settlement). There is an abundant literature on judicial involvement in the settlement process. *See, e.g.*, Judith Resnik, *Managerial Judges*, 96 HARV. L. REV. 376 (1982); *American Law Institute Study on Paths to a "Better Way": Litigation, Alternatives, and Accommodation*, 1989 DUKE L.J. 811, 819-20. For a criticism of judicial coercion of settlements, see Owen M. Fiss, *Against Settlement*, 93 YALE L.J. 1073 (1984).

19. *See generally* Stephen Daniels & Lori Andrews, *The Shadow of the Law: Jury Decisions in Obstetrics and Gynecology Cases*, *in* 2 MEDICAL PROFESSIONAL LIABILITY AND THE DELIVERY OF OBSTETRICAL CARE 161 (Victoria P. Rostow & Roger J. Bulger eds.,

The key issue is whether juries tend, as some observers suggest, to find in favor of sympathetic plaintiffs regardless of the merits of the case. Contrary to popular perception, most studies of malpractice trials have shown that, more often than not, physicians prevail and juries are reasonably competent decision-makers, at least with respect to the liability issue.[20] Despite the fact that physicians usually win, there is growing concern with the number of large verdicts in favor of some plaintiffs.[21]

There is a growing consensus, however, that one of the most serious problems with malpractice juries is their lack of consistency in awarding damages.[22] This raises several questions. First, do malpractice juries award amounts comparable to awards for similar injuries in other litigation contexts, such as automobile accident cases?[23] Second, are existing jury awards sufficiently predictable to provide a "going rate" for settling other malpractice disputes?[24]

1989).

The length of malpractice trials varies considerably; recent evidence suggests that the median trial length is five days, but a significant number of much longer trials exist. *See* Metzloff, *Resolving Disputes*, *supra* note 17, at 49-50.

20. Metzloff, *Resolving Disputes*, *supra* note 17, at 82-83. This fact by itself is not determinative, however, as it is first necessary to know more about why some cases are tried and others dropped or settled. Existing evidence strongly suggests that the trial selection process is far from random. Instead, it is possible that due to insurer unwillingness to settle non-meritorious malpractice cases, many weak plaintiffs' cases are tried, resulting in numerous pro-defendant results.

21. *See generally* David J. Nye et al., *The Causes of the Medical Malpractice Crisis: An Analysis of Claims Data and Insurance Company Finances*, 76 GEO. L.J. 1495 (1988).

With respect to large jury verdicts, one must also consider the impact of possible post-trial adjustments through various mechanisms such as appeal. Recent evidence suggests that particularly large malpractice awards are often reduced, although the specific dynamics of how these awards are challenged is not well understood. *See* Ivy E. Broder, *Characteristics of Million Dollar Awards: Jury Verdicts and Final Disbursements*, 11 JUST. SYS. J. 349 (1986); MICHAEL G. SHANLEY & MARK A. PETERSON, POST-TRIAL ADJUSTMENTS TO JURY AWARDS 27 (1987). While post-trial reductions provide some solace, the evidence does not indicate that the post-trial adjustment process serves as an efficient or reliable "quality control" check on jury awards. Metzloff, *Resolving Disputes*, *supra* note 17, at 87-88; WEILER, *supra* note 1, at 48.

22. This criticism is not necessarily directed to juries per se, but can also be targeted at the substantive law of damages which allows substantial discretion by the decision-maker -- be it judge or jury -- on the appropriate amount to award.

23. *See* Randall R. Bovbjerg et al., *Juries and Justice: Are Malpractice and Other Personal Injuries Created Equal?*, 54 LAW & CONTEMP. PROBS., Winter 1991, at 5.

24. *See, e.g.*, Randall R. Bovbjerg et al., *Valuing Life and Limb in Tort: Scheduling "Pain and Suffering,"* 83 NW. U. L. REV. 908 (1989). Recent empirical studies demonstrate serious problems in predicting the amount of damages a jury may award, and that this factor does indeed negatively impact the settlement process. *See* Metzloff, *Resolving Disputes*, *supra* note 17, at 88-93.

A related concern involves the issue of punitive damages. While the evidence suggests that punitive damages are rarely awarded in malpractice cases, this fact alone does not mean that these concerns are insubstantial. Punitive damages are occasionally awarded against hospitals, often in large amounts. Also, many malpractice plaintiffs, whether they prevail on the claim or not, allege punitive damages, which contributes to the high level of concern

III. THE POTENTIAL BENEFITS OF MALPRACTICE ADR

Numerous commentators have advocated the use of ADR in malpractice cases.[25] In general, the arguments favoring the use of ADR in the malpractice context have been based on the six goals briefly outlined below.

A. Use of a More Qualified Decision-Maker

Many ADR advocates have questioned the legitimacy of lay juries deciding complex malpractice disputes and have looked to ADR to provide a more qualified decision-maker. Often, specific methods -- such as the screening panel procedures discussed below -- directly involve medical professionals in the decision-making process. Other approaches rely on using skilled lawyers with experience in resolving complex claims.

B. Reduction in Litigation Cost

Malpractice litigation is undoubtedly expensive. The best available evidence indicates that the costs of litigating malpractice disputes exceed the amount paid in compensation to injured plaintiffs.[26] ADR is often seen as a means to reduce those expenses.

C. Reducing the Trauma of Malpractice Litigation

Traditional malpractice litigation takes an emotional toll on the parties, particularly the doctor accused of malpractice. Physicians perceive the suit as an allegation of almost criminal misconduct; doctors often speak in terms of innocence or guilt, despite the fact that a malpractice trial is not a criminal proceeding.[27] ADR methods mitigate this problem by being

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exhibited by physician defendants. *See* Stephen Daniels & Joanne Martin, *Myth and Reality in Punitive Damages*, 75 MINN. L. REV. 1 (1990).

25. *See, e.g.*, FRAMEWORK FOR ACTION, *supra* note 1, at 30-31 (noting desirability of evaluating ADR mechanisms for malpractice); Neil D. Schor, Note, *Health Care Providers and Alternative Dispute Resolution: Needed Medicine to Combat Medical Malpractice Claims*, 4 OHIO ST. J. ON DISP. RESOL. 65 (1988); Rhoda M. Powsner & Frances Hamermesh, *Medical Malpractice Crisis the Second Time Around: Why Not Arbitrate?*, 8 J. LEGAL MED. 283 (1987).

26. *See* Kakalik & Pace, *supra* note 5, at 41, 54 (noting that costs and expenses incurred by malpractice plaintiffs constituted approximately 36% of the amount recovered, while aggregate defense costs were approximately 30% of the amount awarded in compensation). Certainly, the high costs are a partial function of the use of the jury as decision-maker. *See* Metzloff, *Resolving Disputes*, *supra* note 17, at 53-59 (discussing costs associated with jury trials and noting that more than half of defense expenditures were directly related to the trial stage of the case).

27. *See* F. Patrick Hubbard, *The Physicians' Point of View Concerning Medical Malpractice: A Sociological Perspective on the Symbolic Importance of "Tort Reform,"* 23

more private and less lengthy, thus diminishing the time the physician must spend away from her practice.[28]

D. Improving the Quality of Expert Witnesses

The medical profession and commentators frequently complain about the low quality of experts who testify on behalf of plaintiffs.[29] In turn, plaintiffs' attorneys note the difficulty in obtaining skilled experts who are willing to testify against colleagues. Certainly, expert evidence plays a crucial role in malpractice litigation; in virtually every malpractice case, both parties must have experts to testify as to the applicable standard of care. A potential benefit of ADR is altering the method by which experts are obtained, such as by requiring the use of court-appointed neutral experts.

E. Handling the Small Case

Given the expense inherent in litigating a malpractice claim through to trial, it is commonly perceived that experienced malpractice plaintiffs' attorneys will only consider those claims involving serious injuries and potentially large damage awards. Certainly, it is more difficult for modestly injured patients to assert a malpractice claim. Accordingly, some view ADR as a less onerous process that will facilitate the assertion of these currently excluded claims.

F. Dealing with Frivolous Litigation

As noted above, many commentators are concerned with the apparently high incidence of non-meritorious malpractice suits.[30] One possible cause of this problem is inadequate screening of potential malpractice claims. Given the complexity of proving a malpractice case, very few plaintiffs can pursue a claim successfully without the assistance of counsel. It is thus widely recognized that plaintiffs' attorneys serve a critical gatekeeping

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GA. L. REV. 295, 320-23 (1989); WEILER, *supra* note 1, at 6-7.

28. The interest in privacy is by no means limited to malpractice defendants. Seriously injured plaintiffs may prefer the less public setting of ADR. For example, the Private Adjudication Center at Duke University recently administered a malpractice arbitration in a case in which the plaintiff was a five-year old child suffering from the after-effects of a drug overdose. His parents did not want him to sit through a lengthy trial listening to experts discuss the nature of his disabilities. The parties agreed that he need not be present during the two-day arbitration and that no transcript of the proceedings be made.

29. *See* PETER W. HUBER, GALILEO'S REVENGE: JUNK SCIENCE IN THE COURTROOM 75-91 (1991) (discussing the inconsistent quality of expert testimony in obstetrical malpractice cases).

30. *See supra* part II.A.

role.[31] While in most states there is a small cadre of highly competent malpractice attorneys who, as a practical matter, specialize, there are also numerous attorneys with little or no malpractice experience who occasionally accept malpractice cases. This may result in the filing of marginal claims by inexperienced attorneys. Accordingly, some suggest that ADR can provide an early review of the merits of the claim, thus serving as an additional gatekeeping tool.

IV. Analyzing Specific ADR Options for Malpractice Cases

As discussed above, there are numerous litigation concerns in the malpractice context which ADR is thought to address. Illustration 2 (Appendix B) presents the malpractice time line revised to indicate how various ADR techniques would operate within the malpractice context. Although the diagram is not exhaustive of all of the possible ADR methods that might be applied to malpractice cases, it does identify those methods that have already been applied to malpractice cases or those that are conceptually well suited to such disputes.[32] In general, each of the ADR methods depicted in Illustration 2 establishes a new settlement point based upon an additional type of input that the parties are to consider.

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31. For a useful discussion of the role of plaintiffs' attorneys see Melvin W. Reder, *Contingent Fees in Litigation with Special Reference to Medical Malpractice, in* THE ECONOMICS OF MEDICAL MALPRACTICE 211 (Simon Rottenberg ed., 1978).

32. An important ADR alternative not directly discussed in text is the American Medical Association's ("AMA") bold and controversial administrative plan to transfer all malpractice disputes from the courts to a specialized administrative tribunal. *See* AM. MED. ASS'N/SPECIALTY SOCIETY MEDICAL LIABILITY PROJECT, A PROPOSED ALTERNATIVE TO THE CIVIL JUSTICE SYSTEM FOR RESOLVING MEDICAL LIABILITY DISPUTES: A FAULT-BASED, ADMINISTRATIVE SYSTEM (1988).

While retaining the general tort rules on negligence, the AMA proposal would employ an elaborate procedural system involving an initial review and investigation by a claims processor; referral to a neutral expert; assignment of a "court-appointed" attorney; mandatory settlement offers; submission of the dispute to a hearing examiner; and review of substantive decisions by an overseeing board. For a more complete description, see Kirk B. Johnson et al., *A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims*, 42 VAND. L. REV. 1365 (1989).

While some commentators have expressed interest in the AMA's proposal, others have been decidedly negative. *Compare* WEILER, supra note 1, at 117 (expressing support for the "AMA's ingeniously designed proposal" which in his view "would likely fare quite well in any open-minded comparison" with traditional litigation) *with* J. Douglas Peters, *Critique of the American Medical Association's Model Medical Liability and Practices Reform Act*, 1 CTS., HEALTH SCI. & LAW 51 (1990). For an insightful examination of the proposal, see Randall R. Bovbjerg, *Reforming a Proposed Tort Reform: Improving on the American Medical Association's Proposed Administrative Tribunal for Medical Malpractice*, 1 CTS., HEALTH SCI. & LAW 19 (1990). The AMA had hoped that at least a few states would adopt the model as an experiment; to date, none have done so.

What follows is a brief description of each ADR process depicted in Illustration 2 and an overview of any experiences or empirical studies relating to each method in the malpractice context.

A. Risk Management

Hospitals routinely employ risk management programs designed to monitor and improve the quality of care. This is done primarily in an effort to minimize iatrogenic injuries suffered by patients by identifying particularly risky procedures.[33] Another aspect of risk management activity is the prompt identification of any negligently inflicted injuries that may occur. To date, however, most hospitals have not aggressively pursued early identification and resolution of potential malpractice claims.[34] Accordingly, one available ADR strategy is for hospitals and other health care professionals to become more directly involved in the early recognition of disputes, before the patient decides to file a malpractice claim. A more active stance could result in early resolution of disputes, by placating angry patients before these disputes are transformed into formal suits.[35]

B. Arbitration

In arbitration, the parties agree to use an *arbitrator*, usually a privately retained individual, to render the decision in place of a judge or jury. Thus, arbitration is both (1) a *voluntary* process, in that the parties have agreed at some point to its use, and (2) a *binding* process that will conclusively resolve the dispute. In addition, the parties have substantial power to determine for themselves the particular details of the arbitration procedure.[36] As depicted in Illustration 2, parties can agree to arbitration at several points. Thus, litigants in a malpractice case can voluntarily agree to submit their claim to binding arbitration in lieu of a jury even after the suit is filed.[37]

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33. *See generally* Laura L. Morlock & Faye E. Malitz, *Do Hospital Risk Management Programs Make a Difference?: Relationships Between Risk Management Program Activities and Hospital Malpractice Claims Experience*, 54 LAW & CONTEMP. PROBS., Spring 1991, at 1; AM. MED. ASS'N/SPECIALTY SOCIETY MEDICAL LIABILITY PROJECT, RISK MANAGEMENT PRINCIPLES & COMMENTARIES FOR THE MEDICAL OFFICE (1990).

34. For a discussion of the role of risk management in minimizing potential malpractice claims or in improving the handling of such claims, see Orley H. Lindgren et al., *Medical Malpractice Risk Management Early Warning Systems*, 54 LAW & CONTEMP. PROBS., Spring 1991, at 23.

35. *Id.* at 41.

36. Procedural variables relating to the conduct of an arbitration hearing include, among others: (1) the length of the arbitration hearing; (2) the number of arbitrators; (3) the required qualification of arbitrators; (4) the process for selecting arbitrators; (5) the amount of discovery permitted to be conducted.

37. Far more problematic, however, is whether the physician and patient can enter into

Currently, the use of arbitration varies widely among litigation contexts, with some areas, such as securities litigation, dominated by arbitration.[38] Legislative action to facilitate the use of arbitration in malpractice cases was an early tort reform agenda item. Approximately fourteen states enacted specific legislation designed to promote malpractice arbitration.[39] Arbitration does not yet play a critical role, however, in resolving medical malpractice cases,[40] although its potential application has been widely advocated.[41]

Empirical research on arbitration's impact on malpractice cases is sparse, primarily because so few malpractice cases have been submitted to arbitration. The scant evidence that does exist suggests that the process is not inherently pro-physician.[42] For example, a recent study found that plaintiffs prevailed slightly more often in arbitration than in traditional litigation and that the process was less time-consuming.[43]

It is not clear why the use of arbitration has not been more prevalent despite efforts to facilitate its use. Several explanations deserve consideration. First, early judicial hostility to the use of arbitration in

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a binding arbitration agreement *prior* to the rendition of the medical services.

38. *See Shearson/American Express, Inc. v. McMahon*, 482 U.S. 220 (1987) (announcing public policy in favor of arbitration, including consumer disputes against securities dealers); *Cf. Gilmer v. Interstate/Johnson Lane Corp.*, 111 S. Ct. 1647 (1991) (upholding arbitration agreement in age discrimination suit).

39. For a useful review of state legislative efforts, see Irving Ladimer & Joel Solomon, *Medical Malpractice Arbitration: Laws, Programs, Cases*, 653 INS. L. J. 335 (1977). The failure of a state to enact a specific malpractice arbitration statute does not preclude the use of arbitration; most states have enacted the Model Arbitration Act, which provides a basis for claiming a right to enter into an arbitration agreement.

40. According to a 1984 study of malpractice claims closed in that year, only 0.2% of malpractice claims were decided following arbitration. CLAIMS CLOSED IN 1984, *supra* note 12, table 2.20, at 37. *See generally* U.S. GEN. ACCT. OFF., MEDICAL MALPRACTICE: FEW CLAIMS RESOLVED THROUGH MICHIGAN'S VOLUNTARY ARBITRATION PROGRAM 7 (1990) [hereinafter MICHIGAN PROGRAM] (noting that legislation to encourage voluntary binding arbitration produced only 247 actual arbitrations out of approximately 20,000 malpractice claims in a 13 year period).

41. On the use of private contractual approaches such as arbitration to the malpractice problem, see Symposium, *Medical Malpractice: Can the Private Sector Find Relief?*, 49 LAW & CONTEMP. PROBS., Spring 1986, at 1.

42. *See* Irving Ladimer et al., *Experience in Medical Malpractice Arbitration*, 2 J. LEGAL MED. 433 (1981) (finding that arbitration tends to skew results in favor of plaintiffs with severe permanent disabilities as compared to those claimants with minor injuries); *see generally* Stephen Zuckerman et al., *Information on Malpractice: A Review of Empirical Research on Major Policy Issues*, 49 LAW & CONTEMP. PROBS., Spring 1986, at 85, 103-06 (summarizing available empirical information on arbitration results); Kevin M. Clermont & Theodore Eisenberg, *Trial by Jury or Judge: Transcending Empiricism*, 77 CORNELL L. REV. 1124, table 3, at 1137 (1992) (finding that malpractice plaintiffs prevailed more often in federal court cases tried by the judge than in cases tried to a jury).

43. *See* MICHIGAN PROGRAM, *supra* note 40, at 8 (noting that plaintiffs prevailed in 22% of arbitrated cases as compared to 18% in traditional litigation). Surprisingly, however, the GAO study found that the average cost to the litigants of resolving the cases were comparable, not cheaper as had been expected. *Id.*

malpractice cases created an obstacle.[44] Second, many of the statutory provisions ostensibly designed as consumer protection measures actually serve to limit the use of arbitration agreements.[45] Third, malpractice attorneys, both on the plaintiff and defense side, generally are averse to routine use of arbitration.[46] The jury is often viewed by *both* plaintiff and defense attorneys (and many insurers) as an appropriate "dispute resolver" in many types of malpractice cases, such as those in which there is a critical factual dispute. Fourth, some attorneys believe that arbitrators tend to make compromise decisions that do not fully vindicate their clients' interests. Particularly in the malpractice context, where physicians possess a strong interest in vindicating their conduct, this perception of arbitrators "splitting the baby" represents a potentially significant problem.[47] Finally, the lack of interest in arbitration on the part of malpractice insurers may represent a concern that if a truly expedited process for asserting malpractice claims were established, the number of malpractice claims asserted would skyrocket.

C. Mediation

Mediation is one of the most overused but misunderstood terms in the ADR lexicon. Although not susceptible to strict definition, mediation is generally a dispute resolution process in which the litigants themselves (and usually their attorneys) meet with an impartial, disinterested mediator in an attempt to settle the case.[48] The mediator's role is primarily to facilitate the parties' understanding of the nature of the dispute and to explore practical solutions, even if those solutions are not necessarily required by applicable substantive law principles. Mediation is thought to be particularly well suited to disputants with a longstanding past

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44. *See, e.g., Obstetrics & Gynecologists Ltd. v. Pepper*, 693 P.2d 1259 (Nev. 1985); *Roberts v. McNamara-Warren Community Hosp.*, 360 N.W.2d 279 (Mich. Ct. App. 1984). *See generally* Mary Bedikian, *Medical Malpractice Arbitration Act: Michigan's Experience with Arbitration*, 10 AM. J.L. & MED. 287 (1984) (reviewing early case law under Michigan arbitration statute).

45. *See, e.g.*, GA. CODE ANN. § 9-9-61 (Supp. 1992) (permitting patient to agree to arbitration only after alleged act of physician negligence has occurred and after consulting with an attorney).

46. *See* Nicolas P. Terry, *The Technical and Conceptual Flaws of Medical Malpractice Arbitration*, 30 ST. LOUIS U. L.J. 571, 574-75 (1986) (suggesting that "for conceptual and technical reasons, malpractice arbitration as currently envisaged is a dangerously inappropriate solution to the real or perceived malpractice crisis").

47. *See* PHYSICIAN INSURERS ASSOCIATION OF AMERICA, A COMPREHENSIVE REVIEW OF ALTERNATIVES TO THE PRESENT SYSTEM OF RESOLVING MEDICAL LIABILITY CLAIMS 49 (1989) (discussing possible disadvantages to arbitration, including the concern with compromise results).

48. *See generally* Lon L. Fuller, *Mediation -- Its Forms and Functions*, 44 S. CAL. L. REV. 305 (1971).

relationship who desire or otherwise need to maintain a working, if not necessarily cordial, future relationship.

Experience with the use of traditional mediation in malpractice cases is very limited.[49] For several years, Wisconsin has unsuccessfully employed a hybrid procedure that is ostensibly labelled as a mediation process.[50] More recently, a few states have enacted legislation empowering trial court judges to mandate the use of mediation in any civil dispute, including malpractice cases.[51] While these programs were not specifically designed for malpractice cases, judges have routinely referred malpractice cases to mediation under these programs. To date, however, there are no empirical evaluations of the results of these hybrid ADR processes in the malpractice context.

D. Screening Panels

In the mid-1970's, a number of states adopted special litigation procedures for malpractice cases. Commonly called "pre-trial screening panels," these early ADR examples usually required plaintiffs to submit their claims to a special panel (often composed of a physician, attorney, and lay member). The panel would consider the parties' respective positions and issue a non-binding decision. In theory, a panel finding of no liability would induce the plaintiff to drop the claim; a finding of liability would provide an impetus to defendants to settle. In any event, either party could insist upon trial by jury, although some states made the panel's finding admissible at the subsequent trial.[52] Recently, several states have abolished their screening panel procedures.[53]

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49. Professor Leonard L. Riskin at the University of Missouri-Columbia has attempted to apply traditional mediation techniques to malpractice cases, but the project has been limited by the paucity of cases voluntarily referred to this process. *See* LEONARD L. RISKIN, CENTER FOR THE STUDY OF DISPUTE RESOLUTION, FINAL REPORT TO THE NATIONAL INSTITUTE FOR DISPUTE RESOLUTION ON INNOVATION FUND GRANT FOR MEDICAL MALPRACTICE MEDIATION 7-8 (1992) (on file with author). There are sporadic reports of successful mediations in individual malpractice cases. *See, e.g.*, Hank De Zutter, *Proponents Say ADR Spells Relief*, ILL. LEGAL TIMES, Jan. 1988, at 1 (describing successful mediation of a malpractice case).

50. *See* Catherine S. Meschievitz, *Mediation and Medical Malpractice: Problems with Definition and Implementation*, 54 LAW & CONTEMP. PROBS., Winter 1991, at 195 (noting several problems relating to a hybrid mediation process in Wisconsin). In fact, the Wisconsin process is probably more aptly described as a variant on the screening-panel model rather than a mediation procedure given the lack of mediation training among the panel members and the lack of discussion among the disputants. *Id.* at 211-12; *see infra* part IV.D.

51. *See, e.g.*, FLA. STAT. ANN. § 44.1011-106 (West Supp. 1992).

52. For a comprehensive overview of the screening panel procedures, see Jean A. Macchiaroli, *Medical Malpractice Screening Panels: Proposed Model Legislation to Cure Judicial Ills*, 58 GEO. WASH. L. REV. 181 (1990).

53. *See, e.g.*, Debra L. Fortenberry, Note, *Screening Panels: Corrective Surgery or*

The most common criticism of the panels is that they are administratively cumbersome and that they sometimes lead to long delays.[54] Other concerns are that the process may come too early in the evolution of the claim before the parties have conducted sufficient investigation. Other commentators continue to express support for this ADR approach.[55] Existing empirical studies are generally mixed, with some indications that screening panels do indeed screen out low-merit cases, but perhaps only because more claimants elect to assert a claim before the panels.[56]

E. Early Neutral Evaluation and Court-Ordered Arbitration

One rapidly growing area in the ADR field is the development of court-sponsored ADR programs. Concerned with burgeoning dockets, numerous state and federal courts have initiated mandatory, but non-binding, ADR processes. Two of these initiatives are potentially well suited to malpractice.

Early neutral evaluation (Number 5 in Illustration 2) calls for the early assessment of the case by an experienced neutral attorney on the basis of brief presentations by the parties.[57] Ordinarily, the evaluator is a skilled litigator with experience in the particular type of case in dispute. The theory is that the parties will benefit by the evaluator's neutral assessment of the value of the case and therefore reconsider their positions. If the case does not settle, the evaluation is usually kept confidential.[58] As shown, this ADR intervention occurs relatively early in the dispute, after the parties have had some time to conduct discovery on key issues, but before

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Amputation, 4 J. DISP. RES. 255, 259-62 (1989) (discussing repeal of Ohio screening panel); Jona Goldschmidt, *Where Have All the Panels Gone?: A History of the Arizona Medical Liability Review Panel*, 23 ARIZ. ST. L.J. 1013 (1992).

54. *See, e.g.*, WEILER, *supra* note 1, at 42 (suggesting that screening panels are "fraught with difficulty" and describing several practical problems with screening panels including delay and imposition of additional expense).

55. *See* Macchiaroli, *supra* note 52, at 239-49.

56. Useful empirical studies include J. MARDFIN, MEDICAL MALPRACTICE IN THE STATE OF HAWAII (1986) (discussing experiences with Hawaii screening panel system); Stephen Shmanske & Tina Stevens, *The Performance of Medical Malpractice Review Panels*, 11 J. HEALTH POL., POL'Y & L. 525 (1986).

For an in-depth discussion of Alaska's medical malpractice advisory panel, see *supra* Jonathan S. Aronie, Note, *Alaska's Medical Malpractice Expert advisory Panel: Assessing the Prognosis*, 9 ALASKA L. REV. 401 (1992).

57. *See* Wayne D. Brazil, *A Close Look at Three Court Sponsored ADR Programs: Why They Exist, How They Operate, What They Deliver, and Whether They Threaten Important Values*, 1990 U. CHI. LEGAL F. 303, 334-35. Brazil explains that a typical case presentation is perhaps 15 minutes in length and entails an explanation of the parties' legal theories as well as short description of the evidence that supports each theory. *Id.* at 335.

58. A secondary goal is for the evaluator to assist the parties in focusing discovery should the case not settle. *Id.* at 336-37.

the bulk of expenditures have been made. To date, formal early-neutral evaluation programs have been limited to the federal courts. Because malpractice cases most often arise in state courts, there is no evidence as to how well this model would work in the malpractice context.[59]

Court-ordered arbitration (Number 6 in Illustration 2) is a process in which certain disputes are channelled to a non-binding arbitration process following the completion of designated period of discovery. As with the other ADR methods, the details of how specific programs operate varies substantially.[60] This particular ADR method originated in the state courts in the mid-1950's and was targeted at minor disputes. After a period of slow or no growth in the use of this process, a wave of states adopted court-ordered arbitration programs during the 1980's.[61] The federal court followed suit with the initiation of experimental arbitration programs.[62]

While programs vary, the following example presents a typical approach, based upon the program in effect in the Middle District of North Carolina.[63] After suit is filed and the case is determined eligible for the ADR program, the parties are given three months to conduct discovery. The parties are urged to agree upon the selection of a single arbitrator from a list of experienced attorneys prepared by the court.[64] If they are unable to agree, one is appointed for them. The arbitrator is paid by the court at the maximum rate of $500 per case. The rules anticipate a pre-hearing exchange of information relating to such factors as the identity of witnesses who will testify at the hearing and the documents that will be produced. The rules do not establish a maximum length for the hearing, but on average the hearings last approximately seven hours.[65] The arbitrator must issue an award within fifteen days of the hearing. Following the decision, either party may request a trial de novo; however, before

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59. Early neutral evaluation was pioneered in the United States District Court for the Northern District of California. For a brief history of the development of the early neutral evaluation model in that court, see David J. Levine, *Northern District of California Adopts Early Neutral Evaluation to Expedite Dispute Resolution*, 72 JUDICATURE 235 (1989).

60. For an excellent overview of characteristics and performance in federal court-ordered arbitration programs, see BARBARA S. MEIERHOEFER, FED. JUD. CENTER, COURT-ANNEXED ARBITRATION IN TEN DISTRICT COURTS (1990).

61. On the history of the growth in state court programs, see Susan Keilitz et al., *State Adoption of Alternative Dispute Resolution*, 12 STATE CT. J., Spring 1988, at 4.

62. *See* Paul Nejelski & Andrew S. Zeldin, *Court Annexed Arbitration in the Federal Courts: The Philadelphia Story*, 42 MD. L. REV. 787 (1983).

63. E. ALLAN LIND, ARBITRATING HIGH-STAKES CASES: AN EVALUATION OF COURT-ANNEXED ARBITRATION IN A UNITED STATES DISTRICT COURT (1990) (containing copy of the local rules controlling the North Carolina federal court's court-ordered arbitration program).

64. The rules require that the arbitrator have been a member of the state bar for at least eight years and be determined by the court to be competent to perform the duties of an arbitrator. *Id.* at 77.

65. *Id.* at 30-31.

proceeding with a conventional trial, the parties must confer with the arbitrator to discuss his or her assessments of the case in an effort to achieve a settlement.[66] If the case proceeds to trial, no evidence relating to the court-ordered arbitration results is admissible.[67]

To date, few malpractice cases have been subjected to court-ordered arbitration. In state courts, programs typically have a jurisdictional cap providing that only cases involving less than a certain amount in controversy (such as $25,000) go through the process. At the jurisdictional amount levels commonly in effect, virtually no malpractice cases are eligible. The federal court programs, however, target higher value cases (up to $150,000 in the Middle District of North Carolina) and, as a result, some malpractice cases have been covered.[68]

In contrast to many of the other ADR programs described in this comment, court-ordered arbitration programs have been subjected to intensive empirical scrutiny. The results of the studies vary in their analysis of the programs' effectiveness. In general, the evidence supports the view that litigants are well satisfied with court-ordered arbitration and that the process does result in more expeditious resolution of claims.[69] Of course, a key element in determining the success of a program is how well the program is administered at the state level.[70]

F. The Summary Jury Trial and Its Variations

The summary jury trial ("SJT") is a relatively new ADR process, first used in 1980 by a federal judge in Ohio.[71] To date, it has been used regularly only in scattered federal district courts, although several state

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66. *Id.* at 84.

67. *Id.*

68. Metzloff, *Researching Litigation*, *supra* note 7, at 225 n.82.

69. *See, e.g.*, Stevens H. Clarke et al., *Court-Ordered Arbitration in North Carolina: Case Outcomes and Litigant Satisfaction*, 14 JUST. SYS. J. 154 (1991) (discussing results of study using random assignment of cases which indicated high levels of party satisfaction and reduced case disposition times for North Carolina state court program); E. ALLAN LIND ET AL., THE PERCEPTION OF JUSTICE: TORT LITIGANTS' VIEWS OF TRIAL, COURT-ANNEXED ARBITRATION, AND JUDICIAL SETTLEMENT CONFERENCES (1989); Lind, *supra* note 63, (evaluating performance of court-ordered arbitration program for the federal district court for the Middle District of North Carolina); *see generally* Deborah R. Hensler, *What We Know and Don't Know About Court-Administered Arbitration*, 69 JUDICATURE 270 (1986).

70. Clarke, *supra* note 69, at 181-82 (noting that the North Carolina state court program "was planned and managed with great care" and that a different program "lacking this kind of planning and management might not work as well").

71. *See, e.g.*, Thomas D. Lambros, *The Federal Rules of Civil Procedure: A New Adversarial Model for a New Era*, 50 U. PITT. L. REV. 789, 798-804 (1989); D. MARIE PROVINE, FED. JUD. CENTER, SETTLEMENT STRATEGIES FOR FEDERAL DISTRICT JUDGES 68-76 (1986). For an interesting critique of the SJT process, see Joan K. Archer Rowland, Comment, *Communication and Psychology Variables: Reasons to Reject the Summary Jury Trial as an Alternate Dispute Resolution Technique*, 39 KAN. L. REV. 1071 (1991).

courts have recently begun experimenting with the process. Because of its federal court origins, only a few malpractice cases (which are usually filed in state courts) have been subjected to SJTs.[72] The process is usually voluntary, although a few judges have attempted to require party participation.[73]

The theory of the SJT is that in cases headed for a lengthy trial, the parties would benefit by having a summary or preview of the case presented to a jury for an advisory verdict. The presentation would be greatly expedited compared to a normal trial; cases that might take several weeks to try in a traditional fashion would be presented in the SJT setting in a day. This efficiency is achieved by taking various shortcuts, most notably having the lawyers summarize the evidence in lieu of witness testimony. In theory, the summary jury's verdict will aid the parties in reaching a voluntary settlement.

Evidence of the SJT's efficacy is mixed.[74] Researchers have had difficulty designing empirically sound studies of the process primarily because its voluntary nature precludes the use of random assignment of cases to control groups to create valid comparative studies.[75]

While proponents of the SJT generally claim that the process is well suited to personal injury suits such as medical malpractice, there are, in fact, serious reasons to question its application.[76] Some malpractice cases turn on factual issues that are better resolved after the jury has had a full opportunity to assess witness credibility. Other cases turn on complex expert evidence that is not easily or fairly summarized in so brief a fashion. Other malpractice cases are tried conventionally in only a few days and are thus not good candidates for the SJT process, which is usually targeted at cases that require a week or more to litigate. While on a case-by-case basis the SJT might be suitable for particular malpractice disputes, it is unlikely that it represents a plausible alternative in the majority of malpractice actions.

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72. For one of the few malpractice cases that is reported to have used the process, see *Lockhart v. Patel*, 115 F.R.D. 44 (E.D. Ky. 1987).

73. The Seventh Circuit has held that federal district courts cannot mandate the use of summary jury trials. *Strandell v. Jackson County*, 838 F.2d 884 (7th Cir. 1988). Numerous district courts in other circuits, however, have held that they have such power. *See, e.g.*, *McKay v. Ashland Oil, Inc.*, 120 F.R.D. 43 (E.D. Ky. 1988).

74. For existing studies, see M. DANIEL JACOUBOVITCH & CARL M. MOORE, FED. JUD. CENTER, SUMMARY JURY TRIALS IN THE NORTHERN DISTRICT OF OHIO (1982); James J. Alfini, *Summary Jury Trials in State and Federal Courts: A Comparative Analysis of the Perceptions of Participating Lawyers*, 4 OHIO ST. J. ON DISP. RESOL. 213 (1989) (describing research study of state and federal court SJT programs in Florida).

75. *See* Richard A. Posner, *The Summary Jury Trial and Other Methods of Alternative Dispute Resolution: Some Cautionary Observations*, 53 U. CHI. L. REV. 366, 374-75 (1986).

76. *See* Thomas B. Metzloff, *Reconfiguring the Summary Jury Trial*, 41 DUKE L.J. 806, 841-50 (1992) [hereinafter Metzloff, *Summary Jury Trial*].

There also exists a potentially important variation on the SJT, which utilizes some of its techniques in a *binding* procedure, which is referred to in Illustration 2 as a "jury-determined settlement."[77] In this process, the litigants agree to a shortened trial usually after negotiating an agreement that specifies the range within which the parties are willing to settle. The summary jury's decision determines the precise amount of the settlement within the confines of the parties' "high/low" agreement. To date, several large malpractice cases have utilized this hybrid process in North Carolina where the state court rules are expressly designed to facilitate binding SJTs.[78] Because the parties must agree on the settlement parameters, this process is necessarily voluntary and cannot be mandated by a court. It is essentially an ADR process to limit the parties' litigation risk both by setting appropriate limits on the result (in lieu of the unpredictable jury process) and by lowering litigation expenses.

V. Determining a Malpractice ADR Strategy for Alaska

Having canvassed several potential ADR choices, the final matter is to develop a strategy as to which specific ADR initiatives should be pursued and in what fashion. For several reasons, this is not a simple task. First, it is clear that ADR program performance is a function not just of the type of process used but of how it is administered. Accordingly, the manner in which a program is implemented may be as important as which process is chosen; certainly, administration issues must be carefully attended to during the planning process. Also, many ADR methods have not been directly applied to complex litigation such as malpractice disputes, and thus there is little or no empirical evidence as to how those processes will work within that context.[79]

In developing an informed ADR strategy for a particular litigation context, it is necessary to establish desired criteria. This comment offers five goals for a malpractice ADR system, as well as four ADR strategies that achieve such goals.[80]

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77. *Id.* at 850-65.

78. *Id.* at 852-53. For a description of some of the North Carolina cases, see THOMAS B. METZLOFF ET AL., SUMMARY JURIES IN THE NORTH CAROLINA STATE COURT SYSTEM 19-28 (1991).

79. *See generally* Edward Brunet, *Questioning the Quality of Alternate Dispute Resolution*, 62 TUL. L. REV. 1 (1987).

80. Even a cursory examination of attributes of some of the existing ADR options suggests that they are not appropriate ADR solutions for the bulk of malpractice disputes. For example, the summary jury trial does not appear well suited to accomplishing these goals. By continuing to employ a jury, the SJT does not address the concern of having a skilled decision-maker or the problem of inconsistency in awarding damages. Second, by occurring so late in the process (usually in the period immediately preceding trial), it does

A. The Goals of a Malpractice ADR System

1. *A Malpractice ADR System Should Be Designed to Produce Decisions on the Merits, Not to Promote Compromise Settlements.* Because of state and federal requirements to report all malpractice settlements for disciplinary and reporting purposes, no system that tries to coerce nuisance value settlements is likely to achieve general acceptance among malpractice insurers or physicians.

2. *A Malpractice ADR System Should Be Focused in Part upon Early Identification of Non-Meritorious Claims.* There is substantial evidence regarding the high frequency of weak or non-meritorious claims in the malpractice context. Accordingly, an ADR system must be cognizant of the medical profession's interest in minimizing the expense and disruptive impact caused by the assertion of marginal claims.

3. *A Malpractice ADR System Should Utilize Decision-Makers Skilled in Understanding Complex Medical Evidence Within the Existing Legal Framework for Assessing Liability and Awarding Damages.* Malpractice cases regularly involve complex medical issues relating to both the standard of care and causation. Accordingly, an ADR system should provide decision-makers who are knowledgeable in the types of medical issues that may arise. This does not necessarily mean that the system must employ physicians in the role of decision-makers. The negligence standard to be applied involves the application of both legal and medical elements. Thus, experienced attorneys may be well suited for this role.

4. *A Malpractice ADR System Should Be Designed to Promote Consistency in the Award of Damages.* Strong evidence demonstrates the inconsistency in malpractice damage awards.[81] Absent substantive law changes to address the problems noted, an ADR system must make a concerted effort to apply the existing law of damages in as rational a manner as possible. This would serve the goals of both equity and predictability.

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not offer significant cost reductions. *See* Metzloff, *Summary Jury Trial*, *supra* note 76, at 843-44 (discussing the lack of potential for meaningful cost savings associated with the use of summary jury trials in malpractice cases). This does not mean that the SJT is necessarily inappropriate for all cases; rather, it suggests that it should not be put forward as a routine or mandatory ADR process for handling malpractice disputes generally.

81. *See supra* note 24 and accompanying text.

5. *A Malpractice ADR System Should Be Designed to Reduce the Cost of Litigation Significantly Through an Efficiently Administered System.* The overall transaction costs associated with malpractice litigation are extraordinarily high. As a result, any ADR system must be designed to reduce litigation expenses, at least for the majority of cases to which it will be applied.

B. ADR Strategies for the Malpractice Context

1. *Use of Voluntary ADR.* One approach would be to rely primarily on the voluntary efforts of litigants and malpractice insurers to use particular ADR methods in appropriate cases. For the past four years, the Private Adjudication Center, a non-profit affiliate of the Duke University School of Law, has been providing ADR consulting services to malpractice litigants on a case-by-case basis with some success.[82] The largest malpractice insurer in North Carolina has commented favorably on this use of ADR, noting that even the consideration of litigation alternatives has assisted it in settling several cases.[83]

A major advantage of a voluntary approach is its ability to utilize any of the different ADR methods discussed in part III. Clearly, each of the different procedures may be better suited to certain types of malpractice disputes. Thus, realizing the full benefits of ADR requires a careful matching of specific malpractice disputes with the particular ADR process best suited to that case.[84] Also, it may be that there are some malpractice cases best suited to traditional litigation, and that any mandatory referral to a particular ADR process will result in increased litigation expenses. The importance of carefully matching ADR procedures with particular disputes might work best under the case-by-case assessment inherent in a voluntary approach. If a state were to enact some form of mandatory ADR, policy-makers should be cognizant of the litigants' legitimate interest in agreeing to alternative ADR methods in appropriate cases. Thus, any

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82. As part of the duties as the Director of the Private Adjudication Center's Medical Malpractice ADR program, this author regularly consults with malpractice insurers, hospitals, plaintiffs' attorneys, and defense attorneys about the use of various ADR methods in specific malpractice cases. Since its inception in 1988, the program has used or observed the use of several of the different ADR methods discussed in this comment, including voluntary mediation, several forms of binding arbitrations, court-ordered mediation, court-ordered arbitration and binding summary jury trials.

83. *See* MEDICAL MUTUAL INSURANCE COMPANY OF NORTH CAROLINA, 1990 ANNUAL REPORT 7 (1990) ("We have found that simply proposing alternative dispute resolution often gets the discussion going again, which leads to settlements in cases that might otherwise go to court.").

84. *Cf.* Maurice Rosenberg, *Resolving Disputes Differently: Adieu to Adversary Justice?*, 21 CREIGHTON L. REV. 801, 809 (1988) ("[T]he ideal system will require deploying a whole battery of dispute-resolving mechanisms, various directed, variously driven and variously employed.").

mandatory program should offer litigants the opportunity to select a different ADR method.

Nonetheless, there are several drawbacks to a voluntary ADR approach. The main problem is the fact that in a voluntary system, one party may block the use of ADR regardless of how well suited the case.[85] Obtaining an agreement to use ADR in even a simple malpractice case requires the consent of five different parties: (1) the plaintiff; (2) plaintiffs' counsel; (3) the defendant; (4) defense counsel; and (5) the malpractice insurer. These actors may have divergent interests that impact their views on the utility of ADR either in general or for their specific case. Reaching agreement becomes even more difficult if the case involves multiple defendants. Likewise, if different malpractice insurers are involved, a voluntary consensus agreement on a particular ADR approach could be nearly impossible to obtain.

Second, even if all the parties agree that ADR should be used, substantial negotiations are often required as to what specific form should be used. Spending time negotiating the alternative ground rules defeats one of the principle benefits of ADR, that of efficiency. Third, certain ADR options, such as court-ordered arbitration, depend upon the court establishing the procedural rules to govern the process and administrate the program. A court is less likely to establish a program without assurances that it will be used.

2. *Facilitating Private Arbitration.* A second approach would be to foster the development of private arbitration agreements between health care providers and patients. A well designed and administered arbitration process provides several advantages over traditional litigation. The primary benefits include the quality of the decision-maker and the speed of resolution (with its attendant potential reduction in litigation expenses). These benefits accrue both to physicians and potential claimants who currently are often unable to access the system because of its exceptionally high administrative costs. An arbitration program with appropriate selection criteria for arbitrators would be as likely to generate reliable and consistent results.

The malpractice arbitration statutes enacted during the 1970's were ostensibly designed to facilitate the use of arbitration, but in retrospect,

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85. Existing empirical studies have regularly shown low levels of utilization for voluntary ADR programs, which is probably attributable either to attorney or litigant unfamiliarity with the processes involved, the economic motivation of attorneys to maintain the status quo, or the adversarial nature of litigation. *See* Sally E. Merry & Susan S. Silbey, *What Do Plaintiffs Want? Reexamining the Concept of Dispute*, 9 JUST. SYS. J. 151, 151-53 (1984); Dwight Golann, *Making Alternative Dispute Resolution Mandatory: The Constitutional Issues*, 68 OR. L. REV. 487, 488 (1989).

their encouragement is minimal. By requiring extensive disclosure to patients, by prohibiting physicians from conditioning the provision of medical services on the signing of an agreement, and by mandating procedurally cumbersome arbitration rules, these statutes -- especially in light of strict judicial scrutiny of any agreements that were employed -- have virtually insured that few physicians would even attempt to enter into arbitration contracts with their patients.

If binding arbitration is desirable (this author believes it is) there is a need for a new generation of malpractice arbitration statutes that more directly promote the use of arbitration. Such new statutes would: (1) reduce the disclosures that a physician has to make to a patient; (2) permit physicians to make acceptance of arbitration a condition for rendering services; and (3) allow greater flexibility to the parties to design less cumbersome arbitration procedures.

At first blush, such a statute would seem contrary to the patient's interests, and as a result politically unfeasible. This view is myopic. The key issue in terms of protecting patient interest is not pre-agreement disclosures and warnings, but providing statutory safeguards to ensure the quality and neutrality of the arbitration procedure itself. On this point, the most important factors are the neutrality and qualifications of the arbitrator.[86] Assuming an arbitration process that is fair to both patient and physician, there is no reason to restrict its use in malpractice simply because it is the physician who takes the initiative in seeing that an arbitration agreement is in place.

If a new statute were enacted, it remains unclear how many physicians would take advantage of such a provision. Especially for individual physicians, it is uncomfortable to discuss the prospects for a potential malpractice claim with a patient. Moreover, plaintiffs' attorneys, at least in some cases, would be likely to attempt to challenge arbitration agreements on a case-by-case basis.

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86. Some of the issues relating to the development of a fair and comprehensive arbitration scheme have been addressed in recent federal legislative proposals. One of the most innovative was a proposal by Senator Peter Domenici (R. New Mexico) that would require the use of arbitration in most malpractice cases. Under the proposed legislation, all medical malpractice cases would have been resolved through arbitration (or another ADR process voluntarily agreed to by the parties) administered by one of several *certified ADR providers*. The bill set forth specific qualifications for what attributes a certified ADR provider must possess. A summary of the proposed statute and a discussion of its implications for ADR providers is provided in Clark C. Havighurst & Thomas B. Metzloff, *S. 1232 -- A Late Entry in the Race for Malpractice Reform*, 54 LAW & CONTEMP. PROBS., Spring 1991, at 179. A major difference between the mid-1970's and the current situation is the growth in private ADR providers. Numerous entities have either entered or expanded their operations in providing ADR services to disputants. Unquestionably, many of these organizations would be interested in establishing a malpractice arbitration program if sufficient demand existed.

3. *Development of Mediation-Based Programs.* Another approach would be to require malpractice litigants to submit their claims to mediation. In this author's opinion, a mediation-based approach is inappropriate for the majority of malpractice cases. A mediation approach makes sense, however, if one assumes that malpractice litigants commonly have litigation goals other than to obtain compensation for their injuries. Indeed, in some percentage of malpractice cases, the plaintiff has filed the lawsuit out of anger at the physician or hospital. In those cases, a mediation session designed to explore the plaintiff's anger and aimed at eliciting appropriate recognition of that emotion by the defendants could well be productive. To be sure, there are malpractice cases that do involve this dynamic;[87] on a limited case-by-case basis, mediation should be considered as an ADR option.[88]

4. *Applying the Court-Ordered Arbitration Model to Malpractice.* This author believes that the optimal ADR strategy would be to apply the court-ordered arbitration model. As an initial matter, court-ordered arbitration has the advantage of being well established in other litigation contexts and constitutional.[89]

The court-ordered arbitration model meets the established criteria in every respect. First, among all ADR options, an arbitration process (be it binding or non-binding) is least "settlement" oriented and more focused upon making decisions on the merits of the case according to controlling

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87. For example, the Private Adjudication Center has conducted a few mediations in medical malpractice cases, one of which involved a classic dispute of the type described in text.

88. In this author's experience, such cases represent the clear minority of malpractice disputes. For the large majority of claims, the parties desire a decision on the merits of the negligence claim.

A variation is the mandatory "mediated settlement conference" approach now used in some states. At this point, it is too early in the development of this process to assess its potential applicability to malpractice.

As currently formulated, there are several potential concerns. First, the mediators' role as a practical matter is to create pressures on both parties to settle. As noted, malpractice defendants have a legitimate interest in refusing to settle non-meritorious claims. Also, it is clear that there is a significant amount of non-meritorious malpractice litigation. The mediation approach, by seeking settlements in all cases, may not be well suited to the need in malpractice cases to identify non-meritorious claims. Second, there is a serious question as to the overall quality of the mediators serving in these programs. Since these programs are applied to a wide variety of civil cases and not just malpractice disputes, few of the mediators have experience in handling malpractice disputes. As such, the programs raise serious concerns about the special interest in malpractice cases of employing skilled ADR neutrals.

In other respects, a mediated settlement conference meets the established criteria in that it is a simple procedure to administer, and it occurs early in the litigation process, thus offering significant cost savings if successful.

89. *See generally* Golann, *supra* note 85, at 565.

legal principles, thus making it responsive to the first criterion. Arbitrators in court-ordered arbitration programs are not expected to assist the parties in reaching a compromise solution; rather, their function is to make an informed decision based upon the parties' presentations. As such, the process is also well suited among the ADR alternatives for identifying non-meritorious cases, thus qualifying under the second criterion.

Third, a court-ordered arbitration program would employ only skilled decision-makers. As noted, most programs currently use experienced attorneys with expertise in a variety of litigation contexts because those programs cover various types of litigation. If the program were focused on malpractice disputes, special selection criteria could ensure the quality of the arbitrators under the third criterion. Skilled arbitrators would predictably be well suited to make consistent damage awards to the extent possible under the current law of damages, as set forth in the fourth criterion.

Finally, while other ADR options perhaps offer greater potential savings because they operate earlier in the litigation process, court-ordered arbitration occurs at an appropriate time in the development of the suit. The arbitration is held only after the parties have had a reasonable opportunity to conduct some discovery, thus avoiding an acknowledged problem of pre-trial screening panels, such as in Alaska. By the same token, the hearing should occur less than a year from the filing of the claim, thus significantly reducing the current disposition time of most malpractice disputes. Overall, this particular ADR intervention point balances the interest in early intervention with the interest in having the dispute sufficiently developed, so that a valid decision on the merits can be made.

As noted above, a key factor in recognizing the benefits of court-ordered arbitration is effective design and implementation of the program. While theoretically well suited to the task, existing court-ordered arbitration programs, which are currently targeted at a general array of smaller stakes cases, may need to be restructured to maximize their potential utility for malpractice. Possible changes include: (1) specialized methods for selecting arbitrators to serve in the program; (2) development of appropriate discovery rules; and (3) design of an arbitration format suited to the malpractice context.

VI. MALPRACTICE ADR AND ALASKA

Alaska has two statutory provisions impacting the use of ADR in malpractice cases. First, it has an elaborate -- and controversial -- expert

screening panel procedure.[90] In light of the descriptions provided in part III, the Alaska panel system is a hybrid. Although commonly referred to as a screening panel, the Alaska process differs from the panels enacted elsewhere in that it operates not as a *pre-trial* review system, but rather only with respect to claims in which lawsuits have already been filed. Moreover, the panel is composed exclusively of medical professionals, unlike the usual mix of physician, lawyer, and lay members utilized in other states. Finally, the panel's task is not to decide the case, but rather to offer a neutral expert opinion. In fact, in terms of the ADR categories shown in Illustration 2, the process is probably more akin to an early neutral evaluation process focused solely on the issues of the appropriateness of the medical care rendered. In short, the panel system is best characterized as requiring the court appointment of neutral experts.

Alaska also has in place an arbitration statute ostensibly designed to facilitate the use of private arbitration.[91] In fact, however, none of those familiar with malpractice litigation are aware of any claim resolved pursuant to an arbitration agreement under the auspices of this statute. Accordingly, for whatever reason, the malpractice arbitration statute has had no impact on the resolution of malpractice claims in Alaska.

As discussed above, an appropriate ADR strategy is to attempt to reinvigorate the use of private arbitration agreements. In Alaska, at a minimum, this would require removing or scaling back some of the disclosure requirements which interfere with physicians and patients entering into a binding arbitration contract, substituting in their place measures to insure the quality of the arbitration process. As noted, this effort is unlikely in the short-term to radically transform malpractice litigation. Many physicians will continue to elect not to offer the arbitration option to patients. Moreover, unless the Alaska Legislature is willing to permit physicians to require patients to sign such agreements as a condition of receipt of services (which is probably politically unlikely, in light of the serious concerns with access to health care in Alaska), a considerable number of patients will continue to refuse to sign arbitration agreements. Thus, while a revised, more pro-arbitration, statute is needed in order to recognize the benefits that this process offers both patients and physicians, this change by itself is likely to have only marginal short-term impact.

Fundamentally reconstructing the expert panel system will have a significantly greater influence. It is clear that there are several practical problems associated with the administration of the expert panels. It is

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90. ALASKA STAT. § 09.55.536 (Supp. 1992). A detailed description of the expert panel system is contained in Aronie, *supra* note 56.

91. ALASKA STAT. § 09.55.535 (Supp. 1992).

becoming increasingly difficult to form the three-member panels.[92] Alaska has a small physician pool, and many have potentially disqualifying conflicts that prevent them from serving on panels involving their business partners or close friends. As currently operated, the panels, either owing to the difficulty of formation or the scheduling of meetings, are delaying the resolution of claims. Also, inconsistent quality of the panel reports is casting a cloud over the reliability of the process.[93]

As noted above, the best suited ADR option for Alaska is the court-ordered arbitration model. Requiring malpractice cases to be submitted to a mandatory but non-binding process offers significant promise for achieving the goals set forth above.

The court-ordered arbitration model proposed for Alaska is based upon the federal court program described in part III.E. The essential elements of the proposal include: (1) providing an appropriate period for the parties to conduct discovery; (2) developing a qualified list of attorney arbitrators skilled in tort litigation;[94] (3) allowing for party choice in selecting the arbitrator for the non-binding arbitration from among the group of qualified arbitrators; (4) requiring pre-hearing exchange of information; (5) conducting a hearing of sufficient length to permit fair exchange of the issues in the case;[95] (6) preparing a reasoned decision to assist the parties in resolving the case; and (7) providing either party the opportunity to seek trial *de novo*, perhaps allowing the arbitrator's decision to be admissible at the subsequent trial.[96]

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92. *See* Aronie, *supra* note 56, at 419.

93. *Id.* at 418.

94. The list need not be long. It would appear from various insurance and litigation sources that there are about 40 medical malpractice cases filed per year in Alaska. Experience from other court-ordered arbitration programs has shown that a fair number of settlements or dismissals occur prior to the scheduling of the arbitration hearing. Thus, on average, it may be necessary to conduct 30 arbitration hearings a year. A small but highly qualified group of five to ten arbitrators would be sufficient to handle this caseload. Using a smaller, carefully selected group of arbitrators rather than a larger list makes it easier to train the group in how to conduct the sessions and permits the court to be more selective in terms of desired qualifications.

95. Based upon this author's experience in administering arbitrations in malpractice cases, there is no one time period that is perfectly suited to a malpractice dispute. The Private Adjudication Center has conducted arbitrations as short as two hours where the issue involved simply determining a plaintiff's damages in a case in which the physician-defendant had accepted responsibility for the injury. On the other extreme was a two and a half day arbitration involving a complex causation and damage issue following a drug overdose. The court-ordered arbitration rules should provide for the arbitrator to establish the length following a presentation by the parties on the nature of the issues involved in the case. In general, one day would be sufficient for the majority of malpractice cases. The rules should also provide a maximum of two or three days. It should also be possible in some cases for the hearing to last a half day or less.

96. Ordinarily, arbitrations do not result in a formal explanation of the arbitrator's decision; rather, an award is simply announced. This orientation, however, is not required. It makes more sense in this context to ask the arbitrator to explain briefly his or her

The opportunity also exists in Alaska to incorporate a modified version of the current expert panel system into the proposed court-ordered arbitration program. The power to use court-appointed experts is well established.[97] In connection with the proposed arbitration procedure, the court could also appoint a neutral medical expert who would testify during the non-binding arbitration hearing, thus serving the same function as that served by the current panel. In order to overcome the administrative delays associated with the current panel procedure, the number of experts involved should be reduced from three to one.[98]

VII. CONCLUSION

Procedural reform by itself is unlikely to solve the perceived problems with our malpractice litigation system. Nonetheless, the increased use of ADR offers much promise. This comment has set forth a structure for considering available ADR options as well as a reasoned set of criteria for distinguishing among them. Based upon those factors and taking into account the current Alaskan procedures, development of a court-ordered arbitration program for malpractice disputes offers to make the malpractice litigation system fairer to all parties, more consistent, and less costly.

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reasoning in reaching the decision that was made. Cf. WEILER, *supra* note 1, at 115-16 (describing AMA plan to require hearing officers to explain their decisions). Providing a written explanation would assist the parties in settling. Such a decision could also be made admissible at the subsequent trial should any party request a trial *de novo*.

97. *See* FED. R. EVID. 706. For an analysis of one state's use of court-appointed experts in appellate cases, see Francis E. McGovern, *Toward a Fundamental Approach for Managing Complex Litigation*, 53 U. CHI. L. REV. 440, 468-78 (1986).

98. Other changes in the current system would also be advisable. First, the current provision could be simplified so that the parties were responsible for providing the neutral expert with information rather than forcing the physician to independently investigate the matter. Second, the series of questions which the panel now is required to answer could be simplified. This author proposes that the neutral expert be asked to report on the liability and causation issues, in addition to any specific questions posed by the arbitrator. In most cases, the expert would be expected to testify at the hearing (either in person or by telephone).

APPENDIX A

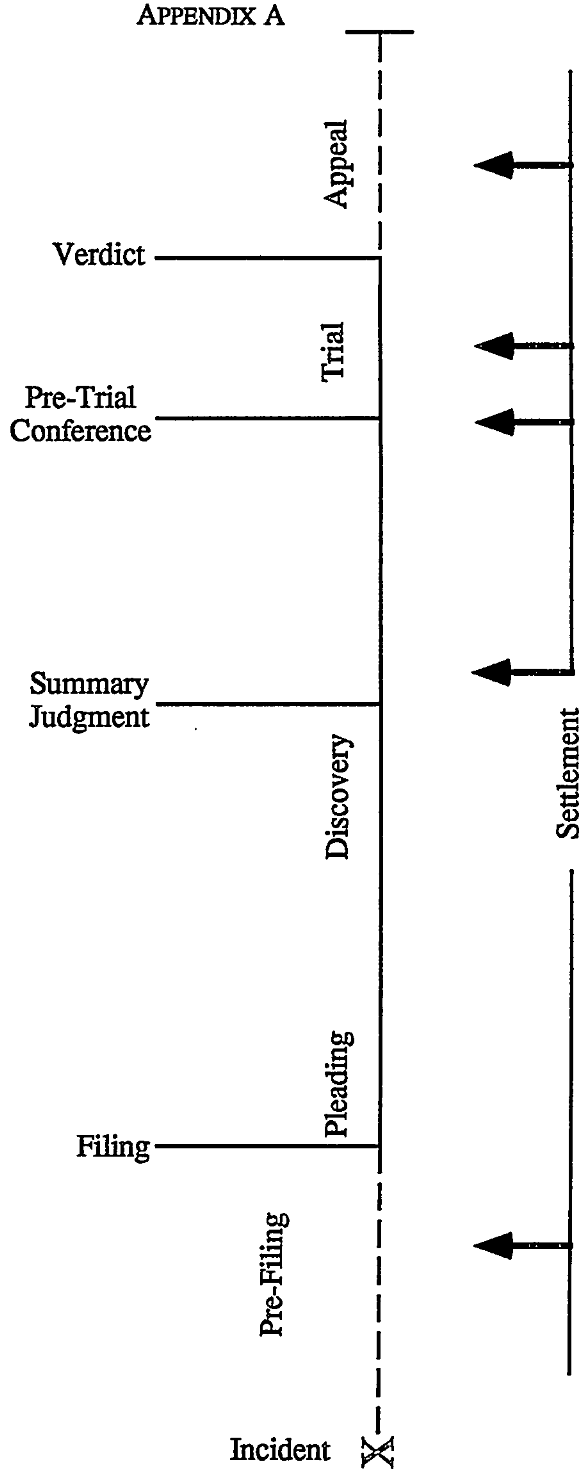

Illustration 1:
Medical Malpractice —
Traditional Litigation Process

APPENDIX B

Illustration 2:
Medical Malpractice —
ADR Options

Arbitration
(2)
(1) Risk Management
(3) Mediation
(7) Jury Determined Settlement
(4) Screening Panel
(5) Neutral Evaluation
Discovery
(6) Court-Ordered Arbitration
(8) Summary Jury Trial
Trial
Appeal